Welcome To
The TRICARE Fundamentals Course
October–December 2012

The TRICARE Fundamentals Course (TFC) is a three-day basic course designed for those who provide assistance and counseling to TRICARE beneficiaries. It offers training on the most up-to-date TRICARE information from skilled instructors and an opportunity to interact with others associated with the Military Health System (MHS). There are no prerequisites; however, the course is tailored to MHS support staff with less than three years of TRICARE experience.

This TFC Participant Guide serves as your training tool and as a valuable resource after course completion. There are 15 modules with specific learning objectives. Discussion topics include TRICARE eligibility, TRICARE program options, transitional benefits, pharmacy and dental coverage, and more. Where convenient, stateside and overseas is presented in parallel. Application exercises and real-world scenarios are offered to test participant's current and newly acquired knowledge.

Throughout the Guide, resources are identified to aid in understanding the concepts of TRICARE. These resources include websites and other electronic resources, acronyms and a glossary of key terms.

On the final day of the course, instructors administer a 50-question final exam. Participants must score at least 80% to pass. They must also complete an online course evaluation to receive a Certificate of Training, which will be sent via e-mail within seven business days following receipt of the evaluation.

Once participants have returned to the workplace, they should visit www.tricare.mil for any further questions they may have regarding the TRICARE benefit. To receive TRICARE updates focused on customer service and support, participants may visit www.tricare.mil/customerservicecommunity and bcacdcao@tma.osd.mil to be added to the update list serve.

At the time of printing, the information in this Participant Guide is current, but must be read in light of governing statutes and regulations and is not a substitute for legal advice from qualified counsel, as appropriate. 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 the managed care support contractor for your region or a local TRICARE Service Center.

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Introduction to Basic TRICARE Concepts and Terms

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Module Objectives

- **Identify the four TRICARE regions**
- **Describe the types of TRICARE-authorized providers**
- **List terms commonly associated with TRICARE costs**

1.0 The Military Health System (MHS)

The Military Health System (MHS) is the interconnected and interdependent web of organizations that carry out the military health care mission. The MHS includes those employed or contracted by the Department of Defense (DoD) to deliver care on the battlefield, on ships, in the air, and in military hospitals and clinics.

Understanding health care under the MHS requires an understanding of the two distinct types of care: direct care, which is health care provided within the military treatment facility (MTF), and purchased care, which is health care received from a civilian TRICARE-authorized or host nation provider.

2.0 TRICARE

- TRICARE is the worldwide purchased care health care program serving active duty service members (ADSMs), Guard/Reserve members, retirees, their families, survivors and certain former spouses.
- As a major component of the Military Health System (MHS), TRICARE supplements the health care resources of the uniformed services with networks of civilian health care professionals, facilities, pharmacies and suppliers to provide access to high-quality health care services, while maintaining the capability to support military operations.

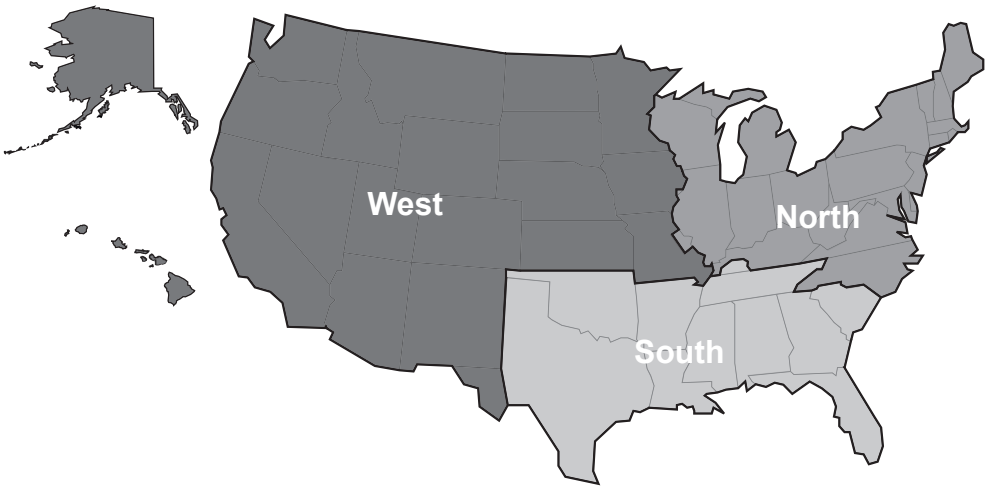
3.0 TRICARE Regional Concept

TRICARE is managed through four geographic health service regions: three in the United States and one encompassing all overseas locations. Each region has a contractor who administers and coordinates health care services between uniformed service/military hospitals and clinics and its network of civilian hospitals and providers.

3.1 Stateside

Each of the three stateside TRICARE regions is overseen by a TRICARE Regional Office (TRO): TRO-North, TRO-South, and TRO-West. The TROs are government offices that oversee health care delivery in their region to ensure regional contractors fulfill their contractual responsibilities.

TRICARE Stateside Regions



3.1.1 North Region

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

3.1.2 South Region

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

3.1.3 West Region

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

3.2 Overseas

- The TRICARE Overseas Program (TOP) is TRICARE's health care program outside the 50 United States and the District of Columbia. The TOP offers health care coverage to beneficiaries living and traveling overseas while allowing for significant cultural differences unique to foreign countries and their health practices.
    - Cultural differences may apply to things like location of care (e.g., a provider comes to a patient's home) or the way care is provided (e.g., medical services commonly performed in the states may be performed by a physician's assistant, depending on the country)
- The TRICARE Area Offices (TAOs) monitor care in the overseas region and are responsible for developing and delivering plans for health care delivery. There is one Overseas Region divided into three overseas areas:
    - TRICARE Eurasia-Africa (encompasses Africa, Europe, and the Middle East)
    - TRICARE Latin America and Canada (TLAC) (encompasses Canada, the Caribbean basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)
    - TRICARE Pacific (encompasses Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries)

TRICARE Overseas Region

4.0 TRICARE Providers

Beneficiaries may see different types of providers, depending on the plan they use.

4.1 Military Treatment Facilities (MTFs)

- MTFs are usually located on or near a uniformed service/military installation and are medical clinics and hospitals where TRICARE beneficiaries may receive care from military and civilian providers and support staff. Pharmacy services are available at most MTFs.
- Active duty service members (ADSMs) and TRICARE Prime-enrolled active duty family members (ADFMs) have the highest priority for MTF care.
- Non-TRICARE Prime enrollees receive MTF care at an MTF on a space-available basis.

4.2 Authorized Providers (Civilian)

- An authorized provider is any individual, institution/organization, or supplier that is licensed by a state, accredited by a national organization, or meets other standards of the medical community and is certified to provide benefits under TRICARE.
- It's the beneficiary's responsibility to determine whether a provider is TRICARE-authorized.
- Regional contractors must verify a provider's authorized status before they pay any portion of a claim.

4.2.1 Subsets of Authorized Provider Types

Provider Type	Stateside	Overseas
Network	An individual, institution, or organization serving TRICARE beneficiaries through a contractual agreement with a regional contractor	A host nation individual, institution, or organization certified to provide care to overseas TOP Prime or TOP Prime Remote beneficiaries through an established agreement with the TOP contractor Provides "cashless, claimless"* care to TOP Prime or TOP Prime Remote beneficiaries, as long as care was authorized by the TOP Contractor
Non-Network Participating	An authorized provider who has no contractual agreement with the regional contractor A participating provider accepts the TRICARE-allowable charge as payment in full	Host nation non-network providers who do not have an established relationship with the TOP contractor May require beneficiaries to pay up front and file their own claims
Non-Network Non-Participating	An authorized provider who does not accept the TRICARE-allowable charge as payment in full for covered services May bill beneficiaries up to 15% above the TRICARE-allowable charge	Not applicable

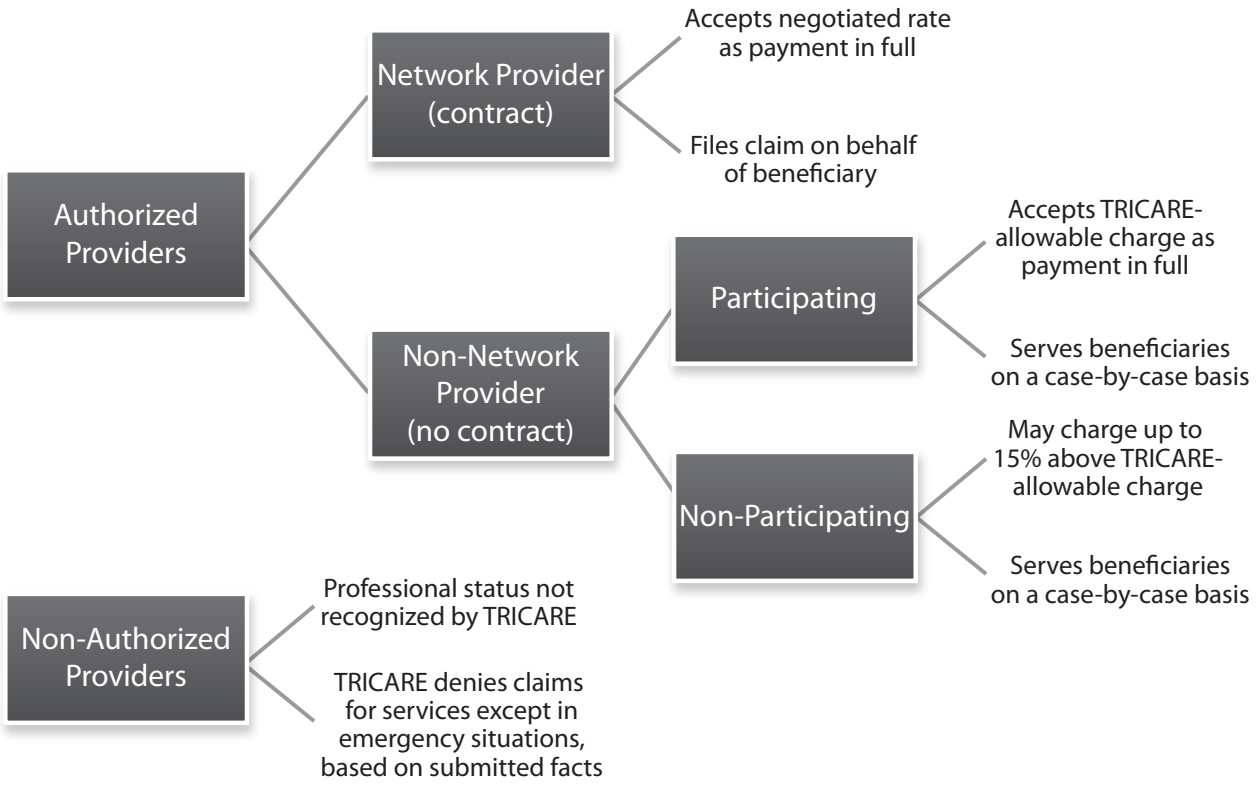
* *"Cashless, claimless" means the overseas contractor authorized a visit and payment to a certified host nation provider. The provider files the claim and doesn't require the enrollee to pay up front.*

4.2.2 Non-Authorized Providers

A non-authorized provider is a provider whose professional status is not recognized by TRICARE. Providers may be non-authorized because they: (a) do not meet state licensing or training requirements; (b) don't seek to or decline to treat TRICARE-eligible beneficiaries; (c) are not in a provider class recognized by TRICARE; or (d) provide care outside TRICARE's benefit structure (e.g., acupuncture).

- TRICARE denies claims from non-authorized providers, except in emergency situations, based on submitted claims and supporting documentation (if needed).
- If beneficiaries ask if their provider can become an authorized provider, refer them to www.tricare.mil/providers or their regional contractor.

4.2.3 Illustration of Provider Types



4.3 Finding a Provider

- Stateside: Before getting care, beneficiaries should ask providers if they're a TRICARE-authorized network or non-network participating provider, as these are less costly options.
- For a list of network providers, visit the following websites or contact the regional contractor:
  - Stateside
    - TRICARE Website: www.tricare.mil/findaprovider
    - TRICARE North Region: www.hnfs.com/apps/providerdirectory
    - TRICARE South Region: www.humana-military.com (Select "Find a Provider" on the Beneficiary tab.)
    - TRICARE West Region: www.triwest.com/onlineproviderdirectory
  - Overseas
    - TRICARE Overseas Region: www.tricare-overseas.com/providersearch

Note: Provider directories are always subject to change. Beneficiaries should check with their regional contractor to locate network providers and call the provider's office to validate the provider's status. A listing in a directory does not guarantee the provider's information is current or that a provider is accepting new patients.

5.0 TRICARE and Veterans Affairs Benefits

- Certain former service members are eligible for both TRICARE and Veterans Affairs (VA) benefits and may choose which benefits to use.
- VA-TRICARE eligibles may seek TRICARE-covered services, even if they have received treatment through the VA for the same medical condition during a previous episode of care.
- TRICARE doesn't pay for service-connected disability care that has been authorized or paid for by the VA.

6.0 Terms Associated with TRICARE Costs

Billed Charge	The provider's proposed total cost without any discounts or reduced fees. **Note:** Beneficiary cost-shares overseas are based on the purchased care/host nation provider's billed charges (with some exceptions—e.g., Philippines, Panama).
TRICARE-Allowable Charge	The maximum amount TRICARE pays for a procedure or service. By law, it's tied to Medicare's reimbursement rates when practical. The TRICARE-allowable charge varies depending on the location of care and type of provider (network versus non-network).
Deductible	The annual amount a beneficiary pays under TRICARE Standard options for covered outpatient services before TRICARE begins to share costs.
Cost-Share	The percentage of the TRICARE-allowable charge beneficiaries and the government pay under Standard options. The cost-share amount depends on the sponsor's status.
Copayment	The fixed amount TRICARE Prime option enrollees will pay for care in the civilian provider network. TRICARE Prime active duty family members are not required to pay copayments (except for pharmacy services).
Catastrophic Cap	The maximum amount a family pays out-of-pocket for TRICARE-covered services or supplies per fiscal year (October 1–September 30). Payments counted toward a catastrophic cap include: ● Deductibles ● Cost-shares ● Prescription copayments ● Prime enrollment fees
Balance Billing	Occurs when a non-network non-participating provider bills the beneficiary the difference between the billed charges and the TRICARE-allowable charge (stateside only).
Explanation of Benefits (EOB)	A statement, prepared by insurance carriers, health care organizations, and TRICARE, informing beneficiaries and providers of actions taken on a claim for health care coverage.
Foreign Fee Schedule	A country-specific payment determination for provider services (currently only used in the Philippines and Panama). Used to calculate deductibles and cost-shares.

Module Objectives

- **Identify the four TRICARE regions**
- **Describe the types of TRICARE-authorized providers**
- **List terms commonly associated with TRICARE costs**

TRICARE Fundamentals Course

Electronic Resources (Online and Mobile Applications)

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References
www.tricare.mil
www.health.mil
www.tricareonline.com
www.tricare.mil/tricareu
http://manuals.tricare.osd.mil
www.TRICARE4u.com
www.myTRICARE.com
www.hnfs.com
www.humana-military.com
www.triwest.com
www.tricare.mil/tricaresmart
www.tricare.mil/factsheets
www.dmdc.osd.mil/milconnect
http://metlife.com/tricare/index.html
www.addp-ucci.com
www.trdp.org
www.pec.ha.osd.mil/formulary_search.php

Brainteaser

What word or phrase is represented below?

Riddle

What comes once in a minute, twice in a moment, but never in a thousand years?

Module Objectives

- **List the online resources available to TRICARE beneficiaries**
- **Recognize the online resources available to BCACs and other MHS support staff**
- **Identify the mobile applications available to TRICARE beneficiaries**

If you serve in a customer service role, you will likely find the following online resources invaluable in finding and providing information and assistance to beneficiaries. Sometimes, you may be looking for benefit information from an official perspective. In these cases, use the TRICARE Manuals website (covered in Section 2.5 of this module). Other times, you may need to help a beneficiary navigate a website or register for self-service options. Please consider the web as the go-to source for help in educating yourself and the beneficiaries you serve.

1.0 General Online Resources for TRICARE Beneficiaries and Customer Service Staff

1.1 TRICARE Website (www.tricare.mil)

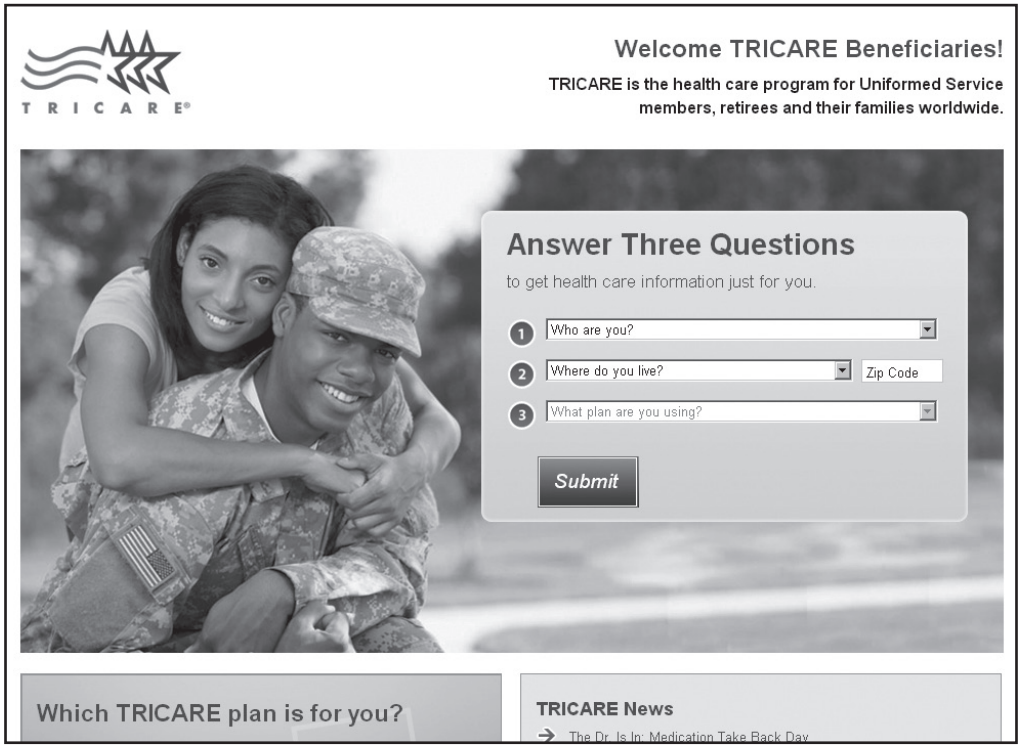
The TRICARE website is the definitive and authoritative online source for TRICARE information. The home page features a simplified profile entry to give beneficiaries the best possible user-experience. After entering their profile by answering three questions, beneficiaries receive health care information that is tailored to them, including sections on Costs, Medical, Dental, Vision, Prescriptions, Mental Health and Behavior, and Life Events.

The home page features:

- Direct access to the Plan Finder for beneficiaries who need help learning what options are available to them
- A search tool for covered services (Visit www.tricare.mil/medical and select the “covered services” tab.)
- News and announcements regarding the latest TRICARE updates
- Quick access to TRICARE’s other web portals which include links for staff, providers, vendors, and the media

Direct links to useful information within the website include:

www.tricare.mil/overview	www.tricare.mil/vision
www.tricare.mil/costs	www.tricare.mil/pharmacy
www.tricare.mil/medical	www.tricare.mil/mentalhealth
www.tricare.mil/dental	www.tricare.mil/lifeevents



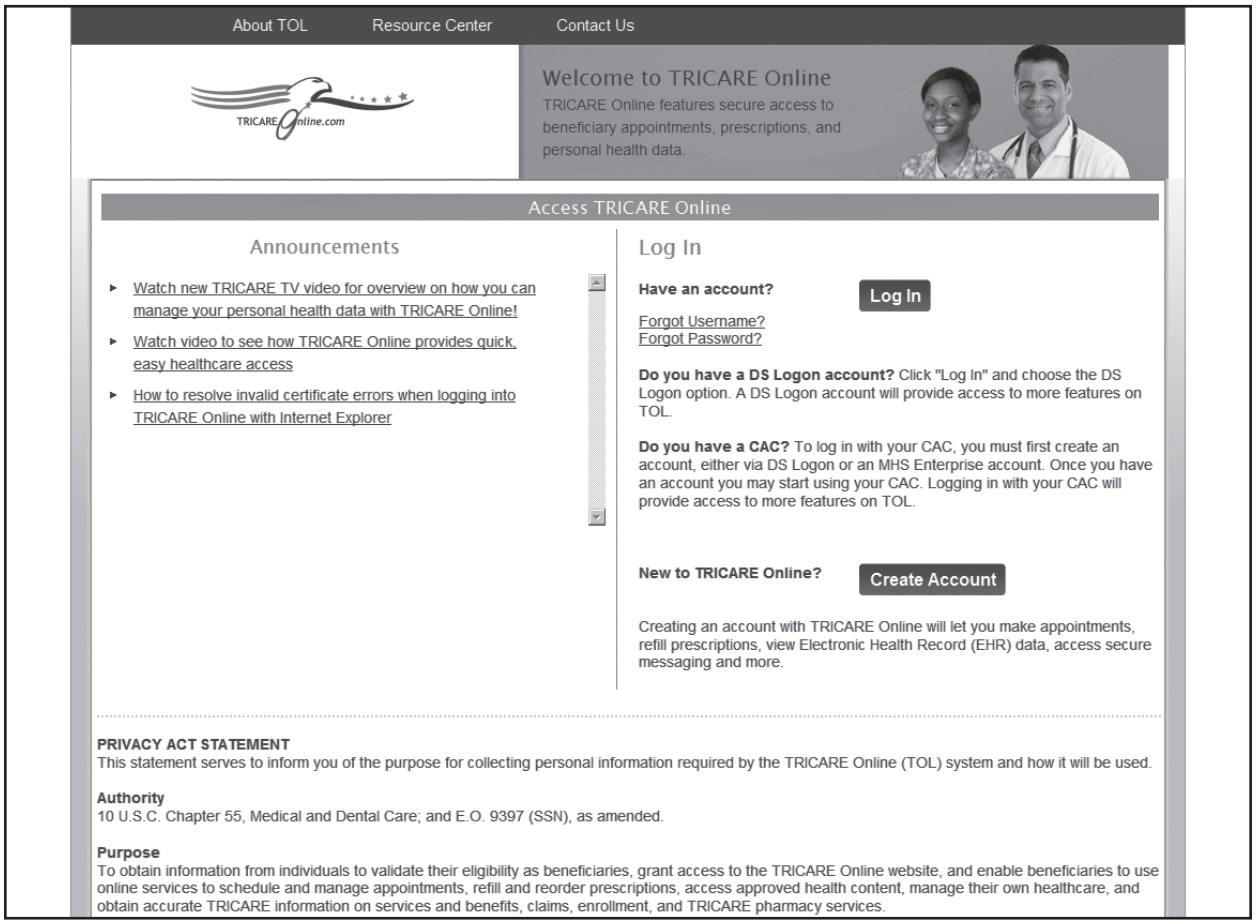
1.2 TRICARE Online Website (www.tricareonline.com)

TRICARE Online is a secure web portal that offers registered users:

- Announcements and news features
- Access to general health information
- Information on available benefits and services
- MTF and regional website information
- Drop-down navigation menus

TRICARE Online authorized users receiving care through a military treatment facility (MTF) can also:

- Schedule MTF appointments online (Prime enrollees only)
- Access personal health information
- Use pharmacy tools
- Check medications
- Access military staff applications



1.3 Military Health System (MHS) Website (www.health.mil)

Health.mil is the official website for the MHS. It features medical news from the following entities:

- Air Force Medicine
- Army Medicine
- Coast Guard Medicine
- Navy Medicine
- Public Health Service
- TRICARE Management Activity
- Uniformed Services University of Health Sciences
- U.S. Department of Health and Human Services (DHHS)
- Veterans Affairs (VA)

The website also contains a blogging feature that enables MHS support staff and other users to share information online.

1.4 Media Center (www.tricare.mil/mediacenter)

The TRICARE Media Center is a website for beneficiaries, journalists, and news media to view basic information about TRICARE and changes to the TRICARE benefit. It also serves as an outreach tool through connections to a variety of social media platforms.

1.5 milConnect (http://milconnect.dmdc.mil)

The milConnect website is provided by the Defense Manpower Data Center (DMDC) and allows sponsors, spouses, and their children (18 years and older) to view information that goes directly into the Defense Enrollment Eligibility Reporting System (DEERS). Sponsors are able to view all information on family members listed in DEERS, while family members can see their own information only.

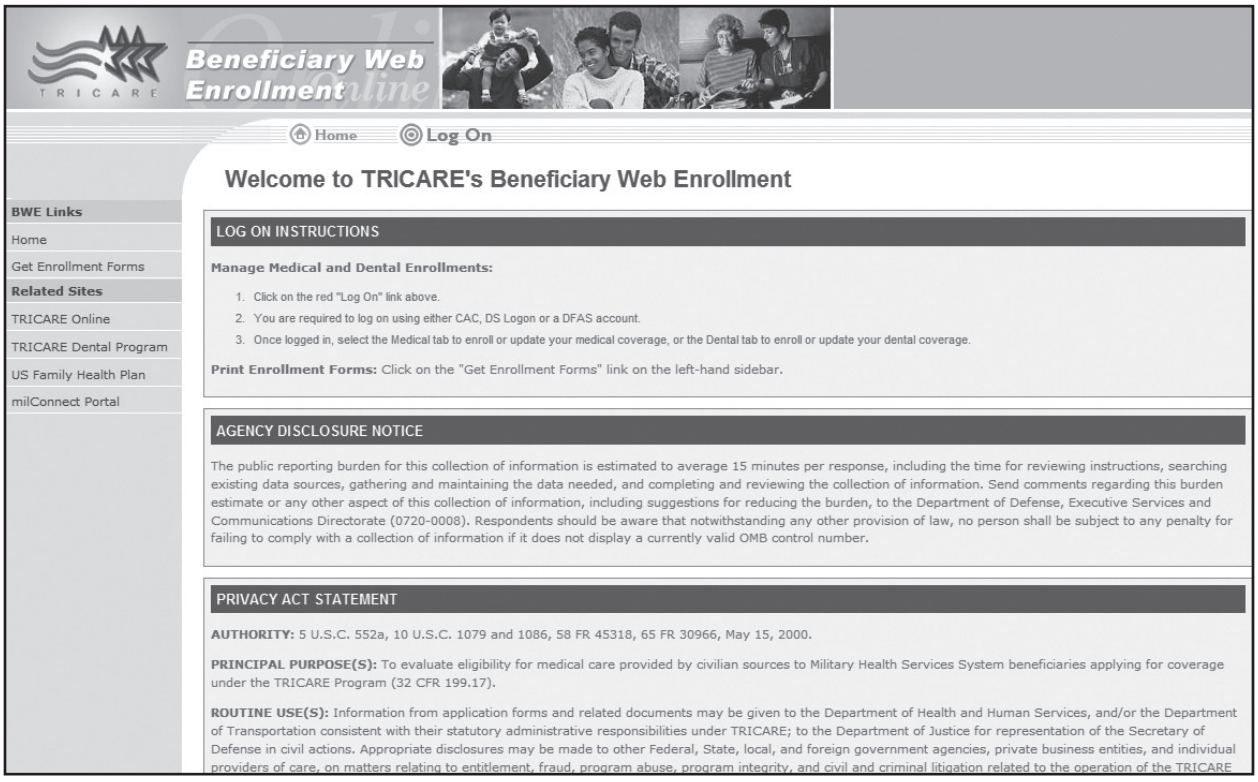
- milConnect allows beneficiaries to:
  - Update DEERS contact information
  - Manage health care enrollment
  - Locate the nearest military ID card-issuing facility
  - View personal information
  - Transfer education benefits to eligible family members
  - View group life insurance information
  - Update civilian employment information (only for Army National Guard, Air Force Reserve and Air National Guard beneficiaries)
  - Manage other health insurance information (OHI)
- Users may log on using one of three secure methods:
  - Common Access Card (CAC)
  - Defense Finance and Accounting Services (DFAS) myPay Account
  - Department of Defense Self Service (DS) Logon

Note: Sponsors must request DS Logons for family members. They should select the “Sign Up” tab and then select “Sign Me Up!” for more information.

1.6 Beneficiary Web Enrollment (www.dmdc.osd.mil/appj/bwe)

- The Beneficiary Web Enrollment (BWE) website allows TRICARE Standard and Extra beneficiaries to:
  - Enroll in a TRICARE Prime program (if eligible)
  - Update contact or personal information in DEERS (e.g., home address, phone number, e-mail address)
  - Enroll in the TRICARE Dental Program (if eligible)
- TRICARE Prime, TRICARE Prime Remote, TRICARE Prime Remote for Active Duty Family Members, US Family Health Plan, TRICARE Young Adult, or TRICARE Dental Program beneficiaries may use BWE to:
  - Enroll or disenroll
  - Change active duty enrollment to retiree enrollment and pay Prime enrollment fee
  - Transfer enrollment within a region or to another region in the United States
  - Choose or change a primary care manager (PCM)
  - Request a new enrollment card
  - Make initial enrollment fee payments
  - Update contact information in DEERS (e.g., home address, phone number, e-mail address)
  - Add OHI information
  - Enroll in the TRICARE Dental Program (if eligible)

Note: Beneficiaries living in an overseas location can't use BWE to enroll in a TRICARE Prime option unless they're transferring from an overseas location to the United States. The transfer must be reported in DEERS before using BWE.



1.7 TRICARE Smart (www.tricare.mil/tricaresmart)

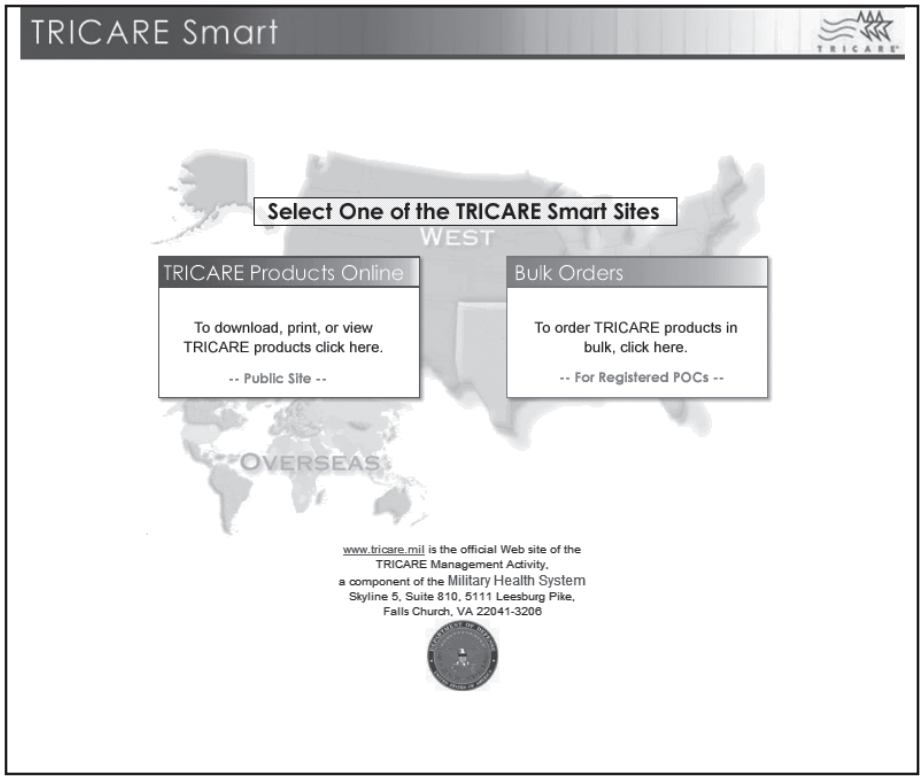
The TRICARE Smart site is the main source for viewing and ordering TRICARE print products online.

Beneficiaries and customer service staff can view, print, e-mail or download copies of TRICARE brochures, booklets, handbooks, and other products.

Registration and approval are required to order products from the TRICARE Publications Bulk Order Site. Registered Beneficiary Counseling Assistance Coordinators (BCACs) can serve as bulk order contacts if there is no one else designated at the same location.

After registration, a representative from TMA's Beneficiary Education and Support (BE&S) Division assists with completing quarterly product ordering or providing access to needed products.

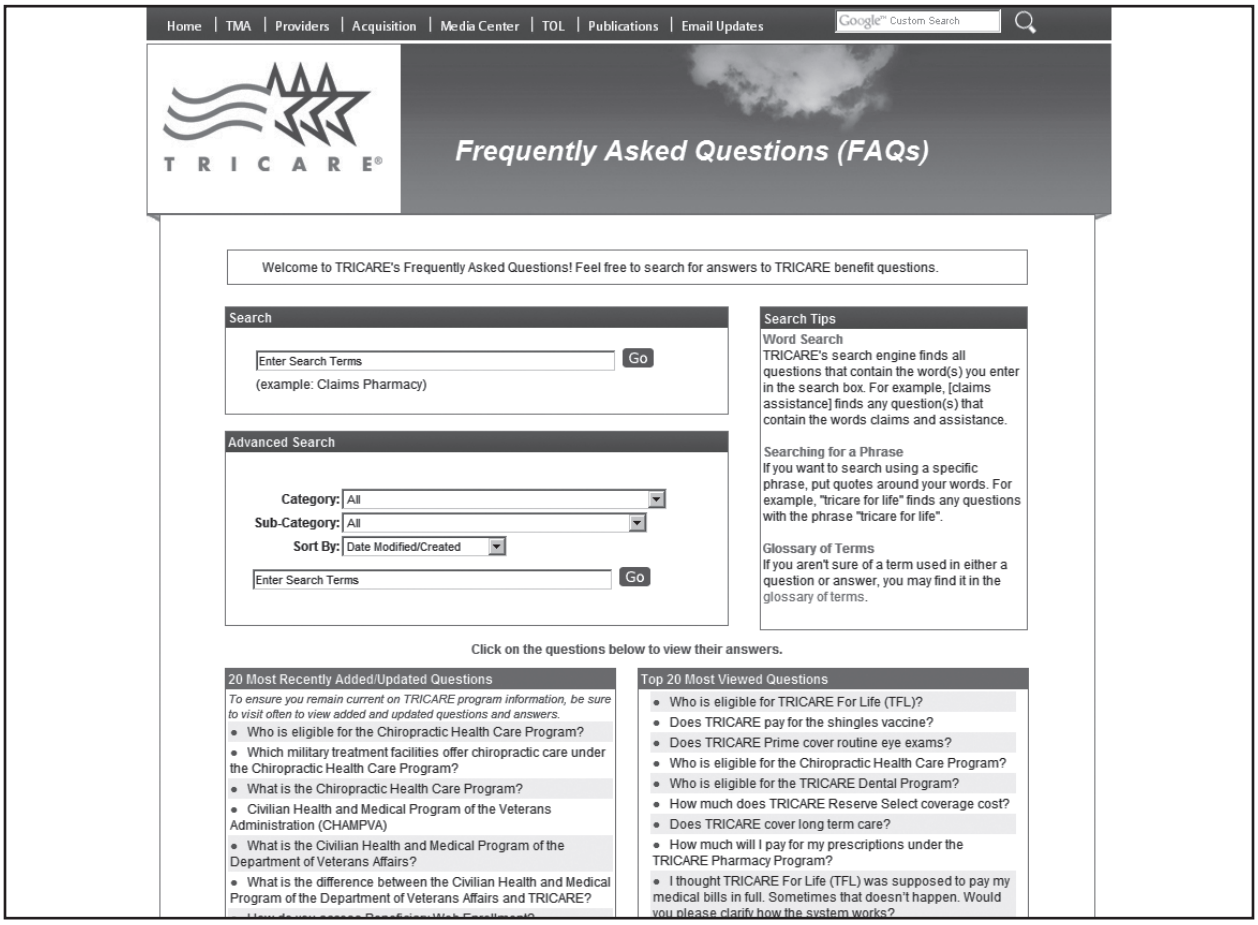
Address questions about TRICARE Smart to: tricarebulkorders@tma.osd.mil.



1.8 Frequently Asked Questions (FAQs) (www.tricare.mil/faqs)

The FAQs are a useful tool for TRICARE beneficiaries, as well as those who assist them. Visitors are able to search FAQs by keyword or with a key phrase. The home screen features the “20 Most Recently Added/Updated Questions” and the “Top 20 Most Viewed Questions”.

To remain current on TRICARE program information, be sure to visit FAQs to view added and updated questions and answers.



1.9 Wisconsin Physicians Services (WPS) (www.TRICARE4u.com)

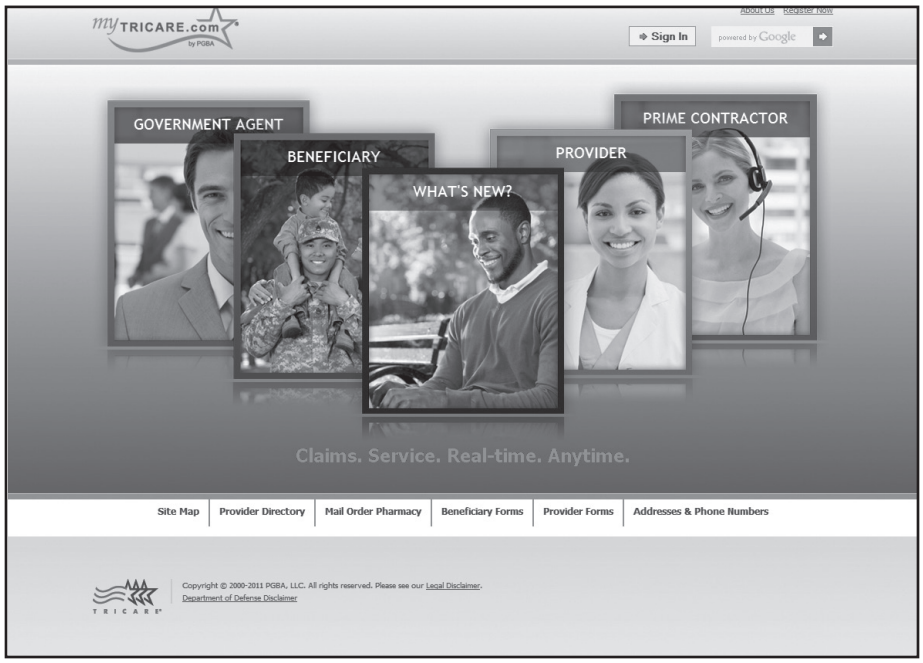
WPS is the claims processor for the West region, Overseas region, and TRICARE For Life (TFL).

"TRICARE4u.com" is the website where registered users (e.g., beneficiaries, BCACs/DCAOs, physicians) can check the status of claims entered into the WPS system.

1.10 Palmetto Government Benefits Administrators (PGBA) (www.myTRICARE.com)

PGBA is the claims processing contractor for the North and South regions.

On the website "www.myTRICARE.com", registered users (e.g., beneficiaries, BCACs/DCAOs, physicians) can check the status of claims entered into PGBA's system.

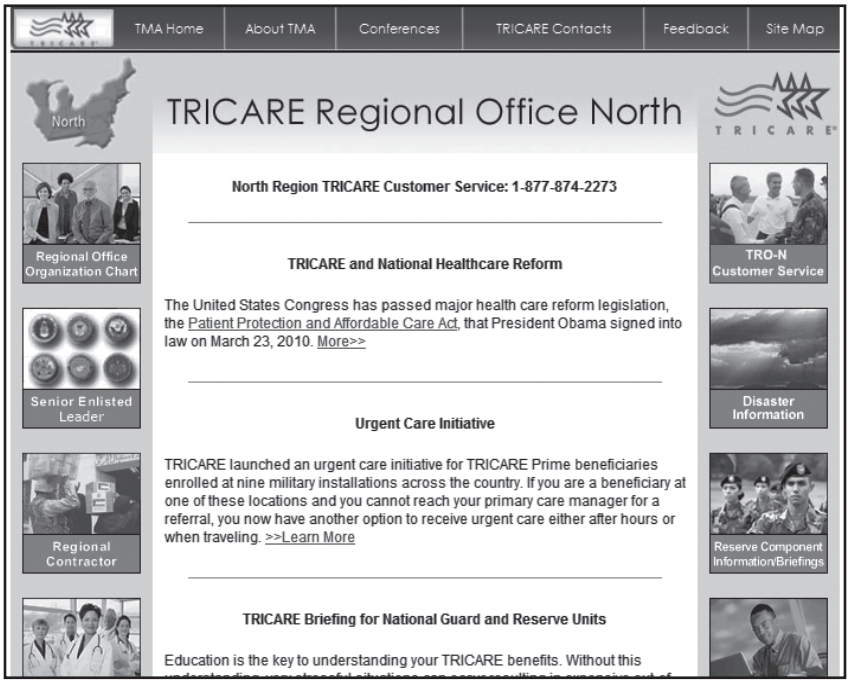


1.11 TRICARE Regional/Area Offices (TRO/TAO) and Regional Contractors

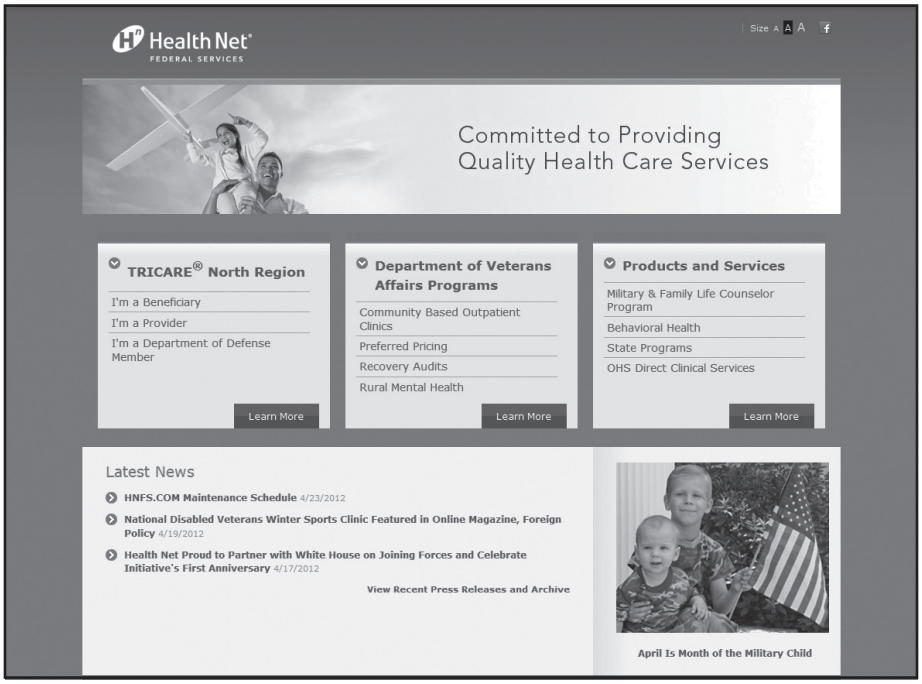
Each TRICARE Regional and Area Office has a website where beneficiaries and MHS staff can go for region specific information, updates, initiatives, and contact information that the TRO/TAO feel are beneficial to readers.

Each regional contractor hosts a website that provides general and specific information for beneficiaries, providers, and MHS staff. They provide information related to enrollment, authorizations and referrals, claims, and covered services.

1.11.1 TRICARE Regional Office—North (www.tricare.mil/tronorth)



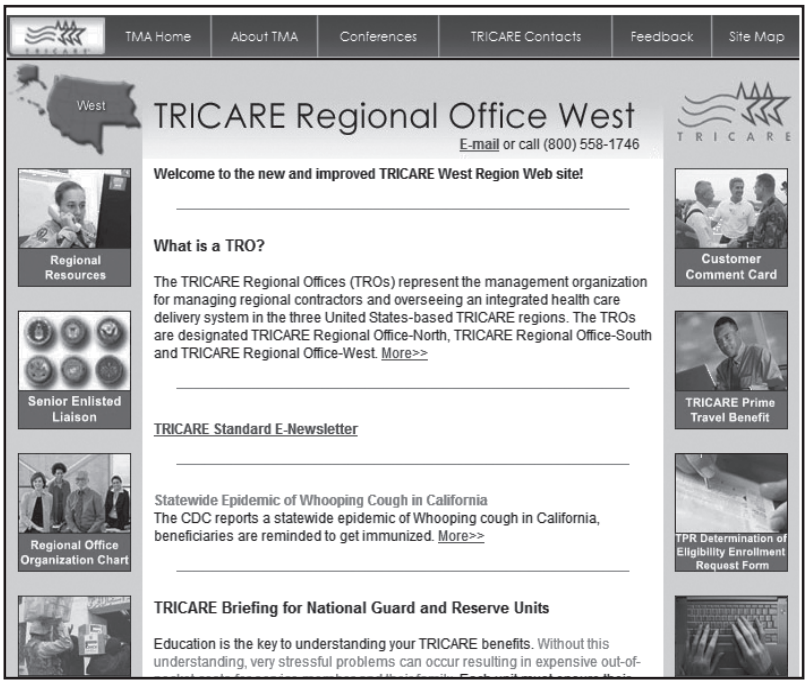
1.11.2 TRICARE Regional Contractor—North Region (www.hnfs.com)



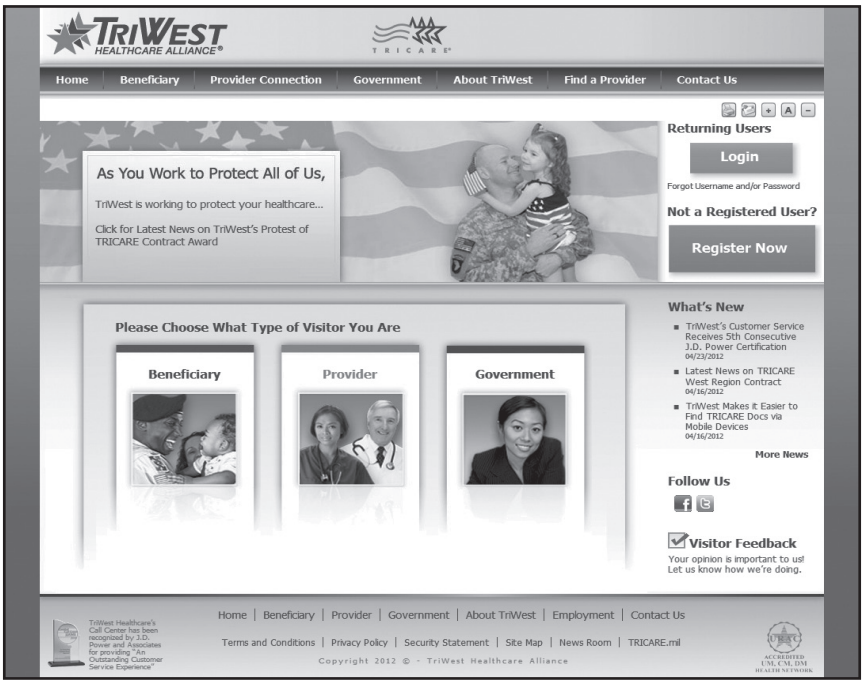
1.11.3 TRICARE Regional Office—South (www.tricare.mil/trosouth)

1.11.4 TRICARE Regional Contractor—South Region (www.humana-military.com)

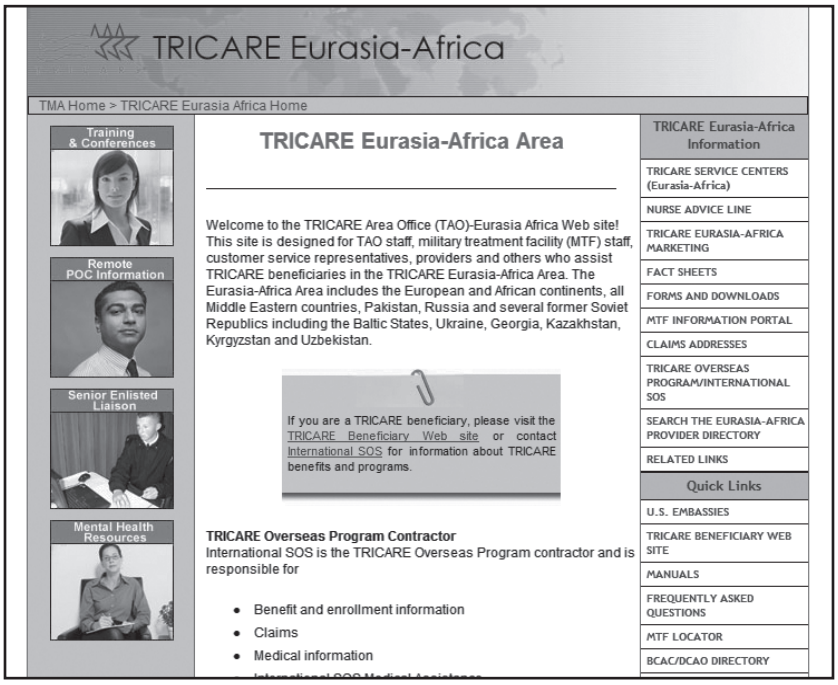
1.11.5 TRICARE Regional Office—West (www.tricare.mil/trowest)



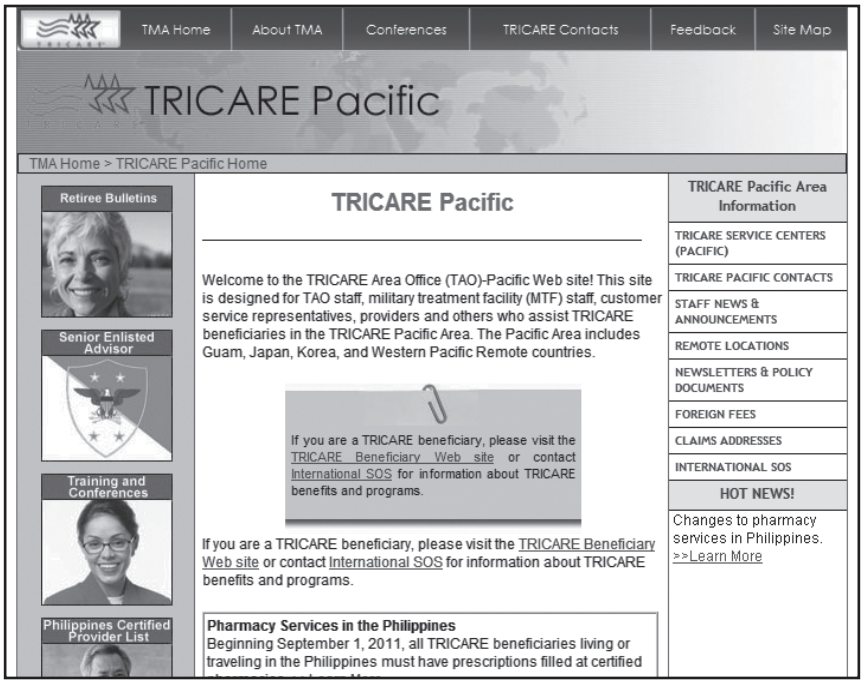
1.11.6 TRICARE Regional Contractor—West Region (www.triwest.com)



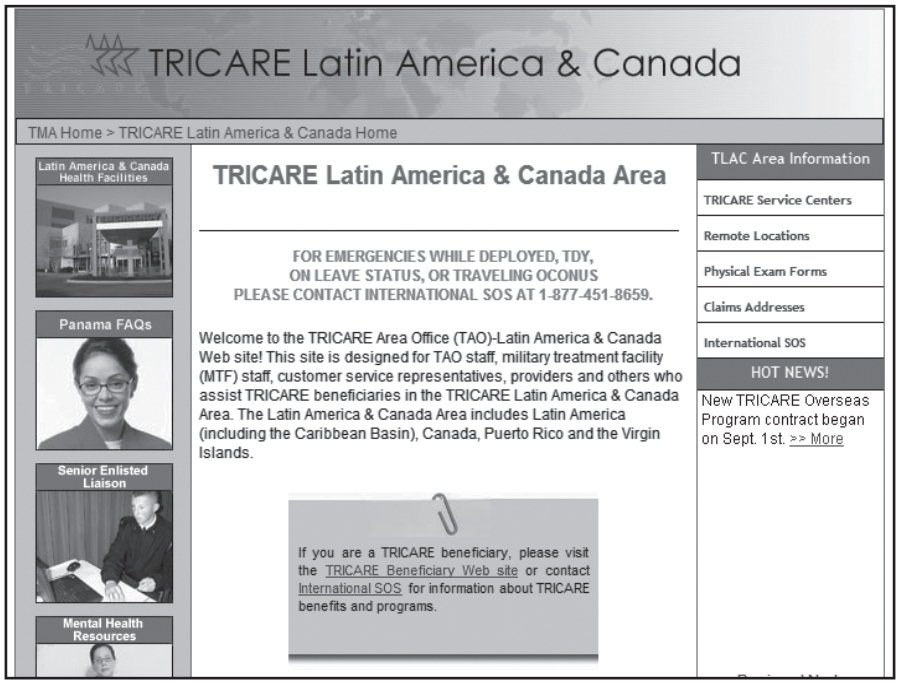
1.11.7 TRICARE Area Office—Eurasia-Africa (www.tricare.mil/eurasiaafrica)



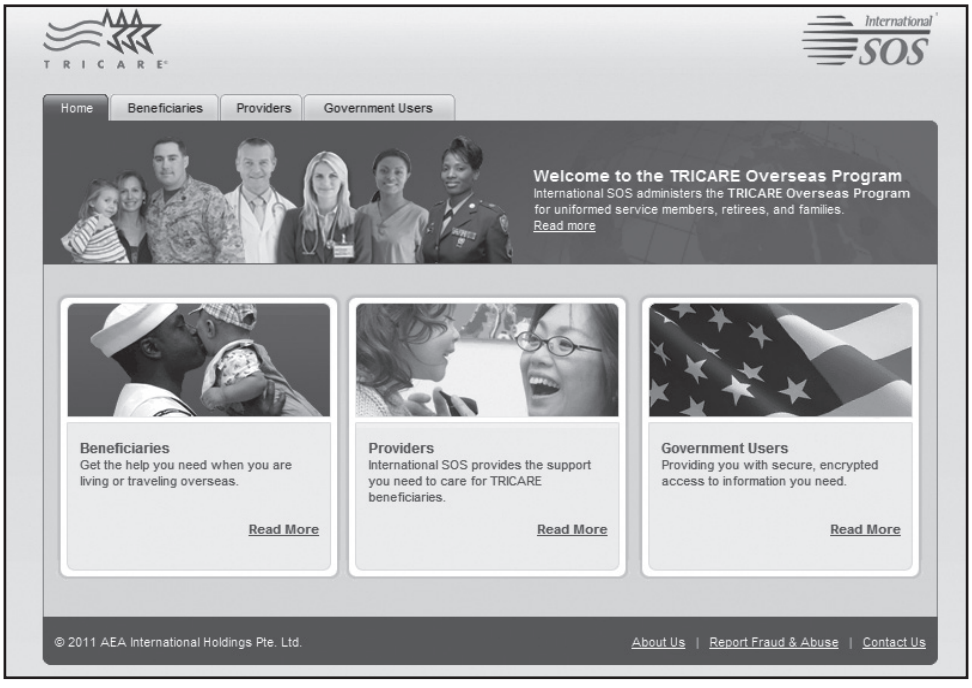
1.11.8 TRICARE Area Office—Pacific (www.tricare.mil/pacific)



1.11.9 TRICARE Area Office—Latin America and Canada (TLAC) (www.tricare.mil/tlac)



1.11.10 TRICARE Regional Contractor—Overseas Region (www.tricare-overseas.com)

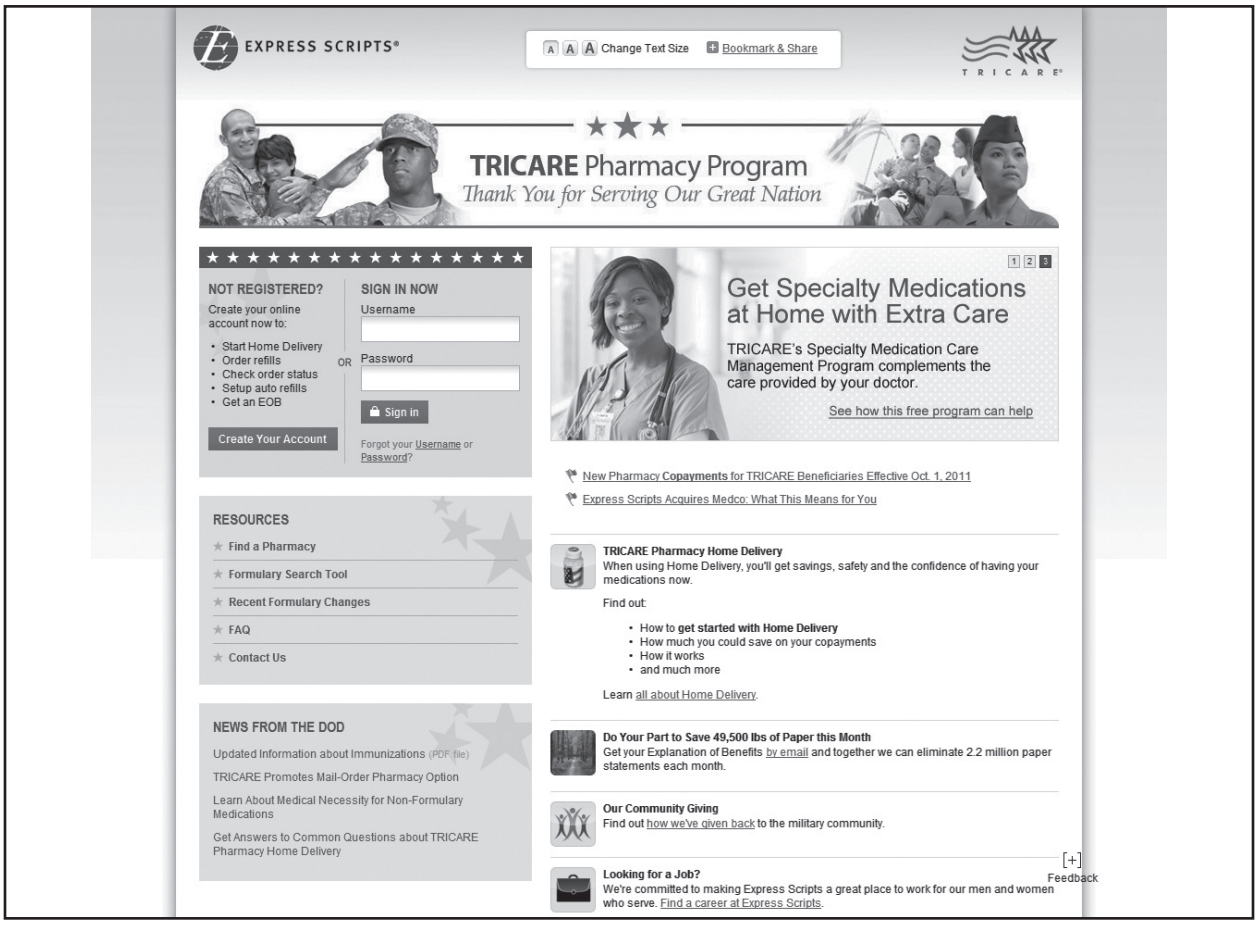


1.12 TRICARE Pharmacy Program Contractor (www.express-scripts.com/TRICARE)

The Express Scripts website is a useful tool for beneficiaries. Once beneficiaries register they are able to:

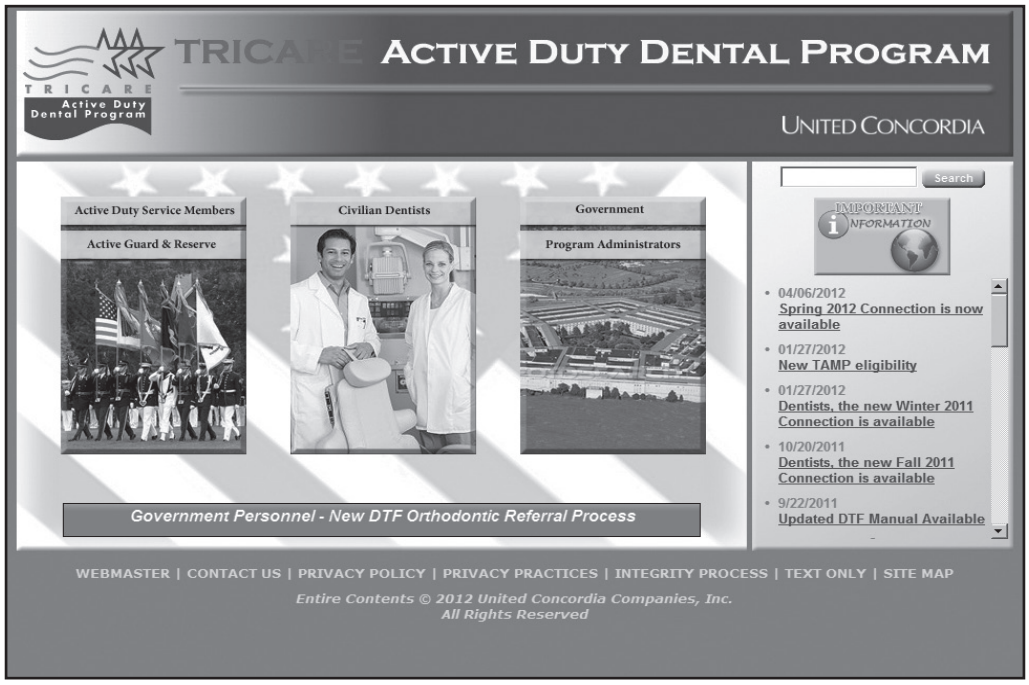
- Find a retail pharmacy
- Enroll in Pharmacy Home Delivery
- Order refills
- Check the status of an order
- Setup order refills
- Review and print their Explanation of Benefits (EOB)

(See Section 2.4 of this module for information on the Formulary Search Tool.)



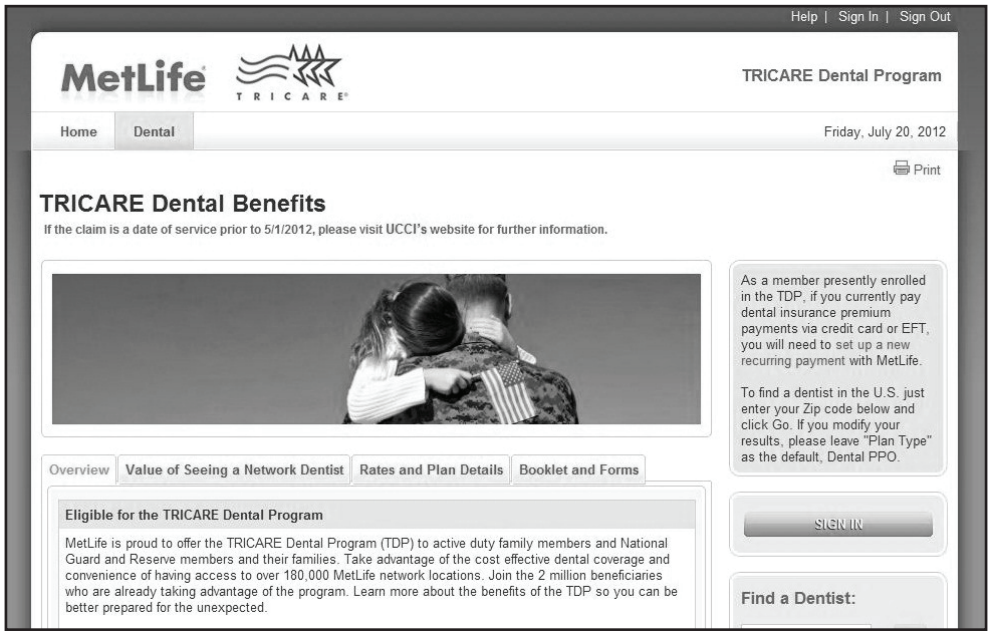
1.13 Active Duty Dental Program (ADDP) Contractor (www.addp-ucci.com)

The ADDP website is designed for active duty service members and provides information about eligibility, benefits, finding a dentist, and making an appointment.



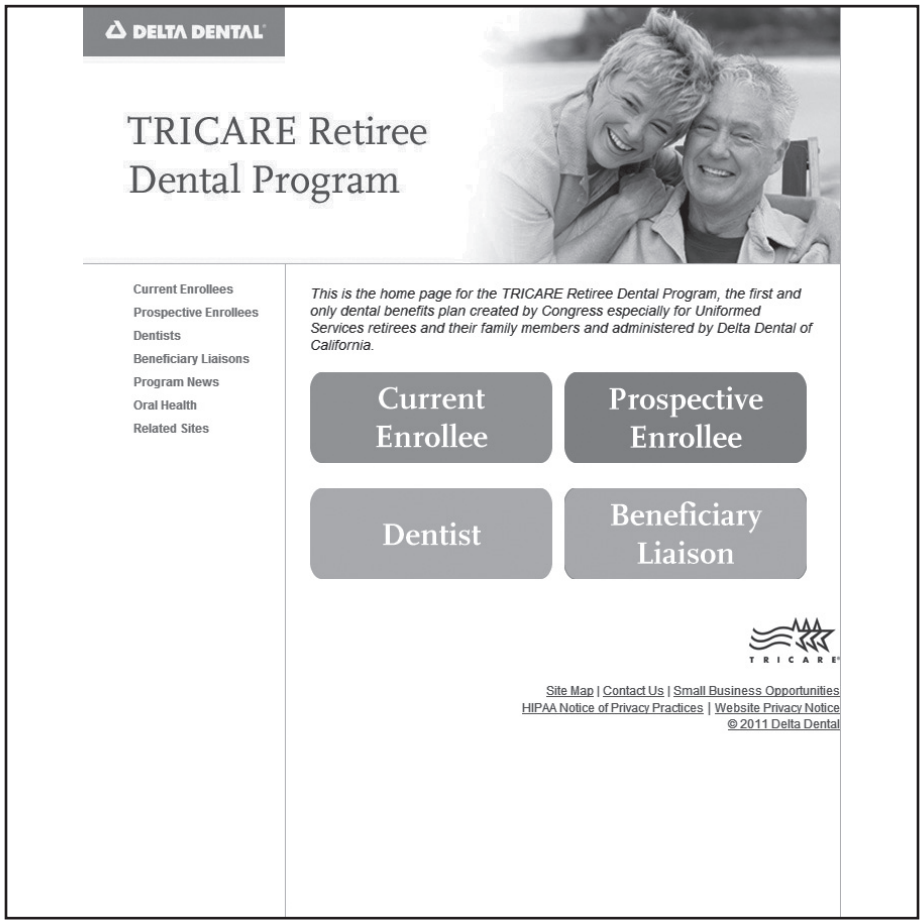
1.14 TRICARE Dental Program (TDP) Contractor (http://mybenefits.metlife.com/tricare)

The TDP website provides beneficiaries an online benefit booklet, forms to download (including a recurring payment/change authorization document), details on rates, and a stateside dentist finder.



1.15 TRICARE Retiree Dental Program (TRDP) Contractor (www.trdp.org)

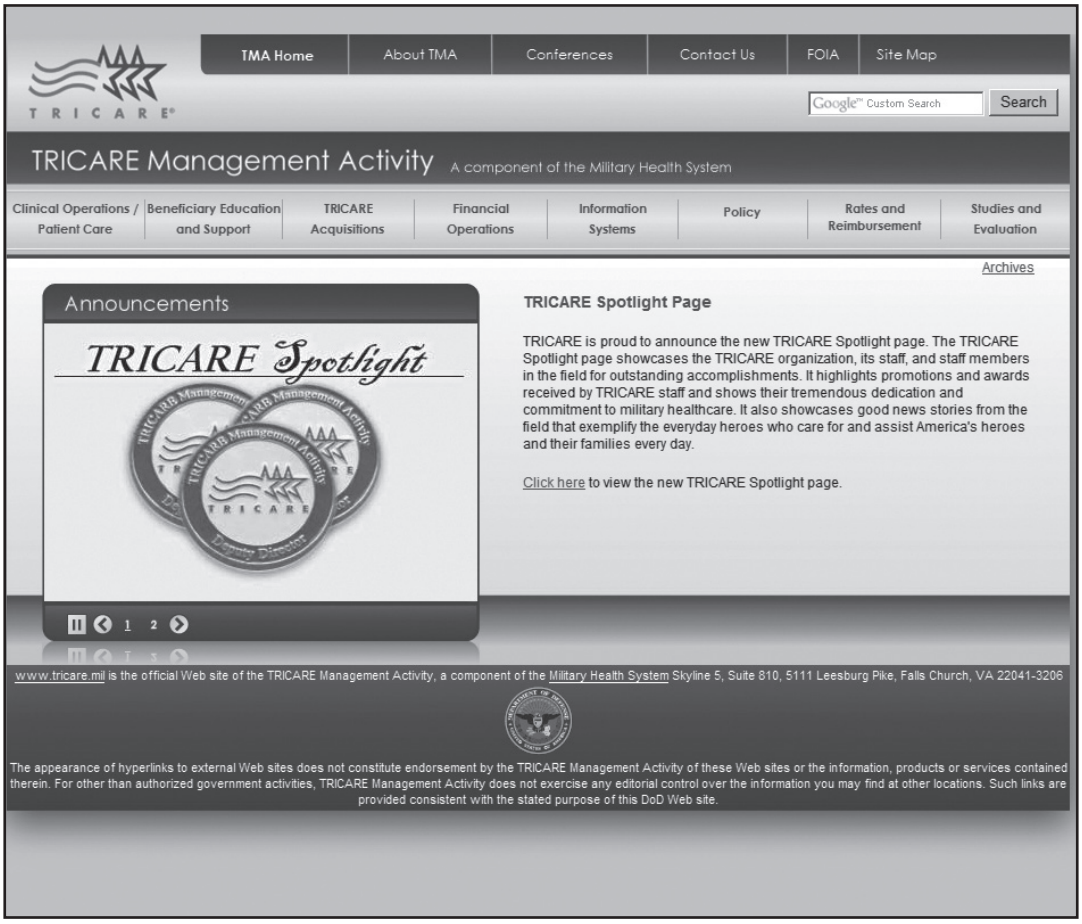
The TRDP website provides information about the program, eligibility, premiums, finding a dentist, and claims. A self-service option is also available for online enrollment.



2.0 Online Resources for Customer Service Staff

2.1 TRICARE Management Activity Corporate Website (www.tricare.mil/tma)

The TRICARE Management Activity (TMA) corporate website is for TMA staff, stakeholders, and business partners. The website includes details about the TMA organization, its mission, and those of its directorates. Customer service staff will find useful information on this website about beneficiary education and support, policy, rates, and reimbursement.



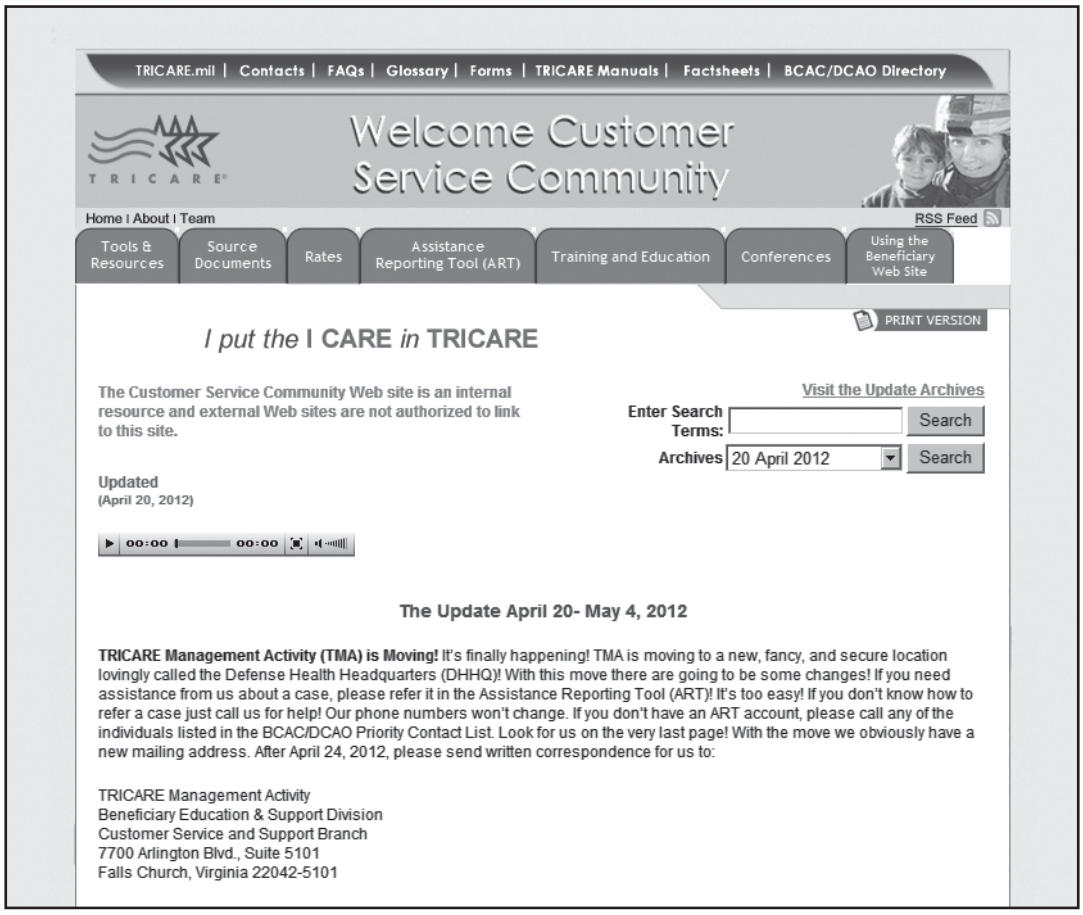
2.2 Customer Service Community Website (www.tricare.mil/customerservicecommunity)

The Customer Service Community Toolkit is an internal resource for BCACs/DCAOs and others who work in a TRICARE customer service capacity.

Do not share this URL with beneficiaries. It is not to be publicly accessible.

It features links to:

- Online tools and resources and hosts TRICARE updates
- Source documents (e.g., copies of letters, confirmations sent)
- TRICARE reimbursement information
- Assistance Reporting Tool (ART)
- Training and education resources
- Beneficiary website updates
- BE&S Training Seminar information
- Assistance for BCACs, DCAOs and other MHS support staff who have TRICARE or ART-related questions via bcacdcao@tma.osd.mil (Select “Contact Us” at the bottom of the page to send an e-mail to TMA.)



2.3 TRICARE University (www.tricare.mil/tricareu)

TRICARE University supports the training and education of MHS support staff who work directly with TRICARE beneficiaries. TRICARE University's core mission is to deliver accurate classroom and online instruction to ensure that a well-informed staff is able to transfer their knowledge to TRICARE beneficiaries.

2.3.1 Classroom Training

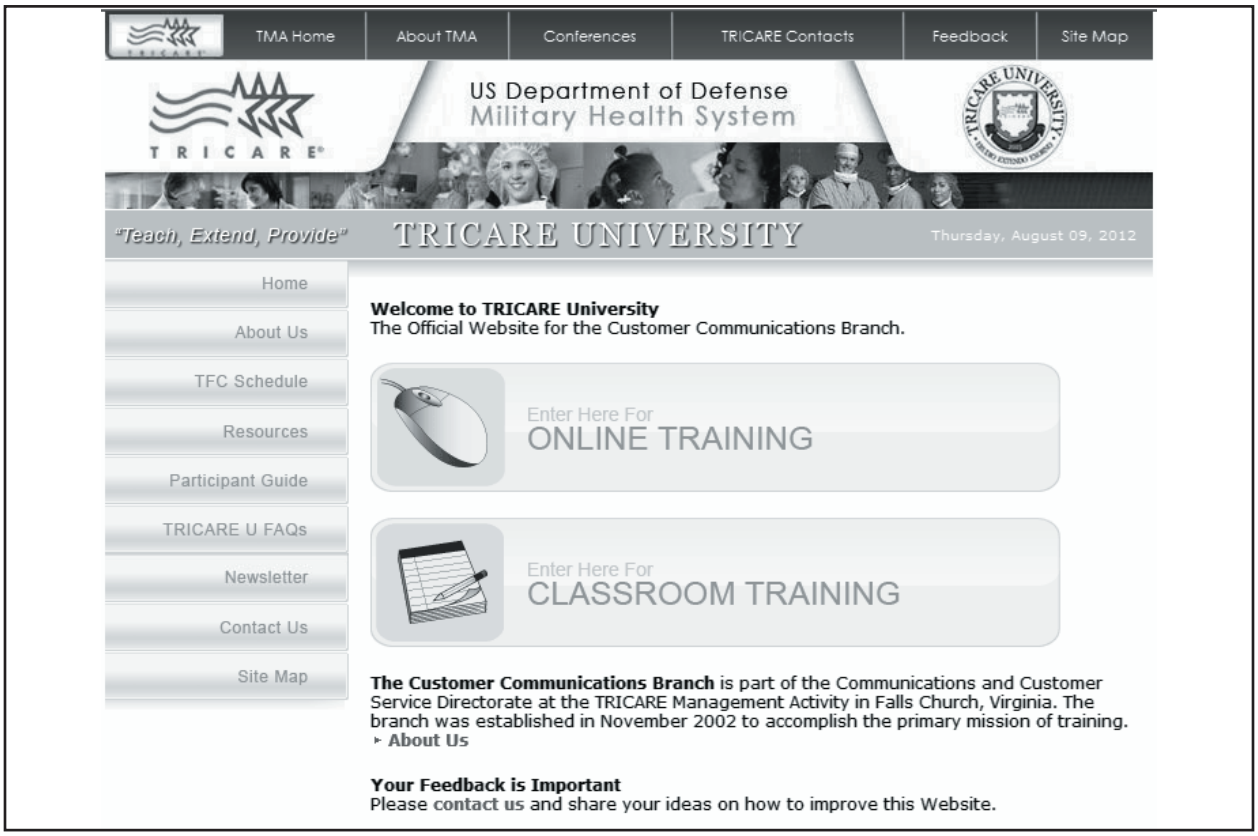
The three-day, in-residence TRICARE Fundamentals Course (TFC) covers the TRICARE program in a broad, yet detailed manner. The course is designed for BCACs, DCAOs, and other MHS support staff who have fewer than three years of TRICARE experience. To register for classroom training visit www.tricare.mil/tricareu.

2.3.2 Online Training

- The online courses cover much of the same content as the classroom course. They are convenient alternatives to the classroom course for those unable to travel or who prefer to work at their own pace.
    - The TRICARE Fundamentals Online Certification Course requires registration and includes an end of course exam.
    - The TRICARE Fundamentals Public Course is less in-depth and provides quick instruction on the basics of TRICARE. No registration is required and the course does not have a final exam.

2.3.3 TRICARE Fundamentals Course Participant Guide

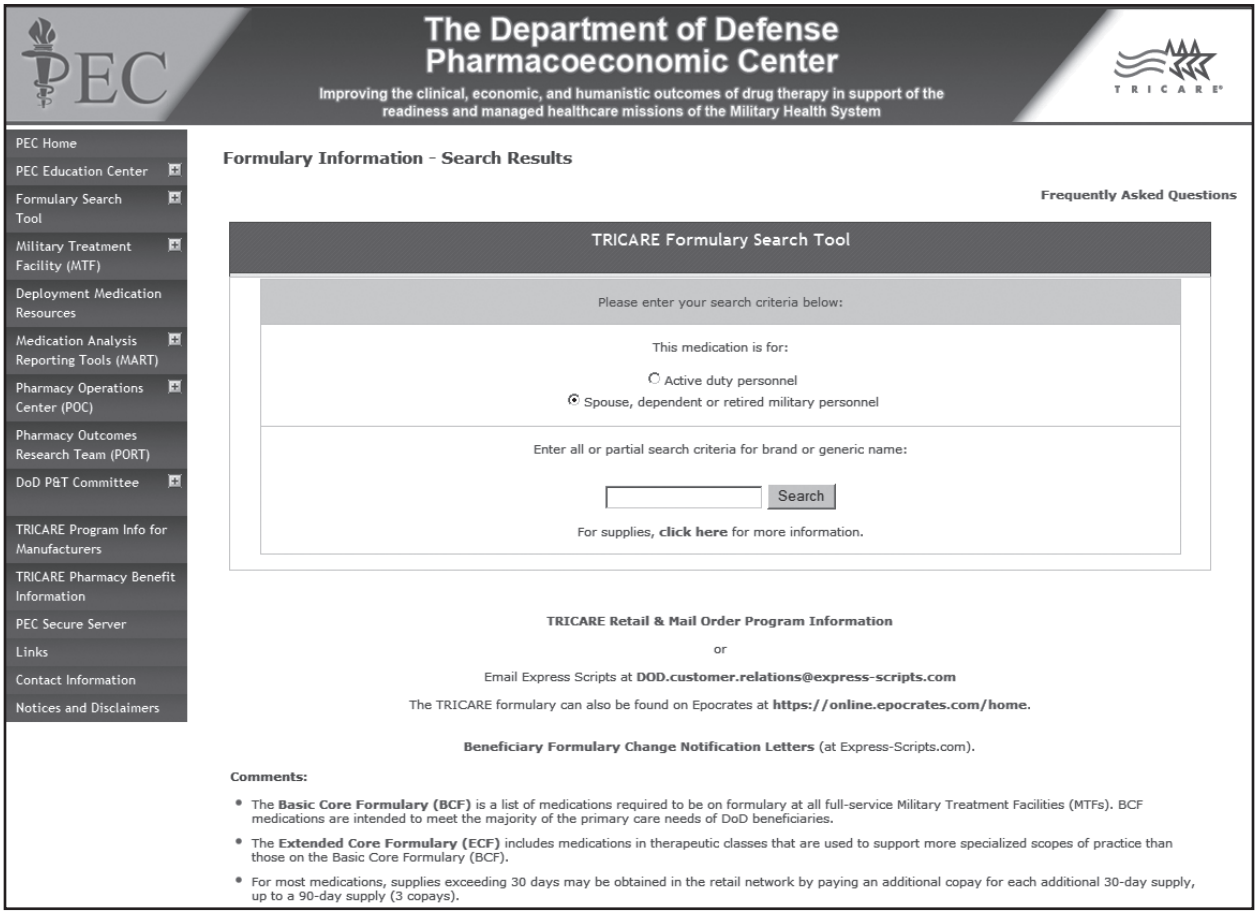
- An electronic version of the TRICARE Fundamentals Course Participant Guide (this book) is available on the TRICARE University website as a PDF. The PDF allows users to easily browse or search the entire book for specific information and is a great reference tool for those who work in a TRICARE customer service capacity.
- The TRICARE Fundamentals Course Participant Guide is updated on a quarterly basis with new policies, programs, and other important information. Users should consider downloadling quarterly versions to ensure they have the most current and accurate information.



2.4 Formulary Search Tool (www.pec.ha.osd.mil/formulary_search.php)

TRICARE's Formulary Search Tool is a database that allows TRICARE beneficiaries and other users to search for TRICARE prescription medication coverage information. The tool is a listing of medicines and other authorized supplies that are available with a prescription. Simply type in the name of a medication to see information about that prescription including generic names, cost-shares, drug warnings, alternative prescription options, and links to forms that are required to obtain certain medications (i.e., quantity limits, prior authorization, and medical necessity).

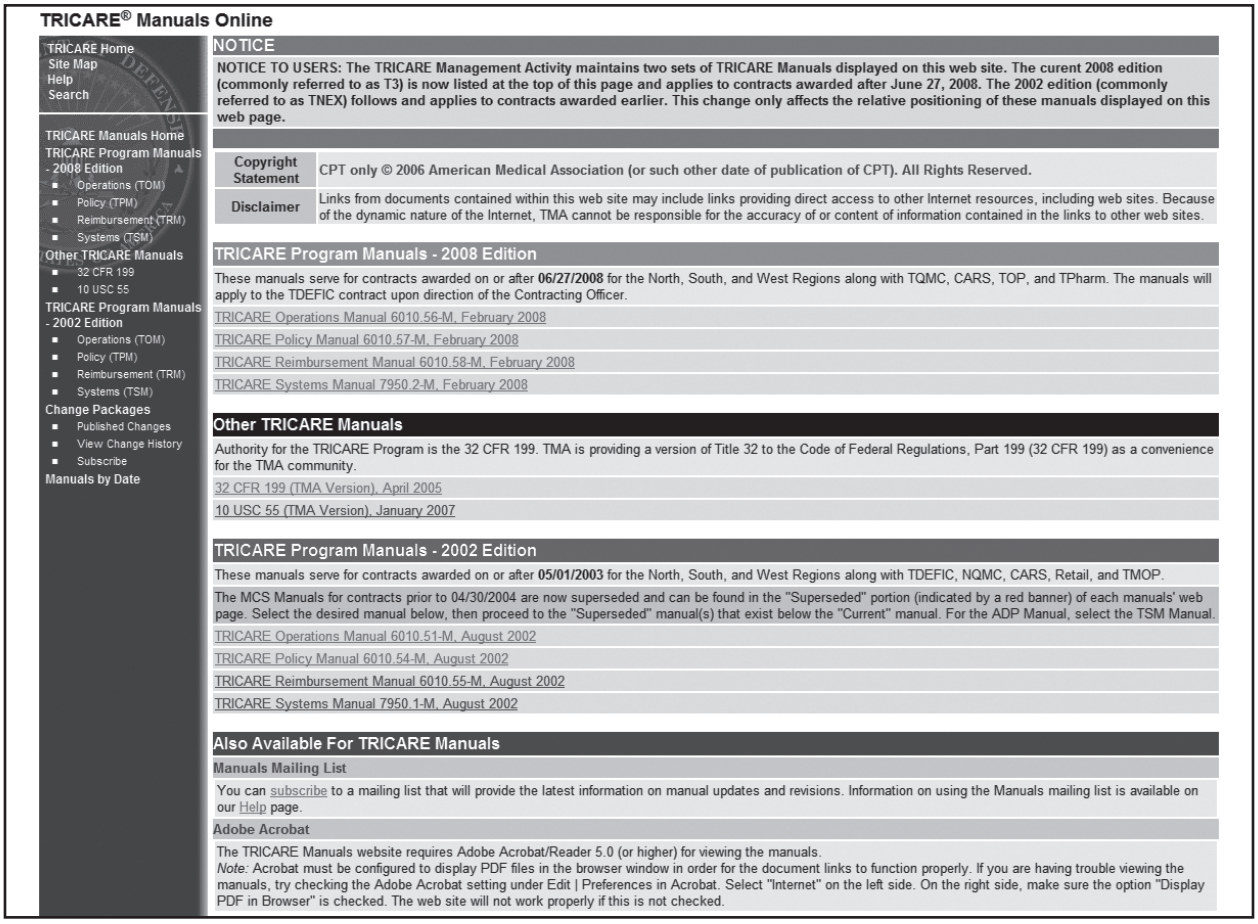
The formulary is managed by the DoD Pharmacy and Therapeutics Committee, with clinical guidance from the DoD Pharmacoeconomic Center (PEC).



2.5 TRICARE Manuals (http://manuals.tricare.osd.mil)

TRICARE Manuals are, in most cases, your primary resource for locating official TRICARE policy and benefit information. Each TRICARE manual posted on the website incorporates updated, published changes. Although changes may be published, they are not implemented by contractors until they receive direction from the TMA Contracting Officer.

Authority for the TRICARE program is Title 32 to the Code of Federal Regulations, Part 199 (32 CFR 199) and USC 10, Chapter 55.



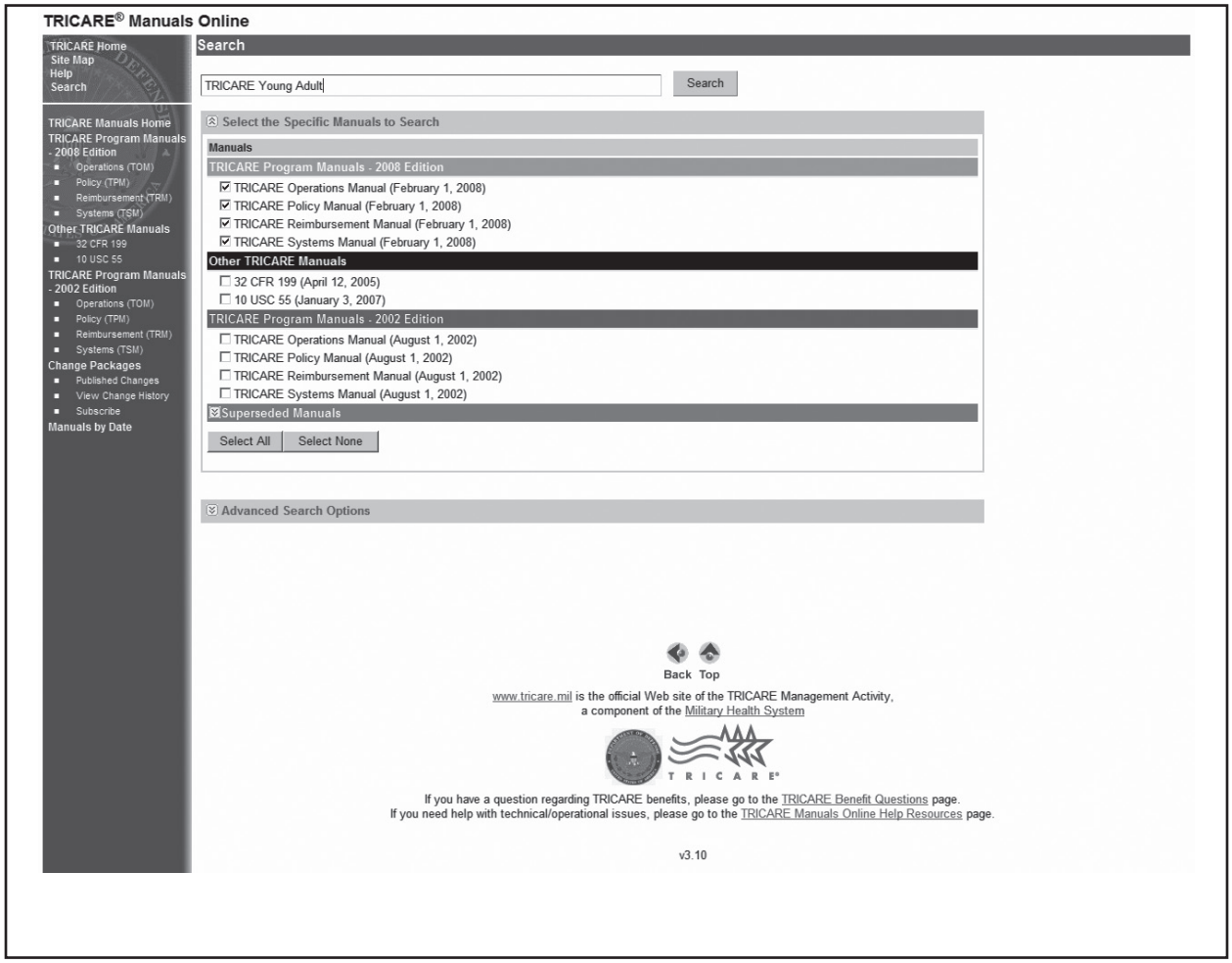
2.5.1 Basic Search

The TRICARE Manuals website includes features for searching the TRICARE manuals. Currently, there are two program manuals available: the 2002 and 2008 editions. Customer support staff should search the appropriate manual version when verifying benefit information.

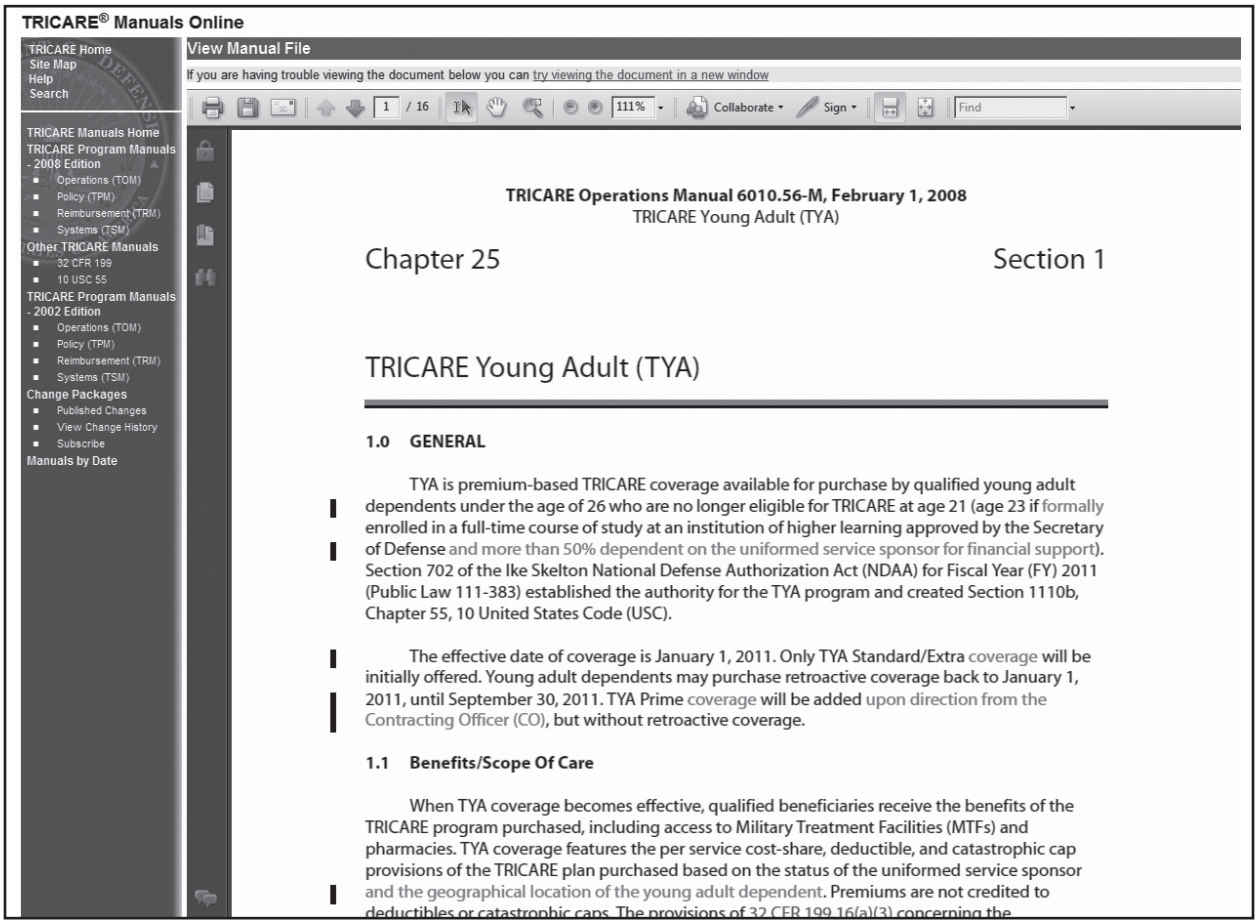
- TRICARE Program Manuals—2002 Edition: Serves only for contracts awarded between 05/01/2003–06/27/2008.
- TRICARE Program Manuals—2008 Edition: Serves for contracts awarded on or after 06/27/2008.

2.5.2 Enter a search string (e.g., TYA) and select the manual(s) you want to search

- To locate the most current benefit information, use the default search setting “Search most recent version of the selected manuals” located in the Advanced Search Options drop down.
- Try to make the search string as specific and simple as possible. The more words you enter in the search function, the less likely you are to get results, as the search engine looks specifically for the string you enter. You are more likely to find the information you are looking for by using short entries and words that are unique to your search.



2.5.3 The website displays the selected manual section



2.5.4 Subscribing to Manual Updates

Users may register to receive updates about changes to the TRICARE Operations, Policy, Reimbursement, and Systems manuals, and 32 CFR 199 and 10 USC 55. To subscribe to published manual update releases, go to http://manuals.tricare.osd.mil/mailingListRegistration.aspx.

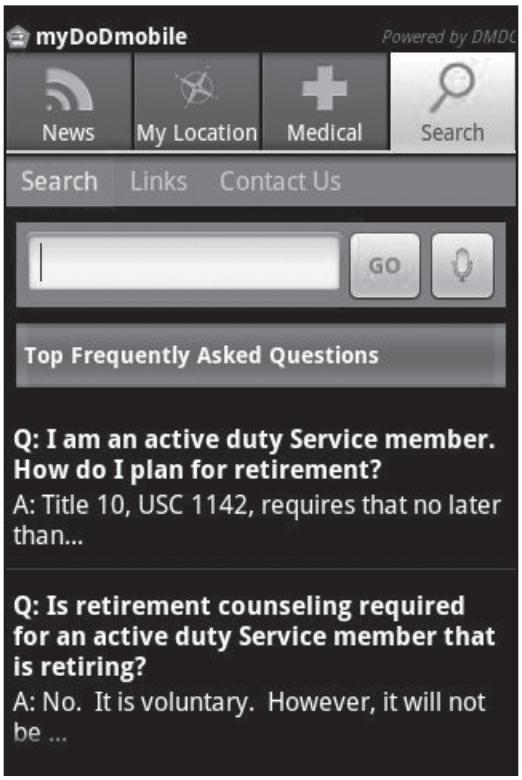
3.0 Mobile Applications

3.1 milConnect Mobile

The milConnect mobile application is provided by the Defense Manpower Data Center (DMDC). Beneficiaries can use the milConnect application to:

- Locate Real-time Automated Personnel Identification System (RAPIDS) ID card issuing facilities
- Find contact information for TRICARE Regional Offices (TROs)
- View a searchable selection of the most Frequently Asked Questions (FAQs)

The free milConnect mobile application is currently available only for Android smart phones.



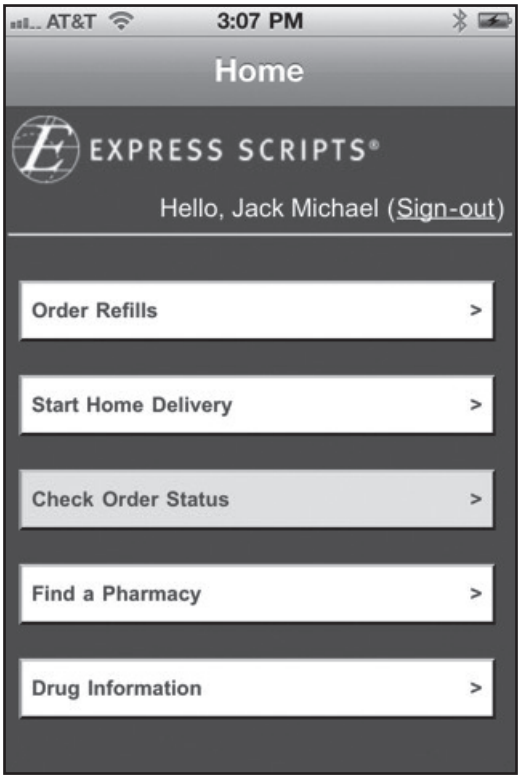
3.2 Express Scripts Mobile

The Express Scripts Mobile site (Express Rx) makes it easier than ever for beneficiaries to take control of their pharmacy benefit. The mobile application is available for both iPhone and Android, and can be downloaded by visiting the iTunes App Store or the Android Marketplace. Beneficiaries with a Blackberry, Windows Phone, or other mobile device with web browsing capabilities can access the Express Scripts mobile optimized site at http://m.esrx.com.

With the Express Scripts mobile app, beneficiaries can:

- Register for an Express Scripts web account
- Enroll in home delivery
- Order refills
- Check order status
- Find a pharmacy
- Get drug information
- Set up reminders for daily medication alerts

Beneficiaries must be registered on www.express-scripts.com before using the mobile website. Beneficiaries can register by visiting www.express-scripts.com/activate and following the instructions for TRICARE beneficiaries.



Module Objectives

Summary:

- **List the online resources available to TRICARE beneficiaries**
- **Recognize the online resources available to BCACs and other MHS support staff**
- **Identify the mobile applications available to TRICARE beneficiaries**

TRICARE Fundamentals Course

DEERS

3

Participant Guide

References

DoD Directive 1341.1 and 1341.2

2002 and 2008 TRICARE Policy Manual, Chapter 10, Sections 1.1, 7.1

2002 and 2008 TRICARE Systems Manual, Chapter 3

2002 TRICARE Operations Manual, Chapter 5, Section 1.5

2008 TRICARE Operations Manual, Chapter 6, Section 1; Chapter 24, Section 1.1

DFAS Military Pay Secondary Dependency Guide

Module Objectives

- **Explain the purpose of DEERS**
- **Identify who determines TRICARE eligibility**
- **State how and when to update DEERS data**
- **List special eligibility categories for DEERS registration**

1.0 The Defense Enrollment Eligibility Reporting System (DEERS)

- DEERS is the central eligibility and enrollment data repository containing personnel and medical information for the Department of Defense (DoD).
- DEERS is the established source to verify benefit and entitlement eligibility information for:
  - Uniformed service members
  - Uniformed service retirees
  - U.S. sponsored foreign military members
  - DoD civilians
  - Eligible family members
  - Others as directed by the DoD
- DEERS maintains information about TRICARE eligibility, enrollment, primary care manager (PCM) assignment, catastrophic caps, deductibles, enrollment fee totals, and other health insurance (OHI).

2.0 TRICARE Eligibility

- **TRICARE eligibility is determined only by the seven uniformed services:**
  - Army
  - Marine Corps
  - Navy
  - Air Force
  - Coast Guard
  - Public Health Service
  - National Oceanic and Atmospheric Administration (NOAA)
- Remember DEERS doesn't determine eligibility, it only reports it. Beneficiaries may contact the Defense Manpower Data Center Support Office (DSO), or nearest identification (ID) card-issuing facility for assistance with eligibility questions.

3.0 DEERS Data

3.1 Information Found in DEERS

- Identity and demographic information
  - Name
  - Social Security number, DoD ID Number, DoD Benefits Number (DBN)
  - Gender
  - Birth date
- Contact information
  - Residence and mailing address
  - E-mail
  - Telephone number

3.2 Sources of Official Personnel Data

- Active duty personnel offices and ID card-issuing facilities
- National Guard and Reserve personnel centers
- Uniformed service academies
- U.S. Military Entrance Processing Stations
- Retiree pay centers

3.3 Systems that Interface with DEERS

- Internal
  - Various personnel systems
  - Armed Forces Health Longitudinal Technology Application/Composite Health Care System
  - Real-time Automated Personnel Identification System (RAPIDS)
  - Defense Online Enrollment Systems (DOES)
  - Contractors' claims processing systems
- External
  - Centers for Medicare and Medicaid Services (CMS)
  - Social Security Administration (SSA)
  - Defense Finance and Accounting Services (DFAS)
- Operator applications
  - General Inquiry to DEERS (GIQD)
- Self-service applications (websites)
  - Reserve Component Purchased TRICARE Application (RCPTA)
  - DoD Self-Service Logon (DS Logon)
  - milConnect
    - **Note:** A companion web service, eCorrespondence, sends benefit change notices to active duty service members (ADSMs). Because eCorrespondence uses e-mail addresses, encourage beneficiaries to update their e-mail addresses via milConnect. E-mails sent from eCorrespondence refers the user back to milConnect to see source materials/documents.
  - Beneficiary Web Enrollment (BWE)

4.0 When to Update DEERS Records

4.1 Sponsor Status/Changes that Require a DEERS Update

- Activation or reenlistment
- Separation or retirement
- Medicare eligibility
- Relocation or change of address
- Death

4.2 Family Member Status/Changes That Require a DEERS Update

- Marriage or divorce
- Birth or adoption

- Death
- Relocation or change of address
- Medicare eligibility or loss of eligibility
- Dependent child's enlistment in a uniformed service
- Student status
    - To remain TRICARE eligible past age 21, a sponsor's child must be enrolled as a full-time student in an accredited institution of higher learning ***and*** dependent on the sponsor for over 50 percent of his/her financial support.
    - A child is TRICARE eligible under student status until graduation from the institution of higher learning or their 23rd birthday, whichever comes first.

4.3 Life Events and Other Status Updates

To make status updates, which usually involves presenting certain documents, beneficiaries should go to the nearest uniformed services personnel office or ID card-issuing facility and provide, when applicable:

- Marriage certificate
- Birth certificate
- Death certificate
- *Certificate of Release or Discharge from Active Duty* form (DD Form 214)
- Medicare card
- *Notice of Disallowed Claim* from the Social Security Administration (SSA), if the beneficiary is not eligible for Medicare Part A at age 65
- Letter from the college, university, or institution of higher learning, indicating the child is a full time student and the anticipated graduation date

4.4 Updating Contact Information in DEERS (address, phone number, e-mail)

- **In Person—**Beneficiaries can go to the nearest uniformed services personnel office or ID card-issuing facility to update contact information, such as the address or telephone number. To locate the nearest uniformed RAPIDS site, visit www.dmdc.osd.mil/rsl.
- **By Internet—**Registered beneficiaries may submit contact information changes at http://milconnect.dmdc.mil. Users securely login with a CAC, DFAS (myPay) account, or with a DS Logon; the user then selects the "update address" link and updates information in the appropriate areas.
- **By Fax—**Defense Manpower Data Center Support Office (DSO): 1-831-655-8317
- **By Mail—**Address changes may be mailed to the DSO:

DMDC Support Office
ATTN: COA
400 Gigling Road
Seaside, CA 93955-6771

It's important to keep personal information (including e-mail addresses) current to receive important letters and notices about TRICARE benefits.

4.5 DMDC Support for TRICARE Eligibility Issues

- ID-card issuing facilities can be located at www.dmdc.osd.mil/rsl
- DSO: 1-800-538-9552 (For the hearing impaired: 1-866-363-2883)
- DSO Support for Military Health System (MHS) Support Staff Only: 1-800-361-2508 (Field Support Help Desk)

5.0 Special Eligibility and DEERS Registration Categories

5.1 Newborns, Pre-Adoptive, Adopted Children, and Court-Ordered Wards

The DoD requires DEERS registration for all TRICARE-eligible beneficiaries, including newborns, pre-adoptive, adopted children, and court-ordered wards. Parents and legal guardians can avoid potential eligibility and claims problems by registering the newborn or adopted child in DEERS as soon as possible.

- Newborns are eligible for TRICARE coverage for 365 days from birth, whether or not they're registered in DEERS.
  - On day 366, newborns not registered in DEERS are no longer TRICARE eligible and claims are denied until they're registered. (See the *TRICARE Options* module for more information about newborn coverage under TRICARE Prime.)
  - **Note**: Enrolled sponsors may purchase TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) coverage for a child's birth or adoption. An application event must be received by the regional contractor or postmarked no later than 60 days after this qualifying life event to make the child eligible.
- Pre-adoptive, adopted children, and court-ordered wards must be registered in DEERS for them to be TRICARE eligible; claims are denied until they're registered.
- To establish TRICARE eligibility in DEERS for a newborn, pre-adoptive, adopted child, or court-ordered ward, the following forms must be submitted through service channels:
  - An *Application For Identification Card/DEERS Enrollment* (DD Form 1172-2) signed by the sponsor. If the sponsor is unable to sign in person, the spouse must present a power of attorney/notice or provide a notarized *DD Form 1172-2* signed by the sponsor; and
  - As applicable:
    - An original or certified copy of a birth certificate or certificate of live birth (signed by the attending physician or other responsible person from a U.S. hospital or military treatment facility) or consular report of live birth for children born overseas
    - A record of adoption or a letter of placement of the child in the home by a recognized placement or adoption agency or the court before the final adoption
    - A court order placing the child with the uniformed service sponsor for a minimum of 12 months
- Families should contact the nearest uniformed services card-issuing facility to find out what their service component requires to establish eligibility. The location and contact information for ID card-issuing facilities may be found at www.dmdc.osd.mil/rsl.

5.2 Dependent Parents and Parents-In-Law

Although dependent parents and parents-in-law aren't TRICARE eligible (except for pharmacy benefits if qualified at age 65 or older), they may receive care at a military treatment facility (MTF) if they're determined to be eligible for direct care by the uniformed services.

- Eligible dependent parents and parents-in-law must be registered in DEERS to receive care at the MTF. The sponsor's service determines if they qualify as dependent parents/parents-in-law.
- To register in DEERS, the following forms must be submitted through service channels:
  - *DD Form 1172-2*, signed by the sponsor
  - *Dependency Statement—Parent* form (DD Form 137-3)
  - Dependency determination letter from the DFAS
- Sponsors should verify with their service the documentation needed to establish eligibility and access to MTF care.
- Eligible dependent parents and parents-in-law may have prescriptions filled at MTF pharmacies.
- When dependent parents and parents-in-law become eligible for Medicare, they may have prescriptions filled at network pharmacies or via home delivery, as long as they're enrolled in Medicare Part B.

5.3 Transitional Survivors and Survivors

Eligible surviving family members whose sponsor died while serving on active duty for a period of more than 30 consecutive days or while on delayed-effective-date active duty orders are entitled to TRICARE benefits as transitional survivors or survivors.

5.3.1 Transitional Survivors

- "Transitional survivor" refers to the spouse and child(ren) of a deceased sponsor. Transitional survivors are provided benefits as active duty family members (ADFMs).
    - Spouses keep their transitional survivor status for up to three years from the sponsor's death.
    - Unmarried dependent children are transitional survivors until they lose TRICARE eligibility, typically at age 21 (or 23 if enrolled as a full-time student in an accredited institution of higher learning and dependent on the sponsor for over 50 percent of their financial support).
        - Surviving dependent children who become incapacitated prior to age 21 are covered as transitional survivors until age 21 (or 23), or three years from the death of the sponsor, whichever is later. Incapacitated status is determined by the sponsor's service. Incapacitated children who maintain eligibility beyond normal age limits or after the three years change to survivor status.
- Transitional survivors may enroll in TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Overseas Program (TOP) Prime, or TOP Prime Remote (shows as TPR in DEERS).
    - Coresidency and overseas command-sponsorship requirements for Prime-option enrollment do not apply.
- Transitional survivors do not pay enrollment fees or copayments for Prime-option benefits (except for pharmacy cost-shares); however, cost-shares and deductibles apply at the active duty family rate when using TRICARE Standard or TOP Standard.

5.3.2 Survivors

- After the three-year anniversary of the sponsor's death, a surviving spouse's and incapacitated child's (if applicable) eligibility status changes to retiree family member.
    - As survivors, they're not eligible for active-duty specific programs (such as TPR, TPRADFM, TOP Prime, and TOP Prime Remote).
    - As survivors, they're also not eligible for active-duty specific benefits, such as the Extended Care Health Option (ECHO).
- Survivors may enroll in TRICARE Prime, but must pay the retiree enrollment fees and copayments.
- Survivors are eligible for TRICARE Standard and TOP Standard and pay retiree cost-shares and deductibles for TRICARE-covered services.
- Survivors must purchase Medicare Part B if they become entitled to Medicare.
- Survivors must pay pharmacy cost-shares when using the TRICARE Pharmacy benefit.

5.4 Additional Special Eligibility Categories

Beneficiaries who fall under the categories below should go to the nearest uniformed service personnel office or ID card-issuing facility for eligibility requirements and assistance:

- Certain family members of ADSMs who were discharged as a result of a court-martial conviction or separated for child or spousal abuse.
- Certain spouses, former spouses, and dependent children of uniformed service members who were eligible for retirement, but had their retirement revoked as a result of spousal or child abuse.

- Foreign Force members and their family members when they're in the United States by official invitation or on official military business.
  - This includes all countries that participate in a Reciprocal Health Care Agreement, the North Atlantic Treaty Organization (NATO), a Status of Forces Agreement, or a Partnership for Peace Agreement.
  - Foreign Force members and their dependents seeking routine care may also contact their home country embassy for assistance with health care coverage.
  - For information about MTF or TRICARE coverage for foreign force members and their families visit https://private.fhp.osd.mil/portal/rhas.jsp.

5.5 Unremarried Former Spouses

- Certain unremarried former spouses are eligible for TRICARE if the former sponsor's service component determines and reflects their eligibility.
- The 20-20-20 rule. To establish eligibility as an unremarried former spouse, the following criteria must be met:
  - Sponsor must have 20 years of creditable service towards determining retirement pay.
  - Former spouse was married to the same sponsor or service member for at least 20 years.
  - All 20 years of marriage overlap the 20 years of creditable, active or reserve, service which counted towards sponsor's retirement.
- The 20-20-15 rule. Some former spouses may qualify for medical benefits for one year from the date of the divorce decree. Eligibility is met when 15 years of marriage to the same sponsor/service member overlap the 20 years of creditable, active or reserve, service which counted towards the sponsor's retirement.
- The following documentation is required to establish eligibility as an unremarried former spouse:
  - Marriage certificate and divorce decree
  - *DD Form 214* from the sponsor's service component
- If the service component determines the unremarried former spouse is eligible, he/she is issued a new ID card under his/her own name the first time the ID is renewed after the effective date of the divorce or annulment. The unremarried former spouse then uses his/her own SSN or DoD Benefits Number (DBN) when seeking services.

5.5.1 Unremarried Former Spouse Loss of Eligibility

TRICARE-eligible unremarried former spouses lose their TRICARE eligibility under the following circumstances:

- Remarriage, even if the remarriage ends in divorce or death of the spouse, unless they gain TRICARE eligibility under the new spouse
- Purchase of or coverage by an employer-sponsored health plan

6.0 Social Security Numbers (SSNs)/DoD Benefits Numbers (DBNs)

SSNs are being removed from uniformed services IDs and common access cards (CACs) and replaced with a:

- DoD ID Number:
  - The DoD assigns a 10-digit number to each person who has a direct relationship with the DoD, either as a sponsor or as an eligible dependent.
- DoD Benefits Number (DBN):
  - The DoD assigns an 11-digit number to each family member.
    - The first 9 digits identify the sponsor, while the last 2 identify the individual family member.
    - The DBN replaces the SSN on uniformed service ID or CAC cards for the management of benefits.
  - Appears on all cards where there is any benefit, such as health care or the use of facilities (e.g., commissary)
  - Used on health care and claims processing forms in place of the SSN (Claims may still be processed if the provider or beneficiary uses an SSN.)

Note: Current ID card holders are not required to get a new card until their current one expires; however, they can get a new card sooner if they want one.

> **Summary:** Any changes that impact a sponsor's or family members' eligibility must be recorded in DEERS. TRICARE eligibility is determined by the Services, but information listed in DEERS affects access to benefits

7.0 Application Exercises

Exercise 1

Army Staff Sergeant Conway recently married his high school sweetheart, Marianne, in their hometown of Hampton, VA, where he is stationed. After the wedding, they immediately left for their honeymoon in São Paulo, Brazil. As luck would have it, Marianne became ill on the second day of their trip. They decided that she should see a host nation provider for routine care.

When Mrs. Conway arrived at the provider's office, she told the receptionist that she had TRICARE coverage, but didn't have a uniformed services ID card yet. The provider treated her and required that she pay up front. She paid the bill and sent her claim to her regional contractor, who denied the claim.

Needless to say, Mrs. Conway was surprised that her claim was denied.

Q1: Was Mrs. Conway eligible to receive TRICARE benefits at the time of service?

Q2: Why was the claim denied?

Exercise 2

Recently retired Army CAPT James (Jim) Walker and his wife, JoAnne, were married for 27 years. Despite their commitment to each other, the Walkers separated just two weeks before their 28th wedding anniversary.

Through the divorce trial, CAPT Walker assured his ex-wife that she would remain TRICARE-eligible and receive benefits. All she would have to do is not remarry.

However, single life wasn't as easy as JoAnne expected. Making ends meet, even on her husband's alimony was getting tough. JoAnne decided to get a desk job to bring in extra income. In addition to the base salary, JoAnne was eligible for and purchased the company's group health plan. Based on what you already know about the importance of DEERS registration and what you have learned from this module, answer the following questions:

Q1: Is JoAnne TRICARE eligible?

Q2: Under what circumstances is JoAnne TRICARE eligible?

Module Objectives

Summary:

- **Explain the purpose of DEERS**
- **Identify who determines TRICARE eligibility**
- **State how and when to update DEERS data**
- **List special eligibility categories for DEERS registration**

TRICARE Fundamentals Course

TRICARE Options

4

Participant Guide

References

10 USC
32 CFR § 199, 199.2
National Defense Authorization Act (NDAA)
2008 TRICARE Policy Manual, Chapters 10, 12
2008 TRICARE Reimbursement Manual, Chapters 1, 2
2008 TRICARE Operations Manual, Chapters 2, 6, 24

Brainteasers

Each of the 8 items below is a separate puzzle.

How many can you figure out?

1.  	2. sailing ccccccc	3. M E N T	4. knee light
5. **TIMING TIMING**	6. MAN BOARD	7. SSSSSSSSSSE	8. $0 all all all all

1. Go long _____

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Module Objectives

Stateside Objectives:

- **Explain the differences between TRICARE Standard, Extra, and Prime**
- **Explain the costs associated with the basic TRICARE options**
- **Describe the Point-of-Service (POS) option**
- **Describe the TRICARE Prime Travel Benefit and the reimbursement process**

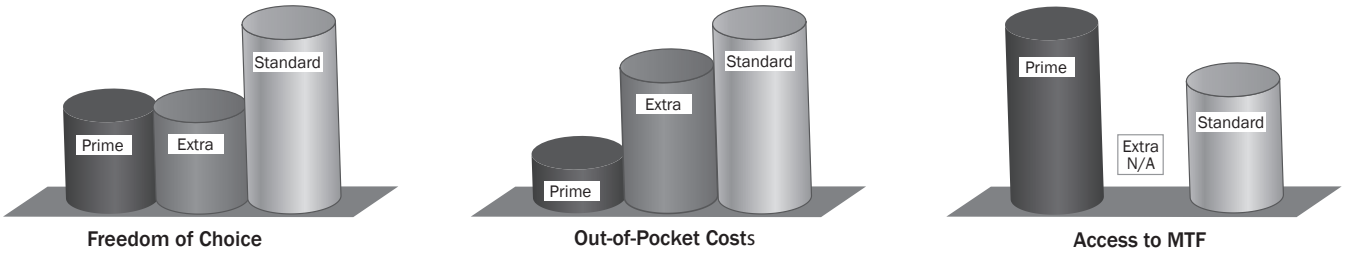
Overseas Objectives:

- **Describe the TRICARE Overseas Program (TOP)**
- **Explain TOP health care coverage options**
- **State the relationship between command sponsorship and TOP**

1.0 The Basic TRICARE Options

- **TRICARE Standard** is a fee-for-service option that offers the freedom to seek care from any TRICARE-authorized provider.
  - No enrollment forms or fees required
  - Available overseas (including U.S. territories) as TRICARE Overseas Program (TOP) Standard
- **TRICARE Extra** is a preferred-provider option where a Standard beneficiary receives a cost-share discount for using a TRICARE network provider.
  - No claims to file (network provider files for beneficiary)
  - No enrollment forms or fees required
  - Five percent cost-share discount
  - Not available overseas
- **TRICARE Prime** is a managed care option similar to a civilian health maintenance organization (HMO).
  - Enrollment is required
  - Offers lowest out-of-pocket cost
  - Care is coordinated through a primary care manager (PCM)
  - No claims to file (provider files for beneficiary)
  - Available overseas as TOP Prime

1.1 Comparing TRICARE Options



- If freedom of choice is the most important factor to a non-active duty beneficiary, TRICARE Standard is the preferred choice for health care.
- If cost savings is most important factor to the non-active duty beneficiary, TRICARE Prime (if available) is the best health care choice. TRICARE Extra is the next best choice due to the cost-share discount.
- If access to an MTF is the most important factor to the non-active duty beneficiary, TRICARE Prime is the best option, as it provides higher priority for accessing care within an MTF.

2.0 TRICARE Standard/TOP Standard and TRICARE Extra

Note: Throughout the text, TRICARE Standard and TOP Standard are referred to collectively as “Standard.”

- TRICARE Standard is a fee-for-service option where non-active duty beneficiaries have the freedom to choose from a larger provider pool without having to get prior authorization for most TRICARE-covered medical services. Standard is the basic entitlement under the law (for other than active duty members). Coverage is automatic as long as the beneficiary shows as eligible in the Defense Enrollment Eligibility Reporting System (DEERS). The Standard option is based on the beneficiary’s address in DEERS.
- TRICARE Standard is the stateside option, while TOP Standard is the overseas option.

2.1 Standard Eligibility

Standard is available for all TRICARE-eligible beneficiaries, except ADSMs. Beneficiaries must show a valid Uniformed Services ID card at the time of service for proof of eligibility.

2.2 Standard Enrollment

There are no fees or forms.

2.3 Military Treatment Facility (MTF) Access

Standard beneficiaries may receive health care from an MTF on a space-available basis.

2.4 Standard Benefit

- Standard covers most inpatient and outpatient care that is medically necessary and considered proven.
- Overseas providers may require TOP Standard beneficiaries to pay the full cost of care at the time of service; beneficiaries then file claims for reimbursement.
- Standard beneficiaries are responsible for making sure a claim is filed.
- Certain services are only available if a facility is Medicare-certified and/or TRICARE participating (e.g., skilled nursing care).

2.4.1 TRICARE Standard Prior Authorizations

- Standard beneficiaries usually require authorization to be seen by a TRICARE-authorized or purchased care/host nation provider for TRICARE-covered services.
- TRICARE requires Standard beneficiaries get prior authorization from the regional contractor for the following services:
    - Adjunctive dental care
    - Inpatient nonemergency behavioral health care or substance abuse admissions
    - Organ and stem cell transplants
    - Hospice care
    - Extended Care Health Option (ECHO) services (some services not available overseas)
    - Outpatient mental health care beyond the eighth visit in a fiscal year (October 1–September 30)

2.4.2 Receiving Care Using Standard

- Emergency care never requires an authorization. In an emergency, Standard beneficiaries should call the local emergency number for the country where they're located or go to the nearest emergency room.
- Beneficiaries may seek routine and urgent care from any TRICARE-authorized or purchased care/host nation provider, or from an MTF if space is available.

2.5 TRICARE Extra

- When a TRICARE Standard beneficiary receives care from a network provider, the beneficiary is using the TRICARE Extra option. Beneficiaries get a 5% cost-share discount.
- TRICARE Extra is not available overseas, or in U.S. territories.
- All rules that apply to TRICARE Standard also apply to TRICARE Extra.

2.6 TRICARE Standard and TRICARE Extra Costs

	ADFM E-1–E-4	ADFM E-5 and Up	Retirees, Retiree Family Members, and Survivors
Enrollment Fee	N/A	N/A	N/A
Annual Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Cost-Shares	**TRICARE Standard:** 20% of TRICARE-allowable charge **TRICARE Extra:** 15% of rate negotiated with regional contractor		**TRICARE Standard:** 25% of TRICARE-allowable charge **TRICARE Extra:** 20% of rate negotiated with regional contractor
Catastrophic Cap	$1,000 per family per fiscal year		$3,000 per family per fiscal year
Civilian Inpatient Cost-Share	Per diem* or $25 per admission, whichever is greater; no charge for separately billed professional charges		**TRICARE Standard:** Per diem* or 25% of the total charge, whichever is less, plus 25% of the TRICARE- allowable charge for separately billed professional services **TRICARE Extra:** $250 per day or 25% of the total charge, whichever is less, plus 20% of the TRICARE-allowable charge for separately billed professional services
Civilian Inpatient Mental Health	Per diem* or $25 per admission, whichever is greater		**TRICARE Standard:** ● High Volume Hospitals— 25% of hospital specific charges ● Low Volume Hospitals— Per diem* or 25% of the billed charges, whichever is less ● Partial Hospitalization— 25% of the TRICARE- allowable charge, plus 25% of the TRICARE-allowable charge for separately billed professional services **TRICARE Extra:** 20% of total charge, plus 20% of the TRICARE-allowable charge for separately billed professional services

* *Per diem rates can be found in the TRICARE Reimbursement Manual or on the TRICARE website at www.tricare.mil/costs.*

Note: Costs are subject to change each fiscal year. Beneficiaries are responsible for paying the annual outpatient deductible and applicable cost-shares. The government shares the cost for TRICARE-covered services after the beneficiary pays the annual outpatient deductible. Deductibles and cost-shares count towards the catastrophic cap.

2.6.1 Balance Billing Limit (Stateside Only)

- A non-network non-participating provider may choose not to participate or not "accept assignment". In other words, a provider doesn't agree to accept the TRICARE allowable charge as payment in full.
- Under federal law, these providers may not bill more than 15% above the TRICARE-allowable charge for covered services, unless the beneficiary signs a statement/document agreeing to pay a higher amount.
- Beneficiaries should wait for their explanation of benefits (EOB) before paying additional money to non-participating providers or follow up with the provider or regional contractor if they overpaid the provider.

2.6.2 Standard Billing Example

A TRICARE Standard E-5 ADFM visits a non-network provider for an outpatient cardiology appointment. The cardiologist does "not participate" on the claim. The provider usually charges $1,000 for this type of appointment. TRICARE's allowable charge is $850. Remember, the provider may balance bill the beneficiary for an additional 15% above the TRICARE-allowable charge.

Provider Billing	Cost
Amount charged by the provider for cardiology appointment	$1,000.00
TRICARE-allowable charge	$850.00
Additional 15% the provider is allowed to bill per federal law	$127.50 (15% of $850)
Total amount the provider can legally bill for services rendered	$977.50 ($850.00 + $127.50)
Settling the Payment with the Provider	
TRICARE-allowable charge	$850.00
Beneficiary pays annual deductible	$150.00
Remaining balance	$700.00
TRICARE payment	$560.00 (80% of the remaining balance)
Beneficiary's cost-share	$140.00 (20% of the remaining balance)
Beneficiary's total out-of-pocket cost	$417.50 ($150.00 + $140.00 + $127.50)

Note: Although the total amount charged is $1,000.00, the beneficiary is not responsible for paying more than 15% above the TRICARE-allowable charge. Under federal law, the provider can not legally hold the beneficiary responsible for the total amount of the visit.

2.7 TRICARE Standard Exercise

Mrs. Teal, an ADFM, and her three children moved in with her mother while her husband (sponsor), an E-4, is deployed. They're using the Standard benefit.

Mrs. Teal had a routine check-up with her new family physician who is a TRICARE participating provider. This was the first outpatient visit of the fiscal year for the Teal family. Mrs. Teal's first visit cost $50 (TRICARE- allowable charge).

She had one follow-up visit, which was $40 (TRICARE-allowable charge). In between her two doctor visits, her three children were seen by the same provider for routine appointments. Each of their visits cost $40 (TRICARE-allowable charge).

	How much was charged per visit?	How much of each charge was applied to the annual outpatient deductible?	How much was Mrs. Teal's cost-share percentage and what was the dollar amount she paid per visit?
Mrs. Teal's First Visit			
Child #1's Visit			
Child #2's Visit			
Child #3's Visit			
Mrs. Teal's Follow-Up Visit			

2.8 TRICARE Extra Exercise

Mrs. Jade, an E-5 ADFM, and her three children are TRICARE Standard. They live with her mother within 10 miles of a military installation.

Mrs. Jade had a routine check-up with her family physician who is a TRICARE network provider. This was the first outpatient visit of the fiscal year for the Jade family.

Mrs. Jade's first visit cost $100. She had one follow-up visit that cost $75. In between her two doctor visits, her three children were seen by the same provider for routine appointments. Each of their visits cost $75.

	How much was charged per visit?	**How much of each charge was applied to the annual outpatient deductible?**	**How much was Mrs. Jade's cost-share percentage and what was the dollar amount she paid per visit?**
Mrs. Jade's First Visit			
Child #1's Visit			
Child #2's Visit			
Child #3's Visit			
Mrs. Jade's Follow-Up Doctor's Visit			

3.0 TRICARE Prime/TRICARE Overseas Program (TOP) Prime

Note: Throughout the text, TRICARE Prime and TOP Prime are referred to collectively as "Prime."

- TRICARE Prime/TOP Prime is a managed care option similar to a civilian health maintenance organization (HMO).
- Prime is available in established geographic locations, referred to as Prime Service Areas (PSAs).
  - PSAs are typically within a 30-minute drive time of an MTF.
  - The contractor may propose additional PSAs; however, the government is ultimately responsible for identifying PSAs and approving the contractor's proposed PSAs.

3.1 The Role of the Primary Care Manager (PCM)

- A PCM is assigned to each Prime enrollee and is responsible for:
  - Providing all routine, nonemergency health care, including urgent care
  - Submitting referrals for specialty care and establishing medical necessity when required
- PCMs are:
  - MTF providers (stateside and overseas)
  - Civilian network providers
  - Members of teams organized to support patient continuity and accountability if the individual's assigned PCM is absent or unavailable
- PCMs may include:
  - Internists, family practitioners, pediatricians, general practitioners
  - Obstetricians/gynecologists, physician assistants, nurse practitioners
  - Certified nurse midwives when determined by the MTF commander or TAO Director or designee, to meet governing country rules and licensure
- PCM preference is noted on the Prime enrollment form and assignment is based on the sponsor's status, beneficiary's address, and PCM availability.
  - Within an MTF, PCMs are assigned according to MTF commander guidelines.

3.2 Prime Eligibility

Stateside	● ADSMs ● ADFMs ● Transitional survivors and survivors ● Certain unremarried former spouses ● Retirees and retiree family members ● Certain National Guard/Reserve members and their eligible family members. Only when the sponsor is called or ordered to active duty on federal orders written for more than 30 consecutive days or when the sponsor is issued delayed-effective date active duty orders to serve for more than 30 consecutive days in support of a contingency operation (also known as "early eligibility") ● Medal of Honor recipients and their eligible family members
Overseas	● ADSMs permanently assigned and residing near an MTF location ● ADFMs on permanent change of station orders and command-sponsored to accompany the sponsor to the overseas location* ● ADFMs on service-funded orders to relocate to an overseas location without the sponsor ● National Guard or Reserve members called to active duty on written federal orders for more than 30 consecutive days with a final assignment to a TOP Prime location ● National Guard or Reserve members on federal orders written for more than 30 consecutive days and their command-sponsored family members if the sponsor was living in an TOP Prime location at the time of mobilization ○ Family members must have had the same overseas residential address as the National Guard or Reserve sponsor at the time of mobilization (as recorded in DEERS)

* *Only ADFMs who meet the Joint Federal Travel Regulation (JFTR) definition of command-sponsored, are eligible for TOP Prime enrollment, with the exception of transitional survivors and certain Guard or Reserve family members. JFTR defines command-sponsored as, "entitled to travel to overseas commands at government expense and endorsed by the appropriate military commander to be present in a family member status."*

3.3 Prime Enrollment

Enrollment is required for Prime coverage.

- ADSMs must enroll based on their assignment status and service guidelines.
  - ADSMs who are permanently assigned to a PSA must enroll.
- Enrollment is voluntary for non-ADSMs, who may choose to enroll on an individual or family basis.
- Eligible beneficiaries (including ADSMs) must be registered in DEERS and submit a *TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form* (DD Form 2876).
  - Beneficiaries may get enrollment forms from the TRICARE Service Center (TSC), from the TRICARE website at www.tricare.mil/forms, or the regional contractor's website.
  - Beneficiaries should submit enrollment forms, along with the initial enrollment fee (if applicable), to the closest TSC or mail it to their regional contractor.
- Stateside Prime-eligible beneficiaries (except ADSMs) may enroll online using the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe. To login to BWE, beneficiaries may use a Common Access Card (CAC), Defense Finance and Accounting Services (DFAS) myPay Account, or Department of Defense Self Service (DS) Logon.
- **Stateside**, the enrollment form and fee must be received (not postmarked) by the 20th of the month for coverage to begin on the first day of the following month. If received after the 20th of the month, Prime coverage begins on the first day of the second month.

- **Overseas**, TOP Prime coverage begins on the date listed on the enrollment form as long as the appropriate command sponsorship orders are received (when applicable) by the TOP contractor.
  - The 20th-of-the-month rule does not apply to ADSMs or to TOP Prime enrollees.
- Eligible beneficiaries, other than ADSMs, remain covered under Standard/Extra until TRICARE Prime coverage begins.
- The enrollment period is equal to one fiscal year and is automatically renewed each year, unless one of the following occur:
  - Enrollee transfers enrollment to another region
  - Enrollee voluntarily disenrolls
  - Enrollee becomes ineligible for Prime or TRICARE eligibility ends (i.e., member retires, the Guard or Reserve member is deactivated, ages out)

3.3.1 Prime Enrollment Fees

- ADSMs and ADFMs do not pay enrollment fees.
- All other Prime enrollees pay an annual enrollment fee per individual or family, per fiscal year (October 1–September 30). Enrollment fees may be adjusted each fiscal year.
  - Prime enrollment fees for survivors of active duty deceased sponsors and medically retired Uniformed Services members and their dependents are frozen at the rate in effect when classified and at the time of enrollment in Prime. (This does not include TRICARE Young Adult Prime.)
  - The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime.
  - For current Prime enrollment fees and exceptions visit www.tricare.mil/costs.
- An initial three-month payment by check must accompany the completed enrollment form (all payments that follow must be electronic with the exception of the West region, until April 1).
  - Acceptable forms of payment include credit card, electronic fund transfers (EFTs) through an enrollee's financial institution, or allotment from retirement pay established through the regional contractor or directly through uniformed service finance centers.
- Enrollment fees may be paid on an annual or quarterly basis or by monthly allotment.
- It's recommended that beneficiaries turning 65 make quarterly payments, monthly allotments, or EFT payments so that they can stop fee payments when they become Medicare entitled.

3.3.2 Prime Lockout and Disenrollment

- The regional or TOP contractor may deny re-enrollment (lockout) for 12 months following the disenrollment date to the following Prime enrollees (other than active duty):
  - ADFMs of sponsors who are E-5 and above who change their enrollment status (i.e., from enrolled to disenrolled or vice versa) more than twice in an enrollment year for any reason
    - The 12-month lockout provision does not apply to ADFMs whose sponsor's pay grade is E-1 through E-4.
  - Those who voluntarily disenroll before the annual enrollment renewal date (October 1)
  - Those who fail to pay required enrollment fees during an enrollment period
- Prime enrollees, other than active duty, may disenroll at any time.
- TOP Prime enrollees are disenrolled 60 days after returning stateside from an overseas assignment.

4.0 Prime Costs

- There are no costs for TRICARE-covered health care services provided to ADSMs and their Prime-enrolled family members, as long as they receive nonemergency/routine care from their assigned PCM and have referrals and authorizations in place for specialty care.
- There are cost-shares associated with pharmacy benefits for those other than active duty service members. (See the *Pharmacy* module for more information on pharmacy costs.)
- Costs for all other enrollees are as follows:

Status	ADFM E-1–E-4	ADFM E-5 and Up	Retirees/Family Members, Eligible Former Spouses, and Survivors
Enrollment Fee	$0		For the most up-to-date enrollment fees, visit www.tricare.mil/primecosts
Copayments	$0		$12 per outpatient visit $17 per outpatient mental health group visit $20 per outpatient ambulance service occurrence $25 per mental health individual visit $30 per emergency room visit
Deductibles	N/A		
Catastrophic Cap	$1,000 per family, per fiscal year		$3,000 per family, per fiscal year
Network Inpatient Cost-Share (Stateside)	$0 per admission Prior-authorization required		$11 per day or $25 per admission, whichever is greater; no charge for separately billed professional charges
Network Inpatient Mental Health (Stateside)	$0 per admission		$40 per day; no charge for separately billed professional charges
Host Nation Provider Overseas	$0 per admission		N/A

4.1 Point-of-Service Option

- The point-of-service (POS) option allows **non-active duty** Prime enrollees to receive nonemergency care from any TRICARE-authorized, purchased care/host nation provider without a PCM referral.
- Prime enrollees pay higher out-of-pocket costs using the POS option. POS has its own deductible. POS out of pocket costs don't apply to the annual catastrophic cap.

4.1.1 POS Costs

POS Charges	Individual	Family
Deductible Per Fiscal Year	$300	$600
Cost-Shares for Outpatient Claims	50% of TRICARE-allowable charge after POS deductible is met*	
Cost-Shares for Inpatient Claims	50% of TRICARE-allowable charge*	

* *50% cost-share applies even after the catastrophic cap for the enrollment/fiscal year is met.*

4.1.2 POS Does Not Apply in the Following Circumstances:

- Emergency department services
- Certain preventive care services from a network provider
- The initial eight behavioral health outpatient visits from a network provider
- TOP Prime-enrolled ADFMs who seek TRICARE-authorized care within 60 days of permanent transfer to the United States
- Prime newborn or adoptee care during the initial 60 days stateside/120 days overseas when they're deemed Prime (See Section 8.0 of this module for more information.)
- Other health insurance (OHI) is primary, including host nation insurance

Note: POS doesn't apply to Prime-enrolled ADSMs (If ADSMs seek care without the proper authorization, TRICARE may deny the claim.)

4.1.3 POS Example

- A TRICARE-authorized provider treated a Prime-enrolled ADFM for medically necessary, TRICARE-covered specialty care.
- The family member sought care on his/her own without a referral from his/her PCM.
- TRICARE's allowable charge is $850.00. Remember, under point of service, the enrollee must pay the POS deductible and a 50% cost-share.

TRICARE-allowable charge	$850
Beneficiary pays POS deductible (individual rate)	$300
Beneficiary pays 50% cost-share	$275
Balance	**$275**
TRICARE pays balance	$275
Beneficiary's total out-of-pocket cost ($300 deductible + $275 cost-share)	**$575**

5.0 Prime Access Standards and Types of Care

- "Access to care" refers to established standards for accessing care in a timely manner and within a reasonable distance for TRICARE Prime enrollees.

	Urgent Care	Routine Care	Referred/Specialty	Wellness/ Preventive
Appointment Wait Time	Within 24 hours	Within 7 days	28 calendar days (4 weeks)	28 calendar days (4 weeks)
Drive Time	Within 30 minutes of beneficiary's home	Within 30 minutes of beneficiary's home	Within 60 minutes of beneficiary's home	Within 30 minutes of beneficiary's home
Wait Time in Office	Not to exceed 30 minutes for nonemergency situations			

- **Emergency care** refers to medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition exists, or the absence of medical attention would result in a threat to life, limb, or eyesight and requires immediate medical treatment. Or, the condition is so painful that sedative treatment is required to relieve suffering.
- **Urgent care** is generally defined as nonemergency acute illness or injury which requires medically necessary treatment, but would not result in disability or death if not treated immediately. This kind of illness or injury does require professional attention and should be treated within 24 hours to avoid further complications.
- **Routine care**, also known as primary care, includes general office visits for the treatment of symptoms, chronic or acute illnesses and diseases, and follow-up care for an ongoing medical condition. The PCM should be the primary source of all routine care.
- **Specialty care** is generally defined as care the PCM is not able to provide.
- **Wellness and preventive care** includes services, such as health screenings and examinations, often conducted at regular intervals, which are meant to keep beneficiaries healthy or detect health problems in a timely manner (e.g., mammograms, pap smears, cholesterol testing).

5.1 Getting Emergency Care

- Prime enrollees should go to the nearest source of emergency care.
- **Stateside**, Prime enrollees are required to notify their PCM or regional contractor within 24 hours of receiving emergency care and/or being admitted to an inpatient facility.
- **Overseas**, TOP Prime enrollees should contact the TOP Regional Call Center or country-specific Call Center after seeking emergency care stateside or overseas.
- Prime enrollees should get a copy of the emergency treatment records in case proof is needed of the reason for and results of emergency care. Please note that a claim may be denied if the diagnosis does not warrant emergency care.
- See Section 10.0 of this module for information on obtaining emergency care in Canada.

5.2 Referrals for Specialty Care

- When Prime enrollees need specialty care, their PCM writes a referral for specialty services from a specialty provider. The enrollee must make sure the regional or overseas contractor authorizes the service before scheduling the specialty appointment.
- MTF Prime enrollees may be referred to a different MTF, a civilian network, or purchased care/host nation provider.
    - MTFs have right of first refusal (ROFR), which provides them the opportunity to review each referral within their PSA to determine whether the MTF has the capability and capacity to provide the care.

- Getting the referral authorized is a multi-step process:

Stateside	● The PCM submits the referral electronically, by fax, or via TSC to the contractor. ○ Regional contractor staff conduct a benefit review and issue the appropriate care determination (approval or denial). ○ It takes at least 48 hours for the referral to be entered into the regional contractor's system. ● The regional contractor sends a letter to the enrollee with the name(s) of a network specialty care provider and the referral authorization, including the number and types of visits authorized. ○ Before scheduling their appointment, beneficiaries may call the regional contractor's toll-free number three to five days after the referral is entered to confirm the authorization. **Note:** A non-network provider may be authorized if there is no network specialist within access standards. ● The Prime enrollee must contact the specialty provider(s) listed on the authorization letter to confirm appointment availability or call the regional contractor to request a change to the identified specialist. ● Before scheduling the appointment, the enrollee should try to get copies of information the specialty provider may need (e.g., x-rays, lab results). ○ MTF Prime enrollees must find out what the MTF's policy is for transferring medical records (e.g., x-rays) to the specialty care provider. ● Prime enrollees should take their PCM's or regional contractor's phone number (listed on their enrollment card) to their specialty appointment in case there are questions.
Overseas	● TOP Prime enrollees who are referred to a purchased care/host nation network provider by the MTF can expect a "cashless, claimless" episode of care, as long as the care is properly coordinated and authorized by the TOP contractor. Before scheduling an appointment, the enrollee must confirm the authorization through their Regional or Country-specific Call Centers. ● All referrals, whether written by an MTF or host nation provider, must be authorized. ○ The TOP contractor conducts a benefit review and issues the appropriate care determination (i.e., approved or denied). ● If approved, the TOP contractor arranges for care to be provided by a certified host nation provider, gives the TOP Prime enrollee information on the specialty care provider, and may assist in coordinating the specialty appointment. ● See Section 10.0 of this module for information on obtaining specialty care in Canada.

5.2.1 TRICARE Prime Stateside Travel Benefits for Specialty Care

- When stateside-enrolled non-active duty TRICARE Prime enrollees are referred for and authorized medically necessary, nonemergency specialty care more than 100 miles from their assigned primary care manager's location, they may be eligible for the TRICARE Prime Travel Benefit, meaning they may be reimbursed for reasonable travel expenses. (This benefit is not available overseas.)
- The "greater than 100 mile rule" is statutory and is not negotiable when determining applicability of the Prime travel benefit. (An exception applies for Coast Guard ADSMs. See the 2002 or 2008 TRICARE Reimbursement Manual, Chapter 1, Section 30.)
- Active duty travel for medical care is handled through their service personnel and medical assets.

- MTF enrollees should contact the MTF point of contact for information on the reimbursement process before traveling.
- Civilian PCM-assigned Prime enrollee should contact a Prime travel benefit point of contact at the TRICARE Regional Office (TRO) before traveling.
- For more information on the Prime travel benefit, visit www.tricare.mil/travelreimbursement

6.0 TRICARE Prime Portability

TRICARE Prime coverage is portable. This means that when Prime enrollees move to a new Prime location, they may continue TRICARE Prime without a break in coverage.

- Enrollees must transfer their enrollment to the new regional contractor and select a new PCM to avoid POS charges and a potential break in Prime coverage.
- The enrollee's address must be updated in DEERS to support a new regional enrollment or PCM assignment.
- Prime enrollees may complete both enrollment transfer and PCM selection by:
  - Calling the losing contractor
  - Using the BWE website at www.dmdc.osd.mil/appj/bwe (except for ADSMs)
  - Visiting a TSC upon arrival at the new location
  - Submitting a new enrollment form via mail or the contractor's website
- The enrollment methods listed above can also be used to transfer between Prime and Prime Remote, stateside and overseas.

6.1 Transferring Prime Within the Same Region

- Enrollees should update their address in DEERS and notify the regional contractor of their address change.
- Enrollees may request a PCM change for the new location by submitting a new *DD Form 2876*, contacting the regional contractor, using the BWE website, or completing the form and dropping it off at the TSC.

6.2 Transferring Prime to a Different Region

- When relocating from one region to another, Prime enrollees should not disenroll from their current region before leaving their location. Remaining enrolled to the current region ensures they avoid an interruption in TRICARE Prime coverage.
- While traveling to the new location, enrollees must get referrals from their PCM and authorization from their current regional contractor before getting nonemergency, specialty, or inpatient care to avoid POS charges. Enrollment transfers are effective on the date the gaining regional contractor processes a signed enrollment form or confirms transfer via phone call (if coordinated before leaving the old location). The gaining regional contractor assigns a new PCM to the enrollee, provides region- or site-specific TRICARE educational materials, and key telephone numbers.

6.3 Transfer Frequency and Enrollment Fees

- The number of moves within the same region per enrollment year is unlimited; enrollees must ensure address changes are updated in DEERS to reflect their new location.
- Prime-enrolled retirees and their eligible family members who move from one region to another and back to the original region are allowed two enrollment transfers per enrollment year.
- After transferring to a new region, enrollment fees are billed by and paid to the gaining regional contractor.
  - Since the unused portions of enrollment fees may not be refunded, when enrollees anticipate moving to an area where Prime is not available they should consider paying their enrollment fee on a quarterly or monthly allotment basis.

6.4 Transferring to a Non-Prime Location

- Enrollees are covered by TRICARE Prime while en route to the non-Prime location.
- Upon arrival in a non-Prime Service Area (PSA), enrollees should update their address in DEERS and call the regional contractor or go to the BWE website to:
  - Transfer their enrollment to TRICARE Prime Remote/TRICARE Prime Remote for ADFMs, or TOP Prime Remote (ADSMs and ADFMs only)
  - Disenroll (other than ADSMs) and revert to Standard/Extra
- Beneficiaries may request a "drive time" waiver of TRICARE Prime access standards to remain enrolled in Prime if they move to a location outside of a PSA. The waiver determination is made by the contractor and must be approved by the MTF commander or regional director.
  - If approved, enrollees then travel a longer distance to see their assigned PCM and network specialty providers. Enrollees must still follow TRICARE Prime rules (e.g., using a PCM for routine care, obtaining referrals and authorizations).

6.5 Split Prime Enrollment Between Different TRICARE Regions

- TRICARE Prime split enrollment offers families the option to enroll one or some members in Prime in one region while the rest of the family is enrolled in Prime in another region. The sponsor or legal guardian must complete and sign an enrollment form for the affected family member(s) and submit it to the regional contractor where the other family member(s) lives.
- For those who pay enrollment fees:
  - The family may pay one enrollment fee to whichever regional contractor is chosen by the family to serve as the home regional contractor; or they may pay two individual enrollments to two different contractors as long as both enrollments are captured under the same sponsor. The regional contractor can provide assistance with this process.
  - Enrollment fees are applied to all family members and payment is recorded in DEERS, when applicable.

7.0 Traveling with Prime

7.1 Stateside Prime Enrollees Seeking Care When Traveling Overseas

When traveling overseas, Prime enrollees have the same patient priority at MTFs as TOP Prime enrollees.

- Enrollees should schedule all routine care through their assigned PCM before travelling to avoid POS charges.
  - Routine care is generally not authorized when traveling outside the enrollment region. Exceptions are made on a case-by-case basis with an appropriate PCM referral or prior authorization from the regional contractor.
- When overseas, Prime enrollees must contact the TOP contractor to get an authorization when seeking urgent, emergency, or specialty care.
  - Claims for care received by Prime enrollees while traveling overseas should be submitted to the overseas claims processor, not the stateside claims processor where they're enrolled.
- When Prime enrollees receive care onboard commercial seagoing vessels while outside of U.S. territorial waters, they should pay the full cost of care up front and file a claim with the TOP claims processor.

7.2 TOP Prime Enrollees Seeking Care When Traveling Stateside

When traveling in the United States, TOP Prime enrollees have the same patient priority at MTFs as stateside TRICARE Prime enrollees.

- TOP Prime enrollees are encouraged to schedule routine care appointments before traveling stateside to avoid POS charges.
- When stateside, TOP Prime enrollees must contact their Regional Call Center or the TOP contractor stateside call center for authorization before receiving services other than emergency care. Visit the TRICARE Overseas "Contact Us" website at www.tricare-overseas.com/contactus for regional call center contact information.
- Claims for care received by TOP Prime enrollees while traveling stateside should be submitted to the overseas claims processor. Enrollees should provide their overseas residential address and the TOP Prime claims address to stateside providers.

7.2.1 TOP Prime: Referrals and Authorizations When Traveling Stateside

- Routine care stateside is generally not authorized when traveling outside the enrollment region. Exceptions are made in unique circumstances on a case-by-case basis.
    - Routine care stateside requires a referral from the TOP Prime enrollee's PCM, with appropriate justification of the unique circumstances, and an authorization from the TOP contractor.
- TOP Prime-enrollees traveling or between duty stations should try to seek all nonemergency care at MTFs whenever possible.
    - Nonemergency and urgent care outside of the MTF requires authorization from the TOP contractor.

Note: TOP Prime care authorizations are not portable to a stateside provider. Likewise, a stateside care authorization is not portable to an overseas provider. A new authorization is required when changing locations.

8.0 TRICARE Coverage for Newborns, Pre-Adoptive, and Adopted Children

8.1 Newborn Coverage

- By policy, a newborn child is covered under TRICARE Prime for 60 days after birth, as long as another family member is already enrolled in a Prime option.
- After the initial 60 days, any claim submitted for the newborn processes as TRICARE Standard until the newborn is registered in DEERS and enrolled in TRICARE Prime.
    - The TRICARE Regional Director or TRICARE Area Office Director may extend the enrollment period up to 120 days on a case-by-case or regional basis.
    - Currently, a regional waiver for 120 days is in effect in all overseas locations.
- TRICARE eligibility ends on day 366 for any newborn who is not registered in DEERS.

8.2 Pre-Adoptive and Adopted Children Coverage

- Pre-adoptive and adopted children must be registered in DEERS as soon as possible. If not registered in DEERS, the child doesn't show as TRICARE eligible.
- Once registered, pre-adoptive/adopted children are covered under TRICARE Prime for 60 days (or 120 days in overseas locations), as long as another family member is enrolled in a Prime option, beginning on the date of placement by the court or approved adoption agency.

9.0 Travel Benefit for Those with a Combat-Related Special Compensation Determination

Certain retirees who are not enrolled in TRICARE Prime or USFHP and were awarded Combat-Related Special Compensation (CRSC) may be entitled to the CRSC travel benefit. This provides these select retirees reimbursement for travel-related expenses when they must travel more than 100 miles from their referring provider's location to obtain medically necessary, nonemergency specialty care for a documented combat-related condition. A written referral from their primary care provider is required. This travel benefit is not available overseas. The CRSC travel benefit is managed by the TROs. See the TRO websites for more information on this benefit.

10.0 Receiving Care in Canada

10.1 Routine Care in Canada

- An informal agreement (based on historical reciprocal health care agreements) between the United States and Canada allows ADSMs and command-sponsored ADFMs stationed in Canada to receive inpatient and outpatient no-cost medical services at Canadian Forces Healthcare Facilities (CFHFs).
- ADSMs can also receive no-cost dental care at CFHFs.
- Service areas include the following Canadian provinces:

Alberta	British Columbia	Manitoba	New Brunswick	Newfoundland and Labrador
Saskatchewan	Nova Scotia	Ontario	Quebec	Northwest Territories

10.2 Emergency Care in Canada

- ADSMs and accompanying family members must contact the CFHF or U.S. Embassy within 24 hours, or as soon as possible, after arriving at the emergency medical facility or being admitted as an inpatient. Timely reporting of emergency care is necessary for arranging visits/transfer to another Canadian facility in the area or to the United States.
- TOP Prime enrollees who are age 17 or younger and reside in Ottawa should receive emergency care from Children's Hospital of Eastern Ontario (if it's the nearest emergency facility available).

10.3 Specialty Care in Canada

- To receive specialty care outside of the CFHF, ADSMs are issued insurance coverage by registering with Canadian Blue Cross Blue Shield (BCBS).
    - To register, ADSMs and their eligible family members must complete a BCBS registration form which is faxed by the TRICARE Overseas Program Point of Contact (TOP POC), located at the nearest U.S. embassy, to the Canadian BCBS Headquarters.
- Specialty care is referred by the Canadian Forces Medical Clinic to purchased care/host nation providers.
- ADSMs must present their BCBS card to the purchased care/host nation provider when checking in for an appointment.

Note: "Cashless, claimless" care is coordinated by the TAO or Canadian Forces—not the TOP contractor in Canada.

Module Objectives

Stateside Objectives:

- **Explain the differences between TRICARE Standard, Extra, and Prime**
- **Explain the costs associated with the basic TRICARE options**
- **Describe the Point-of-Service (POS) option**
- **Describe the TRICARE Prime Travel Benefit and the reimbursement process**

Overseas Objectives:

- **Describe the TRICARE Overseas Program (TOP)**
- **Explain TOP health care coverage options**
- **State the relationship between command sponsorship and TOP**

TRICARE Fundamentals Course

Prime Remote Options

5

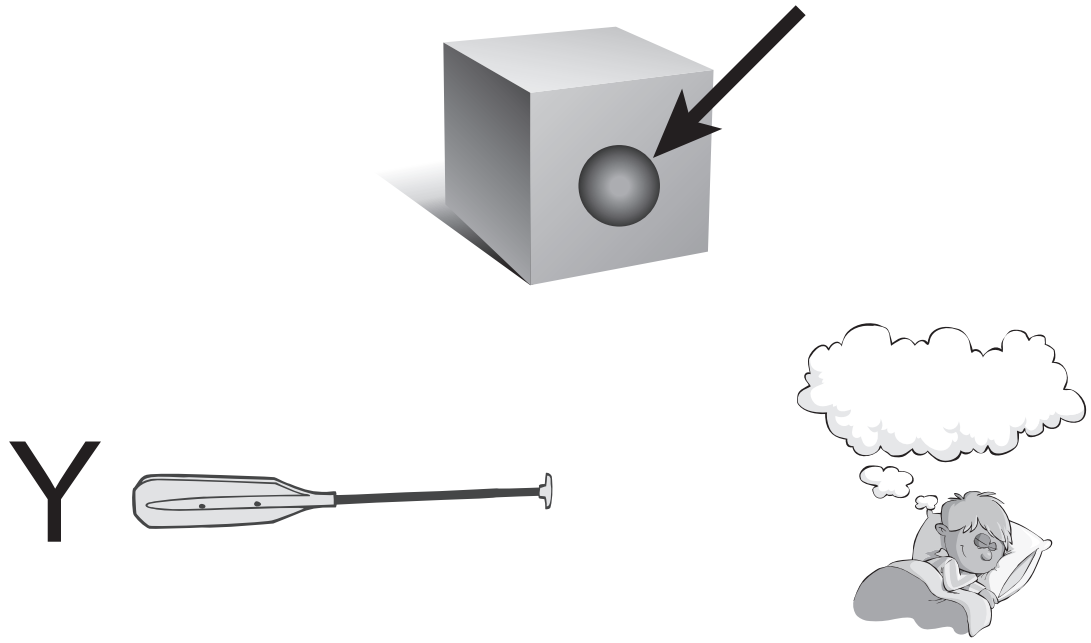
Participant Guide

References

10 USC
32 CFR § 199, 199.20
National Defense Authorization Act (NDAA)
2008 TRICARE Operations Manual, Chapter 16; Chapter 24: Section 12, 18
2002 TRICARE Operations Manual, Chapter 17

Brainteaser

What phrase is represented below?



Riddle

It is the beginning of eternity, the end of time and space, the beginning of the end, and the end of every space. What is it?

Module Objectives

- **Define the TRICARE Prime Remote Options**
- **Identify who is eligible for Prime Remote**
- **Explain how Prime Remote enrollees access health care**
- **Describe the TRICARE Point of Contact's (POC's) role**

1.0 TRICARE Options in Remote Locations

All Prime Remote options offer:

- Access to primary care, clinical preventive, and specialty health care services
- No deductibles, copayments or cost-shares except for stateside pharmacy benefits for active duty family members and for enrolled ADFMs who receive care under the point-of-service option
- No claim forms or paperwork if care is coordinated through a stateside network provider and contractor or the overseas contractor
- Toll-free 24-hour access to health care information, referrals, and authorization
- Medical evacuation (overseas)

Sponsors must ensure their address, unit, and family member information are current and accurate in the Defense Eligibility Enrollment Reporting System (DEERS) so members and families are enrolled in the appropriate remote option. Remember, the services determine TRICARE eligibility, and the regional contractors process enrollments.

1.1 TRICARE Prime Remote (TPR)

TPR is a stateside option that provides health care to active duty service members (ADSMs) who live and work in TPR-designated ZIP codes (greater than 50 miles or one hour drive time) from a military treatment facility (MTF). Like Prime, it provides health care coverage through civilian network or TRICARE-authorized providers, and referrals and authorizations are required for TRICARE-covered specialty care.

1.2 TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

TPRADFM is a Prime-like option for eligible active duty family members (ADFMs) who reside with their active duty sponsor in designated stateside TRICARE Prime Remote locations (residence exceptions may apply for Guard/Reserve members—see table on the following page).

1.3 TRICARE Overseas Program (TOP) Prime Remote

- TOP Prime Remote offers TRICARE Prime coverage to ADSMs permanently assigned to designated remote locations overseas and their eligible command-sponsored family members
    - Only ADSMs and ADFMs who meet the Joint Federal Travel Regulation (JFTR) definition of command-sponsored (defined as entitled to travel to overseas commands at the government's expense and endorsed by the appropriate military commander to be present in a family member status) are eligible for TOP Prime Remote enrollment.

Note: Throughout this module, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), and TRICARE Overseas Program (TOP) Prime Remote are referred to as "Prime Remote" unless otherwise specified.

2.0 Prime Remote Eligibility

ADSMs, Guard/Reserve members on written federal orders for more than 30 consecutive days, eligible family members, and transitional survivors are eligible for the Prime Remote options.

- Beneficiaries who are not eligible for the Prime Remote options:
    - Retirees and their eligible family members, survivors, unremarried former spouses, and ADSMs and ADFMs during their Transitional Assistance Management Program (TAMP) period
    - ADFMs who live in Prime Remote locations, but don't live with the sponsor and/or aren't command-sponsored
- Newborns and adoptees are eligible for TPRADFM/TOP Prime Remote as long as they meet Prime eligibility criteria. (See the *TRICARE Options* module for more information.)

Stateside (TPR/TPRADFM) Eligibility

TPR

- ADSMs and activated Guard/Reserve members must have a permanent duty assignment greater than 50 miles (based on ZIP code) or approximately a one-hour drive from an MTF **and** reside at a location greater than 50 miles (based on ZIP code) or approximately one-hour or more drive from an MTF.
  - To see if they qualify for TPR, direct ADSMs to the "TPR ZIP Code Look-up Tool" at www.tricare.mil/tpr.
- If the active duty member lives within 50 miles of an MTF, but geographic conditions create more than a one hour drive time, the ADSM may apply for a waiver of TPR requirements.
  - ADSMs should complete a *TRICARE Prime Remote (TPR) Determination of Eligibility Enrollment Request Form* and submit it through their unit commander for consideration by the TRICARE Regional Office (TRO). To obtain this form, direct service members to the following websites:
    - North Region: www.tricare.mil/tronorth/eligibilityenrollmentform
    - South Region: www.tricare.mil/trosouth/eligibilityenrollmentform
    - West Region: www.tricare.mil/trowest/tprwaiverrequest

TPRADFM

- ADFMs are eligible for TPRADFM if:
  - The sponsor is enrolled in TPR.
  - The ADFM(s) resides with the sponsor. "Resides with" is defined as the residence address where the family lives/lived with the sponsor while the sponsor is enrolled in TPR, as recorded in the DEERS.
- Transitional survivors who live in Prime Remote designated locations may enroll.
- TRICARE allows activated Guard/Reserve family members to enroll in TPRADFM as long as they meet the following criteria:
  - Family members lived with the Guard/Reserve sponsor when the sponsor was activated.
  - The sponsor's residential address at the time of activation was in a TPR ZIP code as recorded in the DEERS.
  - To remain eligible, the family members must continue to reside at the same residential address.

Note: In this case, the sponsor does not need to be enrolled in TPR to have his/her family enroll in TPRADFM.

Overseas (TOP Prime Remote) Eligibility

TOP Prime Remote—for Active Duty Service Members

- ADSMs or Guard/Reserve members must have a permanent duty assignment at a designated remote overseas location.
- Guard/Reserve members are also eligible if they lived in a TOP Prime Remote location at the time of activation.

TOP Prime Remote—for Active Duty Family Members

- Family members eligible for TOP Prime Remote are:
  - ADFMs on permanent change of station orders and/or command-sponsored to accompany the sponsor to the remote overseas location
  - ADFMs who are command-sponsored or on service funded orders to relocate to a remote overseas location without the sponsor
  - Transitional survivors who live in TOP Prime Remote designated locations
  - Command-sponsored Guard/Reserve family members if the Guard/Reserve sponsor lived in a TOP Prime Remote location at the time of mobilization
    - Family members must have the same overseas residential address as the Guard/Reserve sponsor at the time of the sponsor's mobilization, as recorded in the DEERS

3.0 Enrollment

- When the ADSM/activated Guard/Reserve member is eligible for TPR or TOP Prime, enrollment is mandatory unless there are service specific directions that require assignment to a uniformed service primary care manager (PCM) or if the ADSM elects to waive access standards and enroll at an MTF (subject to commander/TRO approval).
    - Guard/Reserve members are required to enroll unless they're deployed or in transit to a theater of operations where operational medical assets are available.
- Enrollment options (Prime or Prime Remote) depend on the location of the uniformed service sponsor's work unit location, not his/her residence.
- Enrollment is voluntary for ADFMs; they may choose to enroll on an individual or family basis.
    - Eligible family members who live in designated Prime Remote locations but don't enroll in TPRADFM/ TOP Prime Remote are covered under TRICARE Standard/Extra.

3.0.1 Stateside Enrollment

- If a TPR-enrolled sponsor receives orders to an unaccompanied assignment (where family members aren't authorized to accompany the sponsor), the family members may remain enrolled in TPRADFM as long as they continue to reside in the same TPR location they lived in before the sponsor's departure (as recorded in DEERS).
- Guard/Reserve family members may remain enrolled in TPRADFM at the same residence as when the member was activated, regardless of the sponsor's subsequent assignment, enrollment location, or temporary residence as long as the sponsor remains on active duty.

3.0.2 Overseas Enrollment

- When the ADSM sponsor is reassigned on unaccompanied orders to a location that does not permit command-sponsored family members, the TOP Prime enrolled family member(s) may remain enrolled at their current location as long as they remain command-sponsored.
    - **Note:** These family members may remain in TOP Prime Remote for a period of time based on the length of the sponsor's unaccompanied orders. This may not exceed two years. (The normal unaccompanied tour is less than 24 months.)

3.1 Enrollment Processing

ADSMs/ADFMs must submit a *TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form* (DD Form 2876) to the appropriate regional contractor.

- Coverage begins as follows:
    - TPR coverage begins the date the *DD Form 2876* is received.
    - TPRADFM coverage follows the 20th-of-the-month rule. (See the *TRICARE Options* module for more information on the 20th-of-the-month rule.)
    - TOP Prime Remote coverage begins the date TOP contractor receives the *DD Form 2876* and orders to reflect command sponsorship. There is no 20th-of-the-month rule overseas.
- Points of Contact (POCs) may assist beneficiaries in TOP Prime Remote sites by accepting and forwarding enrollment forms to the overseas contractor, as authorized under the TOP POC program.
- Prime Remote enrollment is automatically renewed until the sponsor or family member moves, the sponsor's status changes (from active duty to retiree), or the enrollee loses eligibility.

3.2 Lockouts and Disenrollment

- The same lockout and disenrollment rules that apply to ADSMs/ADFMs enrolled in Prime also apply to Prime Remote enrollees. (See the *TRICARE Options* module for more information on lockouts and disenrollment).
    - ADSMs and family members are disenrolled from Prime Remote when the sponsor retires since the remote options are only available to ADSMs and ADFMs. Though disenrolled, they remain eligible for TRICARE Standard/Extra at that same location.
    - Prime Remote enrollees are disenrolled from their Prime Remote option when they lose eligibility or the sponsor separates from uniformed service.

4.0 Moving and Traveling with Prime Remote Options

- Prime Remote coverage may transfer upon change of duty location within or between regions, and between Prime Remote and Prime. Enrollees must meet the required enrollment criteria (e.g., reside with their sponsor, command-sponsored).
- With permanent change of station assignments, ADSMs must transfer their enrollment to another Prime location (stateside or overseas), or follow Service enrollment guidance when they get to their new duty station.
- Enrollment transfers are effective the date the gaining regional contractor receives a signed *DD Form 2876*.
- When moving or traveling, Prime Remote enrollees follow the same rules and processes as TRICARE Prime and TOP Prime enrollees. (See the *TRICARE Options* module for more information on transferring TRICARE coverage when moving and receiving care while traveling.)

5.0 Primary Care Management

Stateside (TPR/TPRADFM)
● TPR and TPRADFM enrollees are assigned a network primary care manager (PCM) if there is one available in the local area, or may seek care from any TRICARE-authorized non-network provider when a network provider isn't available. (The non-network provider is then considered the provider enrollees will use for primary care services.) ● TPR/TPRADFM enrollees may ask to change their PCM or primary care provider at any time as long as the new PCM or primary care provider is accepting enrollees.
Overseas (TOP Prime Remote)
● TOP Prime Remote enrollees coordinate their health care through the TOP contractor. ● The overseas contractor's Call Centers serve as PCM by coordinating all medical and dental care for ADSMs and medical care only for command-sponsored ADFMs. ● Whenever possible, the overseas contractor contacts qualified purchased care/host nation providers and coordinates an authorization for services to facilitate a "cashless and claimless" episode of care. ○ A "cashless, claimless" episode of care means the provider won't make the TOP Prime Remote enrollee pay up front for TRICARE covered services. The provider also files the claim on the enrollee's behalf.

6.0 Seeking Care, Referrals, and Authorization

Under the Prime Remote options, enrollees are provided access to routine, urgent, emergency, and specialty care services similar to Prime, as well as aeromedical evacuation for TOP Prime Remote enrollees.

6.1 Routine Care

Routine care includes general office visits for the treatment of symptoms, chronic or acute illnesses, disease, and follow-up care for an ongoing medical condition including preventive care (also known as primary care).

Stateside Routine Care (TPR/TPRADFM)
● TPR/TPRADFM enrollees receive routine care from their assigned PCMs (network providers where available) or chosen TRICARE-authorized providers.
Overseas Routine Care (TOP Prime Remote)
● Routine care is typically provided by a U.S. Embassy provider or clinic. If they cannot provide the needed service, then care is coordinated through the overseas contractor's Regional or Country-specific Call Center. ● Enrollees should expect to receive a routine care appointment within seven days.

6.2 Urgent Care

Urgent care is generally defined as nonemergency acute illness or injury which requires medically necessary treatment, but would not result in disability or death if not treated immediately. This kind of illness or injury does require professional attention and should be treated within 24 hours to avoid further complications.

Stateside Urgent Care (TPR/TPRADFM)
● TPR enrollees should contact their PCM or primary care provider or regional contractor for urgent care needs. ● If the PCM or primary care provider cannot provide the required urgent care, the provider should write a referral. The regional contractor issues the care authorization. ○ The contractor forwards TPR-enrolled ADSMs referrals to the Military Medical Support Office (MMSO) for fitness-for-duty review and an authorization determination. The MMSO may require these ADSMs to seek services from an MTF or may authorize the enrolled ADSM to seek services from a network or authorized provider. (See Section 7.0 of this module for more information.)
Overseas Urgent care (TOP Prime Remote)
● Urgent care is coordinated through the overseas contractor's Regional or Country-specific Call Centers. Enrollees should expect to receive an urgent care appointment within 24 hours.

6.3 Specialty Care

Specialty care is generally defined as care the PCM is not able to provide.

- All Prime Remote enrollees require a referral and prior authorization for specialty care. The PCM or primary care provider routes the referral to the regional contractor. The regional contractor reviews the referral to conduct a medical necessity and benefit review and then issues an authorization determination (approval or denial).
- Regional contractors notify enrollees of authorization determinations, information about the authorized provider, and services the enrollee is authorized to receive. The contractor provides authorization information to the specialty provider as well.
- If a Prime Remote-enrolled ADFM seeks specialty care without a referral and authorization, point-of-service (POS) charges apply. (See the *TRICARE Options* module for more information on POS.)

Stateside Specialty Care (TPR/TPRADFM)
TPR ● The regional contractor refers **all active duty** TPR-enrollee specialty care and inpatient referrals to the Military Medical Support Office Service Point of Contact (MMSO SPOC) for review, fitness-for-duty determination, and care authorization. (See Section 7.0 of this module for more information.) **TPRADFM** ● TPRADFM enrollees should only seek specialty services after an authorization is issued to avoid POS charges.
Overseas Specialty Care (TOP Prime Remote)
● Enrollees are to coordinate specialty care through the overseas contractor's Regional or Country-specific Call Centers. Specialty care overseas includes diagnostic tests. ● Appointments are "cashless and claimless" if coordinated by the overseas contractor's call centers. ○ The TOP contractor forwards the authorization for services to the purchased care/host nation provider. ● Enrollees should expect to receive a specialty care appointment within 28 days. ○ For non-urgent specialty care appointments, enrollees may set up appointments for themselves, but should allow the overseas contractor at least 48 hours advanced notice to prepare the authorization. ● TOP Prime Remote enrollees who seek care without prior authorization may have to pay up front and file a claim on their own for reimbursement; POS charges would apply.

6.4 Emergency Care

Medical services provided for a sudden or unexpected medical, dental, or psychiatric condition, or the sudden worsening of a chronic (ongoing) condition that is threatening to life, limb, or sight and needs immediate medical treatment, or which has painful symptoms that need immediate relief to stop a beneficiary's suffering.

Note: When emergency care is required, Prime Remote enrollees should go to the nearest emergency care location. They don't need to call their PCM or primary care provider before seeking emergency care.

Stateside Emergency Care (TPR/TPRADFM)
● TPRADFM enrollees are to notify their PCM or primary care provider within 24 hours, or the next business day, to get a referral and authorization for emergency care and to coordinate ongoing services. ● TPR-enrolled ADSMs should contact the MMSO SPOC as soon as possible after receiving emergency services. A referral should be sent by the member's provider or the member to the regional contractor as soon as possible for the MMSO review and authorization.
Overseas Emergency Care (TOP Prime Remote)
● Enrollees may contact the overseas contractor's Regional or Country-specific Call Center for assistance to find a purchased care/host nation emergency medical facility, if time permits. ○ Enrollees should notify the contractor of an emergency care visit within 24 hours, or the next business day, so that ongoing care can be coordinated and properly authorized. ○ Enrollees should provide the hospital's contact information to the contractor and/or a copy of the emergency room bill. ● For emergency care, ADSMs should also contact their parent service unit as soon as possible before, during, or after care is provided. ● If enrollees follow the process above, they typically won't have to pay out-of-pocket for TRICARE covered services.

7.0 Role of Service Points of Contact (Stateside)

- The services retain health care oversight of ADSM TPR-enrollees (including those assigned to the Virgin Islands) through their Service Points of Contact (SPOCs) and nurse consultants at the MMSO or other headquarters.
- The SPOCs serve as liaisons between:
  - Active duty service members
  - The branch of service
  - Regional contractors
- SPOCs review referrals and medical claims to determine the impact diagnosis or treatment may have on the ADSM's fitness-for-duty and whether the member requires care at an MTF.
- Nurse consultants authorize ADSM TPR-enrollee specialty care.
- SPOCs review deferred medical claims from regional contractors and execute approval or denial of payments.
- SPOC questions may be directed to:
  - Army, Marine Corps, Navy, Air Force, Coast Guard, and National Guard:
    - 1-888-MHS-MMSO/1-888-647-6676 (toll free)
    - Military Medical Support Office
      P.O. Box 886999
      Great Lakes, IL 60088-6999
  - United States Public Health Service (USPHS): 1-800-368-2777, option #2
  - National Oceanic and Atmospheric Administration (NOAA): www.noaa.gov
- **Note:** BCACs/DCAOs, providers, and health care finders are encouraged to contact the SPOC in specific situations for information and clarification on health care for TPR-enrolled ADSMs. (A partial listing in Appendix B of this module provides basic guidelines as to what types of health care services require fitness-for-duty review by the SPOC.)

8.0 The TOP Point of Contact (POC) Program (Overseas)

- The TOP POC Program is a liaison service that assists TOP Prime Remote enrollees by facilitating enrollment, medical travel, and timely TRICARE claims filing.
  - TOP POCs are designated by various government agencies.
  - TOP POCs:
    - Assist beneficiaries with the timely completion and filing of TOP claims forms
    - Secure and safeguard Protected Health Information (PHI), Personally Identifiable Information, and Sensitive Information
    - Assist ADSMs and Prime enrolled ADFMs with coordinating their return travel after medical evacuation and hospital discharge with the ADSM or ADFM
  - TAOs develop and distribute a region-specific POC Program booklet outlining specific POC duties and responsibilities. Each TAO office also develops and implements region-specific POC training.
    - Questions regarding specific POC duties and responsibilities are addressed to the appropriate TAO office for resolution.

9.0 Medical Travel for Active Duty Service Members (ADSMs) Overseas

9.1 Non-Availability of Care in the TOP Prime Remote Region

- When necessary medical care (including diagnostic services) is not available in the overseas remote location, the overseas contractor contacts the TRICARE Area Office (TAO) to begin coordination of medical care (travel and appointments) to the nearest MTF or purchased care/host nation medical facility. Part of the coordination involves determining medical necessity for the out-of-country appointment. When appropriate, the TAO may coordinate the appointment with a designated medical facility based on the availability of care and cost effectiveness of travel and per diem costs.
    - ADSMs are required to complete a medical TAD/TDY form and contact their respective POC for assistance with coordinating and receiving funding through their respective command or service. Travel orders for flights, per diem, and other associated costs are funded through the command or service fund site.
- Each time specialty care or diagnostics services are needed (e.g., follow-up appointments, MRIs, CT scans) the overseas contractor must be contacted to facilitate a new referral/authorization. In some instances, multiple visits may be authorized in advance based on the proposed treatment plan.

9.2 Aeromedical Evacuation

Aeromedical evacuation funding is service-specific and may be requested through the TOP POC.

9.2.1 Role of the TOP Contractor in Aeromedical Evacuation

- The TOP contractor's regional call center arranges medically necessary aeromedical evacuations for the following beneficiaries:
    - TOP Prime Remote enrollees
    - ADSMs who are deployed, TAD/TDY, or in an authorized leave status overseas
    - Stateside Prime enrolled ADSMs and ADFMS (regardless of enrollment location) while traveling outside of the US.
- The TOP contractor:
    - Determines medical necessity
    - Identifies the most appropriate method of evacuation
    - Schedules the evacuation
    - Authorizes the services needed
    - Arranges medical records transfers
    - Coordinates patient transfers with the receiving health care provider or institution
    - Ensures the ADSM's unit is aware of the medical evacuation

9.2.2 Role of POCs in Aeromedical Evacuations

- POCs determine command/service-specific fund sites for out-of-country medical travel.
    - Enrollees must travel with their TOP Prime Remote enrollment card, uniformed services ID card, and travel orders.
    - Enrollees are advised to review their travel orders and itinerary prior to traveling.
    - Enrollees are informed that any deviation from the approved itinerary will not be reimbursed.
- POCs should provide enrollees with a reliable contact number for the medical travel order issuing authority. Enrollees may then contact the travel authority if the approved itinerary doesn't provide adequate travel time in either direction.
- POCs should inform enrollees that commercial travel is only authorized as indicated by the fund site memorandum; commercial travel to a location other than the Temporary Additional Duty/Temporary Duty (TAD/TDY) destination will not be reimbursed.

9.2.3 Aeromedical Evacuations and Fund Sites

The services issue a fund site to pay claims filed by the TOP contractor on behalf of TOP Prime Remote enrolled ADSMs for approved medically necessary medical evacuations.

- TOP POCs usually work with two types of fund sites to cover certain costs for health care and medical travel for ADSMs not covered under TOP Prime Remote:
  - Service-specific fund sites: for TRICARE-covered services received in remote locations without contractor coordination
  - Command/service fund sites: travel for specialty care/diagnostic tests
- Approval of payment is at the discretion of the fund site holder; medical travel funds are allocated for travel and per diem and do not cover the cost of rental cars, telephone calls, or personal expenses.

9.3 Care Onboard Commercial Seagoing Vessels

- When Prime Remote enrollees receive care onboard commercial seagoing vessels while outside of U.S. territorial waters, they should pay the full cost of care up front and file a claim with the TOP claims processor.
  - Claims are processed as foreign claims regardless of the provider's mailing address.
    - If the provider is licensed to practice medicine in the United States, reimbursement rates are based on the provider's address.
    - If the provider is not licensed to practice medicine in the United States, reimbursement rates follow the same rules as other purchased care/host nation provider claims.

10.0 TOP Prime Remote Physical Exams (Overseas)

- TOP Prime Remote enrollees may require physical exams for the following reasons:
  - Fitness for duty/flight physicals
  - Routine
  - Retirement
  - School*
  - Sports and others*

***** *Not all types of physical exams can be covered by TRICARE. Service-specific guidance regarding ADSM physicals is described below. TRICARE coverage information can be found on www.tricare.mil or by contacting the regional contractor.*

10.1 Fitness for Duty

- TOP POCs should contact the ADSM's service (e.g., Army, Marine Corps) representative for guidance on issues related to medical care, flight physicals, periodic medical exams, and retirement physicals and funding for travel.

10.2 Routine Physicals for ADSMs

- Based on service-specific guidelines purchased care/host nation providers may perform (three-year/five-year) physicals. ADSMs should contact the overseas contractor for appointments and authorizations.
- When physicals can't be performed in-country and TAD/TDY funds for medical travel to the United States are not available, the physical may be authorized and scheduled in conjunction with non-medical stateside TAD/TDY or while the service member is on leave in the United States.

10.3 Retirement Physicals

- Retirement physical guidelines vary between the services.
- TOP POCs can assist enrollees by directing them to their respective service representative for assistance.

10.4 School Physicals for ADFMs

- When required in connection with school enrollment, TOP Prime Remote enrollees ages 5–11 are authorized to receive school physicals.
- Enrollees should schedule these physical appointments through the overseas contractor.

10.5 Sports and Other Physical Exclusions

- TRICARE doesn't cover sports physicals, which are considered elective and not medically necessary.
- TRICARE doesn't cover any physicals for administrative purposes (e.g., visa and passport physicals).

11.0 Overseas Maternity Care

TOP Prime Remote covers maternity care, including prenatal care, delivery, and postpartum care.

11.1 In-Country Maternity Care

- TOP Prime Remote enrollees should contact the overseas contractor to inquire about maternity care in the country where the enrollee resides.
    - The overseas contractor attempts to locate a purchased care/host nation provider who can provide the appropriate services for the duration of the pregnancy.
    - If appropriate maternity care is not available in-country, the overseas contractor coordinates medical travel with the TAO.
- Upon delivery, TOP Prime Remote enrollees continue to receive postpartum care, generally for up to six weeks after the baby's delivery. Postpartum care appointments are coordinated through the overseas contractor's Regional or Country-specific Call Center.
- When the enrollee needs treatment for something other than maternity care while she's pregnant (e.g., cold, sprained ankle) the TOP contractor can schedule a routine appointment with a qualified host nation provider.

11.2 Requests to Deliver in the States

- When care is available in the host nation, but the ADFM requests to deliver stateside:
    - The TOP POC or the enrollee must contact the overseas contractor for assistance to coordinate care with a designated stateside MTF, TRICARE network, or authorized provider near the enrollee's chosen location, depending on Prime/TPRADFM availability.
- If the enrollee chooses to deliver stateside, the sponsor's service or command issues a fund site for travel to the nearest point of entry into the United States.
    - Upon arrival to the States, enrollees may transfer their TOP Prime enrollment if Prime is available in the local area.
    - If the enrollee moves to an area that is not a Prime Service Area and she does not qualify for TPRADFM because she doesn't reside with her sponsor, TRICARE coverage reverts to TRICARE Standard.
    - If the enrollee moves to a Prime Service Area, but fails to transfer enrollment within 60 days of departure from the overseas region, coverage reverts to TRICARE Standard.

12.0 TRICARE and Non-Combatant Evacuation Operations (NEO)

- NEO guidelines are designed to ensure that family members experience no lapse in their TRICARE coverage due to an evacuation.
  - There are special TRICARE policies that apply to ADFMs evacuated from overseas locations. (See *Health Affairs Policy 03-006,* available at www.health.mil.)
  - TOP Prime and TOP Prime Remote enrollees are allowed up to 210 days from the date of the initial evacuation order to travel and transfer enrollment to a new region.
  - When ADFMs relocate to a new overseas location offering TOP Prime or TOP Prime Remote, they can transfer enrollment to the appropriate TRICARE program based on their orders and location.

13.0 TPR Application Exercises

First Lieutenant John Smith, an Army National Guard member, lives with his wife and two children in Brookline Station, Missouri, a TPR-designated location. He just received active duty orders for 365 consecutive days. Effective tomorrow, he will report to Fort Smith, Arkansas, for 15 days with a subsequent deployment to Afghanistan in support of Operation Enduring Freedom.

He and his wife agree that the family should continue to live at their current residence during his deployment.

Given the scenario above and what you have learned about TRICARE Prime Remote, answer the following questions, and prepare to explain your answers.

Q1. What coverage options are available to the Smith family?

Q2. Is the Smith family eligible for TPRADFM during Lieutenant Smith's deployment?

Q3. How can you be sure whether they're eligible?

Module Objectives

Summary:

- **Define the TRICARE Prime Remote Options**
- **Identify who is eligible for Prime Remote**
- **Explain how Prime Remote enrollees access health care**
- **Describe the TRICARE Point of Contact's (POC's) role**

Appendix A: Medical Matrix Homework

Medical Benefit Program Matrix Homework Instructions

- Using your TRICARE Fundamentals Course Participant Guide and class notes, write the appropriate answer in each of the squares on the Program Matrix.
- Answers for the matrix:
  - Can be either “Yes,” “No,” or “N/A” (not applicable)
  - May require dollar amounts only
    - Some costs are covered in this book; others may require you to do additional research on the TRICARE Costs website (www.tricare.mil/costs)
  - Some “Yes” answers may require additional information
- **Suggestion:** Complete the homework with the help of a study group.

	Prime			Prime Remote			Standard/Extra		
	ADSM	**ADFM**	**Retired**	**ADSM**	**ADFM**	**Retired**	**ADSM**	**ADFM**	**Retired**
Enrollment required (Y/N)									
Command sponsorship required (Y/N)									
Enrollment fee (Y/N)									
PCM assigned (Y/N)									
Copays (Y/N)									
Cost-shares (Y/N)									
Catastrophic cap (amount)									
Deductibles (amount)									
Claims filed by beneficiary (Y/N)									
MTF access (Y/N)									
Portable (Y/N)									
Available overseas (Y/N)									
Civilian equivalent plans									
Advantages									

Appendix B: Active Duty Care Guidelines

The following is a partial list of guidelines for providers and the contractors as to what types of health care services require a fitness-for-duty review by the SPOC.

For a sampling of additional treatment situations that require SPOC review, please see the 2008 TRICARE Operations Manual, Chapter 16, Addendum B.

For additional information on the SPOC review process, visit the MMSO website at www.tricare.mil/mmso.

Health Care Service	SPOC Review Required?	Who Provides Care?
Primary care medical services	No	PCM (TRICARE-authorized civilian provider or MTF)
Emergency/urgent consults and tests required within 48 hours	Yes, but care won't be delayed while waiting for SPOC response	TRICARE-authorized civilian provider
	Follow-up specialty care requires SPOC review	
Periodic health assessments	No	PCM (TRICARE-authorized civilian provider) or MTF
Periodic eye and hearing exams	No	TRICARE-authorized civilian provider or MTF as designated by SPOC
Eyeglasses/contacts	Yes	MTF or service labs; SPOC provides information to ADSM
Service specific physical exams (For DoD/Service Forms)	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC

Appendix C: TOP Prime Remote Resources

Eurasia-Africa	Latin America and Canada	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 1-877-678-1207 (Calling from U.S.) tricarelon@internationalsos.com +44-20-8762-8384 (calling from overseas) Medical Assistance: +44-20-8762-8133	**TOP Regional Call Center** 1-877-451-8659 (Calling from U.S.) tricarephl@internationalsos.com 1-215-942-8393 (calling from overseas) Medical Assistance: 1-215-942-8320	**TOP Regional Call Centers** Singapore (Calling from U.S.): 1-877-678-1208, opt. 4 sin.tricare@internationalsos.com Sydney (calling from U.S.): 1-877-678-1209, opt. 4 sydtricare@internationalsos.com Medical Assistance: Singapore: +65-6338-9277 Sydney:+61-2-9273-2760
TRICARE Area Office Toll Free Phone (Calling from U.S.): 1-888-777-8343, opt. #1 Commercial Phone: + 49-6302-67-6314 DSN: 1-314-496-6314 Commercial Fax: +49-6302-67-6378 DSN Fax: 1- 314-496-6378 E-mail: teoweb@europe.tricare.osd.mil Address: TAO-Eurasia-Africa Unit 10310 APO AE 09136-0130	**TRICARE Area Office** Toll Free Phone (Calling from U.S.): 1-888-777-8343, opt. #3 Commercial Phone: +1-210-292-8520 DSN: 554-8582 Commercial Fax: +1-210-292-3224 E-mail: taolac@tma.osd.mil Address: TAO-Latin America & Canada 7800 IH-10 West, Suite 400 San Antonio, TX 78230	**TRICARE Area Office** Toll Free Phone (Calling from U.S.): Singapore: 1-877-678-1208, opt. 4 Sydney: 1-877-678-1209, opt. 4 Commercial Phone: + 81-6117-43-2036 DSN: 315-643-2036 Commercial Fax: +81-6117-43-2036 DSN Fax: 315-643-2037 E-mail: tpao.csc@med.navy.mil Address: TAO-Pacific NH Okinawa PSC 482, Box 2749 FPO AP 96362
Overseas Claims Information		
All Overseas Active Duty Claims TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7969 1-608-301-2311		
All Other Claims (Separated by Region)		
TRICARE Overseas Program P.O. Box 8976 Madison, WI 53707-8976 1-608-301-2310, opt. 2	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7989 1-608-301-2311, opt. 2	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-608-301-2311
Website: www.tricare-overseas.com		

TRICARE Fundamentals Course

Transitional Benefits

6

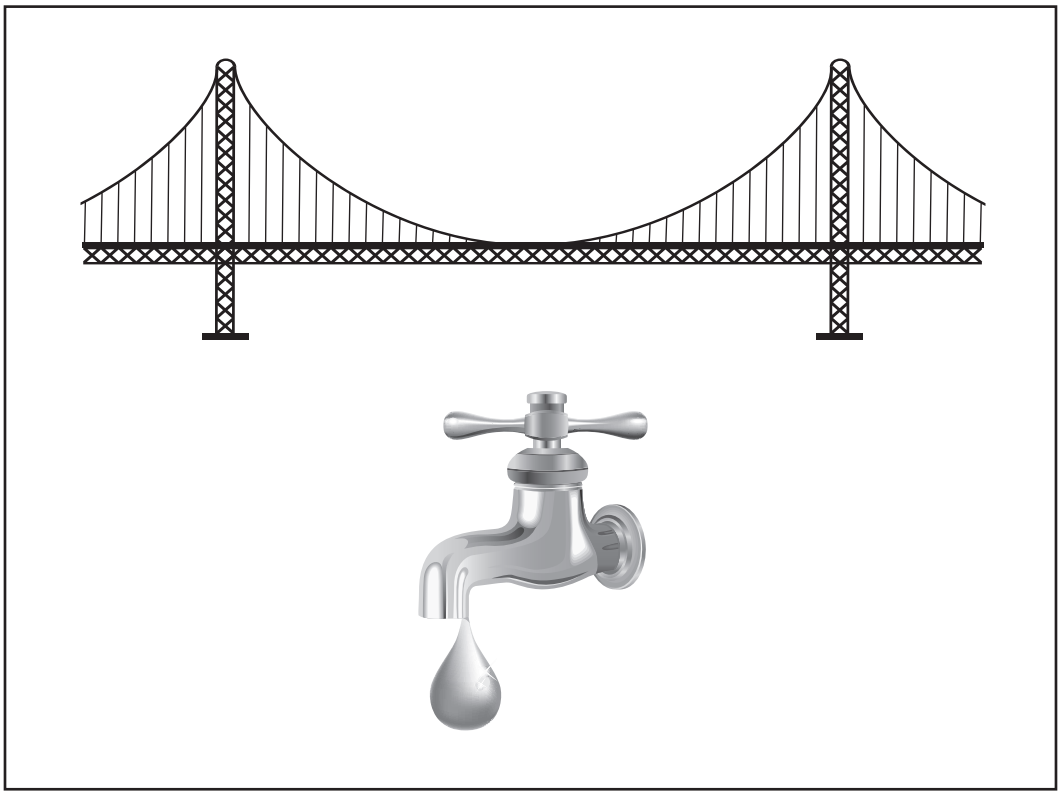
Participant Guide

References

10 USC
32 CFR §§ 199.20, 199.3
Public Law 102-484, 102-125, 103-337,108-375,101-510
National Defense Authorization Act, FY 1993
2008 and 2002 TRICARE Policy Manual, Chapter 10
2002 TRICARE Policy Manual, Chapter 12

Brainteaser

What phrase is represented below?



Riddle

I have three changing faces. When I give my signal, I start races. What am I?

Module Objectives

- **Explain the purpose of the Transitional Assistance Management Program (TAMP)**
- **State who is eligible for the Continued Health Care Benefit Program (CHCBP)**
- **Explain the purpose of a Certificate of Creditable Coverage**

1.0 TRICARE Transitional Health Care Coverage

The transition from military life back to civilian life can be challenging. TRICARE assists certain active duty service members (ADSMs), eligible National Guard or Reserve members, eligible family members, and others losing TRICARE eligibility with this transition by continuing to provide TRICARE benefits.

Military retirees remain TRICARE eligible. Certain other beneficiaries are offered continued health care coverage through select transitional programs:

- Transitional Assistance Management Program (TAMP)
- Transitional Care for Service-Related Conditions (TCSRC)
- Continued Health Care Benefit Program (CHCBP)

2.0 Transitional Assistance Management Program (TAMP)

TAMP provides 180 days of transitional health care coverage for certain members of the uniformed services and their families, based on the sponsor's eligibility.

2.1 TAMP Eligibility

Each branch of service determines eligibility for TAMP and records it in DEERS.

2.1.1 Eligibility for Service Members

A uniformed service member is considered TAMP eligible if he or she is:

- A member who is involuntarily separated from active duty under honorable conditions
- A member who is separating from active duty after being involuntarily retained (stop-loss) in support of a contingency operation
- A member who is separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation
- A National Guard or Reserve member separating from a period of active duty that was more than 30 consecutive days in support of a contingency operation
- A member receiving a sole survivorship discharge when the service member is the only surviving child in a family in which the mother or father, or one or more siblings, served in the Armed Forces and as a result of their service either died or were severely injured resulting in permanent disability
- A member separating from active duty who agrees to become a member of the Selected Reserve

Note: Involuntarily separated service members may or may not be eligible for TAMP and should check with their service personnel department to see if they qualify for TAMP benefits.

2.2 Health Care Coverage During TAMP

- TAMP provides 180 days of health care coverage under:
  - TRICARE Standard and Extra
  - TRICARE Overseas Program (TOP) Standard
  - TRICARE Prime (enrollment required)
  - TOP Prime (enrollment required)
  - US Family Health Plan (USFHP)
- TAMP coverage, by default, is TRICARE Standard/Extra or TOP Standard.
- Under TAMP, beneficiaries aren't eligible for TRICARE Prime Remote (TPR),TRICARE Prime Remote for Active Duty Family Members (TPRADFM), or TOP Prime Remote.

2.2.1 Enrollment in TRICARE Prime, TOP Prime, and USFHP During TAMP

- The following guidelines apply to TAMP eligibles who are enrolling in TRICARE Prime, TOP Prime, or USFHP after the sponsor separates from active duty:

Stateside	Overseas
● TAMP eligibles who were enrolled in TRICARE Prime, TPR, TPRADFM, or USFHP before the sponsor's separation may reenroll in TRICARE Prime or USFHP (but not TPR or TPRADFM) without a break in coverage, as long as they submit a new *TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form* (DD Form 2876) before the TAMP period ends. ○ The enrollment effective date is the date the eligible sponsor separated from active duty. ● TAMP eligibles who weren't enrolled in TRICARE Prime, TPR, TPRADFM, or USFHP before the sponsors' separation may choose to enroll in TRICARE Prime or USFHP (if available at their location). However, enrollment is subject to the "20th-of-the-month" rule. (See the *Glossary* module for more information.)	● TAMP eligibles who were enrolled in TOP Prime before the sponsor's separation may reenroll in TOP Prime without a break in coverage, as long as they submit a new *DD Form 2876* before the TAMP period ends. ○ The TOP Prime effective date is the date the eligible sponsor separated from active duty. ● TAMP-eligible family members who were eligible to enroll in TOP Prime before their sponsor's separation, but didn't, may enroll in TOP Prime by submitting a *DD Form 2876*. ○ The TOP Prime effective date is the date the *DD Form 2876* is signed. ● TAMP-eligible family members who **weren't** eligible to enroll in TOP Prime before their sponsor's separation (e.g., because they weren't command sponsored), cannot enroll in TOP Prime during the TAMP period; they are covered under TOP Standard.

- If the sponsor is recalled to active duty during the TAMP period, the following guidelines apply to family members wanting to remain enrolled in TRICARE Prime, TOP Prime, or USFHP:
  - TAMP-eligible family members who were enrolled in TRICARE Prime or TOP Prime before their sponsor's reactivation may continue their enrollment with no break in coverage if they submit a new *DD Form 2876* within 30 days of their sponsor's return to active duty status.
  - If they don't submit a new *DD Form 2876* within 30 days of the sponsor's return to active duty status, they revert to TRICARE Standard or TOP Standard, until a new *DD Form 2876* is submitted. The "20th-of-the-month" rule applies and there may be a break in Prime coverage.

2.3 Dental Coverage During TAMP

- During TAMP, former ADSMs may receive dental care at dental treatment facilities on a space-available basis.
- Former ADSMs may also choose to purchase TRICARE Dental Program coverage for themselves and their families.
- National Guard and Reserve members activated for more than 30 days in support of a contingency operation continue active duty dental benefits during TAMP.
  - They may receive care at a uniformed services dental treatment facility (no matter how close they live to a dental treatment facility) or from civilian dental providers through the Active Duty Dental Program (ADDP).
  - All orthodontics, implants, and certain complex treatments received through the ADDP must have prior authorization and able to be completed within the TAMP period.
  - This coverage is limited to the sponsor only and doesn't apply to family members.
- See the *Dental* module for more information.

2.4 Claims

Though the sponsor's status is neither active duty nor retiree, claims for individuals covered under TAMP, including the former active duty member, are processed as active duty family member claims; active duty family member deductibles, copays, and cost-shares apply. In cases where TAMP beneficiaries have other health insurance (OHI), TRICARE pays after the OHI.

2.5 TAMP Application Exercises

Q1. True or False: The purpose of TAMP is to provide health care coverage for transitioning service members and their family members indefinitely.

Q2. Lieutenant Karen Anderson is an active duty navy officer, and is pregnant. She decided to separate from active duty later this month. Will she be eligible for TAMP upon separation? Explain.

Q3. Active Duty Air Force Senior Airman, John Stephenson failed to meet Air Force fitness standards. He is being processed for honorable involuntary separation today. Is Senior Airman Stephenson eligible for TAMP? Explain.

Q4. Marine Corps Lance Corporal Amy Roberts was on active duty in support of a contingency operation for 9 months. One month prior to her separation date, she was extended another 6 months under stop-loss. She separates from active duty today. Is she eligible for TAMP? Explain.

Q5. Army Reserve Staff Sergeant Roger Burke was activated in support of a contingency operation for one year. One month prior to his separation date, he volunteered to serve another 180 days. He separates from active duty tomorrow. Is he eligible for TAMP? Explain.

3.0 Transitional Care for Service-Related Conditions (TCSRC)

The TCSRC benefit provides extended transitional health care coverage to former ADSMs with certain service-related conditions.

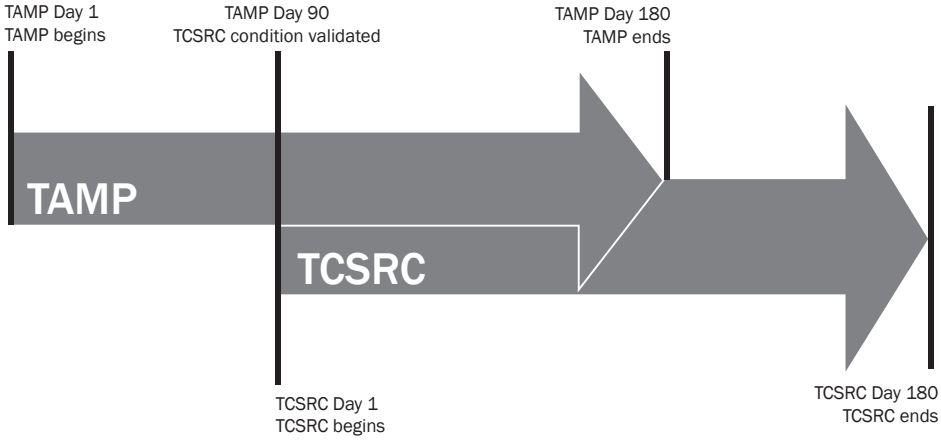
3.1 Eligibility

- Eligibility is limited to TAMP-eligible former ADSMs with a "newly diagnosed" or "newly discovered" medical condition identified during the TAMP period that they believe is related to active duty service.
    - Family members aren't eligible for this benefit.
- These members may receive extended transitional care for that condition and that condition only.
- The medical condition must meet the following criteria:
    - Must be service-related
    - Must be diagnosed by the member's civilian or TRICARE provider during the TAMP period and validated by a DoD physician
    - Must require treatment and can be resolved within 180 days from the date the condition is validated
- TAMP-eligible members may have multiple conditions covered under TCSRC as long as each condition meets the criteria for coverage. Conditions may have different coverage start and end dates.
- Additional information on applying for the TCSRC benefit can be found at www.tricare.mil/tcsrc.

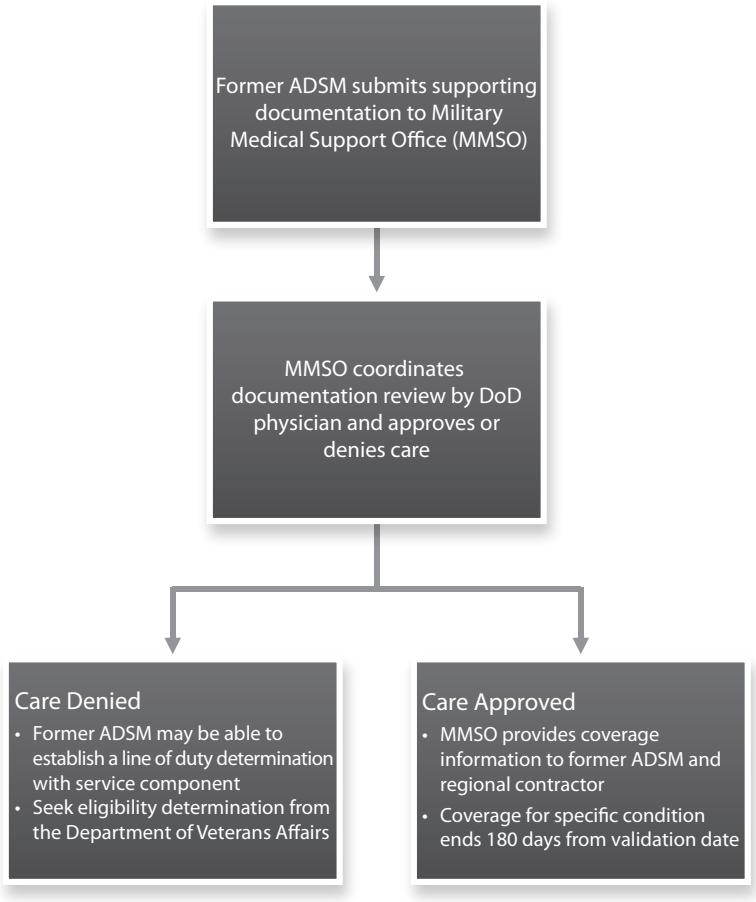
Note: If a former ADSM has a service-related condition that cannot be resolved within the 180-day TCSRC period and cannot be approved for the TCSRC benefit, he or she may be eligible to receive medical care for this condition through the Department of Veteran's Affairs (VA). The VA determines eligibility for VA benefits. These members should call 1-877-222-8387 or visit www.va.gov for more information.

3.2 TCSRC Example

A former ADSM is diagnosed with a service-related condition 90 days into TAMP. TAMP coverage ends on day 180. Care for the service-related condition terminates 180 days from the date a DoD physician validates the service-related condition.



3.3 TCSRC Process



4.0 Continued Health Care Benefit Program (CHCBP)

CHCBP is a premium-based health care program that offers temporary transitional health coverage after uniformed service health care benefits end.

- CHCBP uses existing TRICARE-authorized providers and either follows most of the rules and procedures of the TRICARE Standard option. CHCBP enrollees aren't eligible for Prime.
  - When using TRICARE network providers, CHCBP enrollees' cost-shares are reduced.
- Health care is limited to TRICARE-covered services.

4.1 CHCBP Eligibility

CHCBP-eligible beneficiaries must purchase CHCBP within 60 days of loss of TRICARE eligibility, including loss of coverage under TAMP, TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult. This includes:

- Former ADSMs and their family members
- Certain former active duty Guard/Reserve members and their family members
- Certain unremarried former spouses
- Children who lose coverage due to age
- Certain unmarried children by adoption or legal custody

4.2 CHCBP Coverage

CHCBP is time-limited and varies based on the individual's classification.

18-Month Limit	36-Month Limit
● Former active duty service members and their eligible family members	● Emancipated children ● Unmarried children by adoption or legal custody ● Certain unremarried former spouses

In some cases, unremarried former spouses may continue coverage beyond 36 months if they meet certain criteria.

4.3 CHCBP Enrollment Requirements

To enroll, eligible beneficiaries must submit the following to the CHCBP contractor:

- *Continued Health Care Benefit Program Application* (DD Form 2837), available at www.tricare.mil/forms
- Premium payment
- Required documentation as indicated on the enrollment form, to include copies of:
  - *Certificate of Release or Discharge from Active Duty* (DD Form 214)
  - *Uniformed Services Identification and Privilege Card* (DD 1173)
  - Final divorce decree, if applicable

4.4 CHCBP Premium Payment

- The enrollment application must include a premium payment for the first quarter.
- Quarterly premiums are subject to change on an annual basis. The CHCBP contractor bills beneficiaries quarterly until they lose eligibility for CHCBP coverage.
- Visit http://tricare.mil/mybenefit/home/overview/SpecialPrograms/CHCBP for the most recent premium rates.

4.5 CHCBP Contractor

The CHCBP contractor is responsible for:

- Verifying of health plan eligibility
- Processing enrollments
- Collecting premiums
- Disenrolling participants if eligibility expires or premiums aren't paid
- Issuing certificates of creditable coverage when CHCBP coverage ends

4.6 CHCBP Claims Processing

- TRICARE-authorized providers may file for enrollees; however, enrollees are responsible for making sure all claims, including provider and pharmacy claims, are filed within one year from the date of service stateside and Puerto Rico or within three years from the date of service overseas.
- To file a claim, the enrollee must submit:
  - A *TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment* (DD Form 2642)
  - The provider's bill
  - A copy of their CHCBP enrollment card
- Mail all CHCBP claims to:

  PGBA, LLC
  P.O. Box 7031
  Camden, SC 29020-7031

- For questions about CHCBP claims, beneficiaries and providers may contact the CHCBP contractor at 1-800-403-3950 or visit the PGBA website at www.myTRICARE.com.
- For more information on CHCBP, visit: www.tricare.mil/chcbp.

5.0 Certificate of Creditable Coverage

- A certificate of creditable coverage is a document that provides proof of prior health care coverage.
- It's used to reduce the time a civilian health care plan may exclude an individual from coverage for a pre-existing condition.
  - Pre-existing conditions are medical conditions which are present before an individual purchases health insurance plan coverage.

5.1 Eligibility

- The Health Insurance Portability and Accountability Act (HIPAA) requires TRICARE to issue a certificate of creditable coverage to TRICARE beneficiaries who lose TRICARE eligibility (other than retirees).
- The Defense Manpower Data Center (DMDC) issues certificates when:
  - An active duty member separates
  - A Guard or Reserve member separates (demobilizes) from active duty
  - A family member loses eligibility
  - A spouse loses eligibility following divorce

5.2 Additional Details

- The certificate reflects each period of continuous TRICARE coverage that occurred 24 months before eligibility was lost.
- Each certificate identifies the sponsor's or family member's name for whom it's issued, the dates TRICARE coverage began and ended, and the certificate issue date.

5.3 Requests for Certificate of Creditable Coverage

- Former TRICARE beneficiaries may request certificates of creditable coverage.
- Certificates can take several weeks to process; however, if the request is urgent, beneficiaries may request expedited processing.
- If the certificate is going to a third party (e.g., a health insurance carrier), former beneficiaries must submit their request in writing and include the following:
  - Sponsor's name and social security number
  - Name of person or entity requesting the certificate
  - Signature of the requester
  - Name and address where the certificate should be sent
  - Reason for the request
- Beneficiaries may request certificates in writing, by phone, or fax at any time.
  - Phone: 1-800-538-9552
  - Fax: 1-831-655-8317 (**Note:** Only use the fax option when in urgent need of a Certificate of Creditable Coverage)
  - TYY/TDD: 1-866-363-2883
- Mail written requests to:

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

- E-mail: hipaamail@tma.osd.mil

See *Appendix A* of this module for a sample certificate of creditable coverage.

Module Objectives

Summary:

- **Explain the purpose of the Transitional Assistance Management Program (TAMP)**
- **State who is eligible for the Continued Health Care Benefit Program (CHCBP)**
- **Explain the purpose of a Certificate of Creditable Coverage**

Appendix A: Sample Certificate of Creditable Coverage

DEPARTMENT OF DEFENSE
MANPOWER DATA CENTER
400 GIGLING ROAD
SEASIDE, CALIFORNIA 93955-6771

COCC

Case Number: xxxxxxxx

NAME
ADDRESS
ADDRESS

Certificate of Creditable Coverage

IMPORTANT This certificate provides evidence of your prior health care coverage under one of the TRICARE administered programs. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll (also known as pre-existing conditions). This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within a certain time period (often six months to one year) prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: Date

2. Participant (Sponsor) name: Name

3. Participant (Sponsor) Identification Number: xxx-xx-####

4. Names of individual(s) to whom this certificate applies:

   Name

5. All questions concerning this certificate should be directed to the address listed above, ATTN: CoCC, or call for further information: 1-800-538-9552; TTY/TDD: 1-866-363-2883

6. Date coverage began: Date

7. Date coverage ended: Date

NOTE: *Separate certificates will be furnished if information is not identical for the participant and each dependent.*

TRICARE Fundamentals Course

Pharmacy

7

Participant Guide

References

10 USC 32 CFR § 199
2008 TRICARE Policy Manual, Chapter 8
2008 TRICARE Operations Manual, Chapter 23
www.tricare.mil
http://member.express-scripts.com
MMSO Process Guide

Brainteaser

Each of the eight items below is a separate puzzle.

How many can you figure out?

1. TOOL O O O O LOOT	2. Bathing Suit	3. gone let gone gone be gone	4. N N N N N N N A A A A A A A C C C C C C C
5. (ice)^3	6. Gun Jr.	7. GI cccc	8. **BLOOD** WATER

1. Toolbox _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Module Objectives

- **Describe the TRICARE Pharmacy Benefits Program**
- **Identify who is eligible for TRICARE Pharmacy Benefits**
- **Compare the TRICARE pharmacy options**
- **List TRICARE pharmacy costs**

1.0 Pharmacy Benefits

- The TRICARE Pharmacy Benefits Program cost-shares on prescription drugs and medicines that:
  - Are approved for marketing by the U.S. Food and Drug Administration (FDA)
  - By U.S. law, require a prescription from a physician or other authorized professional provider, acting within the scope of his or her license
  - Are ordered and prescribed in accordance with state and federal law
- The TRICARE Pharmacy Benefits Program offers services through:
  - MTF pharmacies
  - TRICARE Pharmacy Home Delivery (including specialty services)
    - Restrictions apply for home delivery outside of the United States and U.S. territories (See Section 6.0 of this module for details.)
  - TRICARE network retail pharmacies (stateside and U.S. territories)
  - Non-network retail pharmacies
    - Host nation pharmacies are considered non-network pharmacies. (Beneficiaries are responsible for the total cost of pharmacy services up front and must file a claim for reimbursement.)

Note: U.S. Family Health Plan (USFHP) enrollees aren't eligible for the TRICARE Pharmacy Benefits Program and must use USFHP pharmacy providers.

2.0 TRICARE Uniform Formulary

2.1 Uniform Formulary

- The Department of Defense Pharmacy and Therapeutics (P&T) Committee's Uniform Formulary process determines and lists covered prescription medications.
- The DoD P&T Committee can also make recommendations for the Basic Core Formulary.
  - The Basic Core Formulary is a list of medications from the TRICARE Uniform Formulary that all full-service MTFs are required to have available.
- The Uniform Formulary process evaluates the clinical and cost effectiveness of drugs within therapeutic drug classes, where medications are placed in one of three cost tiers:
  - Tier 1: Generic Formulary
  - Tier 2: Brand Name Formulary
  - Tier 3: Non-Formulary
- The DoD mandates prescriptions be filled with a generic equivalent if one is available. ADSMs cannot fill prescriptions for non-formulary medications unless medical necessity is established.
  - If a brand name medication has a generic equivalent, the brand name medication may only be dispensed if a provider establishes medical necessity (brand name copays apply). If medical necessity isn't established, the beneficiary is responsible for the full cost of the brand name medication.

2.1.1 Uniform Formulary Limits and Prior-Authorization

- TRICARE has quantity limits on certain medications, meaning TRICARE only pays for a specific amount of medication when that prescription is filled.
- Certain medications require prior-authorization.
- TRICARE denies payment for medications used to treat conditions that aren't covered by TRICARE or aren't in the formulary due to federal regulations (e.g., food supplements, drugs for cosmetic purposes).

2.2 TRICARE Formulary Search Tool

- Information about the Uniform Formulary and the status of various medications can be found in the TRICARE Formulary Search Tool at www.pec.ha.osd.mil/formulary_search.php. The TRICARE Formulary Search Tool allows users to:
  - View which medications are on the Basic Core Formulary
  - Check benefit coverage of specific medications and generic equivalents
  - Find copayment information for prescription medications, including injectables
  - Learn about generic equivalents for brand name medications, quantity limits, and prior authorization requirements
  - View and print prior authorization criteria and medical necessity forms

3.0 Eligibility

The TRICARE Pharmacy Benefits Program is available to:

- Active duty service members (ADSMs)
- Active duty family members (ADFMs)
- Beneficiaries listed in the Defense Enrollment Eligibility Reporting System (DEERS) as TRICARE eligible or as direct care eligible (only use the MTF pharmacy)
- Certain Guard and Reserve members
- TRICARE Reserve Select (TRS) members, TRICARE Retired Reserve (TRR) members, TRICARE Young Adult (TYA) members, and Continued Health Care Benefit Program (CHCBP) enrollees
- Foreign force members and their families

Note: Enrollment isn't required to use the pharmacy benefit. Eligibility is verified through DEERS.

3.1 Pharmacy Benefits for Dependent Parents and Parents-in-Law

Dependent parents and parents-in-law aren't TRICARE eligible. However, they may be eligible to use the TRICARE Pharmacy Benefits Program if they:

- Meet the uniformed service's requirements to be considered a dependent
- Show as eligible in DEERS
- Turned 65 years old on or after April 1, 2001, and are entitled to Medicare Part A and purchased Part B (**Note:** Before turning 65, a dependent parent or parent-in-law may only fill prescriptions at an MTF pharmacy.)

4.0 Military Treatment Facility (MTF) Pharmacy

- Each MTF is required to stock the medications listed on the Basic Core Formulary.
  - Non-formulary drugs generally aren't available at MTFs. Based on its scope of care and beneficiary population, MTFs may add select medications to their local formulary.
- MTFs fill most prescriptions with a 90-day supply.
- MTFs can fill prescriptions written by licensed civilian providers if the MTF carries the medication.
- Prescriptions are filled at no cost to the beneficiary.

5.0 TRICARE Pharmacy Home Delivery

- The TRICARE Pharmacy Home Delivery option is a cost-effective and convenient way for beneficiaries to get maintenance prescription medications for chronic conditions, while helping the DoD reduce health care costs.
- Beneficiaries may also have specialty medications filled through home delivery if the medication is on the formulary.
    - Specialty medications are usually high-cost; self-administered; injectable or oral medications that treat serious chronic conditions.

5.1 Pharmacy Home Delivery—Overseas

- There are unique restrictions for home delivery overseas (not including U.S. territories):
    - Outside of the United States and U.S. territories, home delivery is only available to registered beneficiaries with Army Post Office (APO), Fleet Post Office (FPO), or Diplomatic Post Office (DPO) addresses.
        - Beneficiaries who are assigned to a U.S. embassy and do not have APO/FPO/DPO addresses must use the embassy address.
        - DPO (U.S. embassy) mailings are restricted to TRICARE eligible persons on official duty.
    - Beneficiaries can update their APO/FPO/DPO and e-mail addresses online at www.express-scripts.com/TRICARE or www.dmdc.osd.mil/appj/bwe.
    - Refrigerated medications cannot be shipped to APO/FPO/DPO addresses.
    - All prescription medications are subject to local customs or policies.
    - Prescriptions must be written by U.S.-licensed providers.

5.2 Opening a Pharmacy Home Delivery Account

- To begin using home delivery, beneficiaries must register for an account. A separate account must be created for each family member.
- Registration can be accomplished:
    - Online: www.express-scripts.com/TRICARE
    - Phone: Stateside and overseas call toll-free: 1-877-363-1303
    - Mail: Download the registration form on www.express-scripts.com/TRICARE and mail it to:

Express Scripts, Inc.
P.O. Box 52150
Phoenix, AZ 85072-9954

5.3 Using Home Delivery

- Beneficiaries can fill or refill home delivery prescriptions by mail, fax, phone, or online.
    - By law, **new** prescriptions can only be submitted by mail, fax, or through a provider's e-prescribing system.
        - Faxed prescriptions (new or changes) must be faxed directly from a provider's office to the pharmacy contractor.
    - Controlled substance prescriptions can only be mailed.
- A 90-day supply and three refills are available for most medications.
    - For certain medications, such as controlled substances, there may be a 30-day or other limitation imposed by federal law.

- Registered users have online access to account and general prescription drug and health information.
    - Registered users mail their provider's written prescription(s) and pay their copayments (by check or credit card) to the pharmacy contractor. The following must be included on each new prescription:
        - Patient's full name, date of birth, address, and sponsor's identification (ID) number (sponsor's SSN or DoD Benefits Number may be used)
        - Prescriber's name, address, phone number, license, and Drug Enforcement Agency (DEA) number
        - Prescriber's handwritten signature
- Once the prescription is processed (usually within 10–14 days), the contractor sends medications directly to the beneficiary.
- The contractor recommends beneficiaries have a 30-day supply on hand when first requesting home delivery.
- Beneficiaries can then use the auto-refill option or request refills based on the refill date on the medication label.
- Beneficiaries can convert their retail or MTF prescriptions to home delivery by either going online or contacting the pharmacy contractor.
- Deployed service members may get medications mailed overseas through the Overseas Deployment Prescription Program. (See Appendix A of this module for more information.)

6.0 Network Retail Pharmacy

6.1 Network Retail Pharmacy

The network retail pharmacy option allows beneficiaries to fill prescriptions at network pharmacies in the United States and U.S. territories (currently, there are no network retail pharmacies in American Samoa).

6.2 Using Network Retail Pharmacies

- Beneficiaries must present their uniformed services ID card.
- Licensed providers may submit prescriptions to a network retail pharmacy of choice by the beneficiary, or by internet, fax, or phone, depending on pharmacy laws for that state or territory.
- Beneficiaries can find network retail pharmacies by using the Pharmacy Locator at www.express-scripts.com/tricare/pharmacy or calling 1-877-363-1303.

7.0 Non-Network Retail Pharmacy

- A non-network retail pharmacy doesn't agree to be part of the TRICARE retail pharmacy network. This includes host nation pharmacies.
    - Using a non-network retail pharmacy should be a beneficiary's last option when getting a prescription filled within the United States or U.S. territories, as it's the most expensive option.
- When using a non-network retail pharmacy or overseas host nation pharmacy, beneficiaries, including ADSMs, pay the total cost up front and file claims for reimbursement after applicable cost-shares, deductibles, or copays are met. (See Section 11.0 of this module for claims filing information.)

7.1 TRICARE Pharmacy Services in the Philippines

- As of September 1, 2011, to be reimbursed for out-of-pocket costs TRICARE beneficiaries living or traveling in the Philippines must obtain prescription medications from either a TRICARE-certified licensed civilian retail pharmacy outlet or TRICARE-certified hospital-based pharmacy.
- TRICARE won't reimburse beneficiaries for medications purchased in an individual provider's office in the Philippines.
    - Beneficiaries can get help locating a TRICARE-certified licensed civilian retail pharmacy by calling the TRICARE Overseas Program Singapore Regional Call Center at +65-6339-2676 (overseas) or 1-877-678-1208 (stateside).

8.0 Pharmacy Program Cost Overview

8.1 Stateside and U.S. Territories

	Formulary Medication		Non-Formulary Medication
	Generic	Brand Name	Brand Name
MTF (up to a 90-day supply)	$0	$0	Not Applicable (generally not available at MTFs)
Home Delivery* (up to a 90-day supply)	$0	$9	$25
Network Retail Pharmacy* (up to a 30-day supply)	$5	$12	$25
Non-Network Retail Pharmacy* (up to a 30-day supply)	TRICARE Prime options (stateside and overseas): 50% cost-share after the point-of-service (POS) deductible is met ($300 single/$600 family) All other beneficiaries: $12 or 20% of the total cost, whichever is greater, after the annual outpatient deductible is met		TRICARE Prime options (stateside and overseas): 50% cost-share after the POS deductible is met ($300 single/$600 family) All other beneficiaries: $25 or 20% of the total cost, whichever is greater, after annual outpatient deductible is met

* *ADSMs' prescriptions are filled at no cost to ADSMs. They are reimbursed 100% of the cost if they use a non-network pharmacy.*

Note: Copayments are applied to deductibles and catastrophic caps.

8.2 Overseas

- Beneficiaries filling prescriptions at overseas host nation pharmacies file claims with the overseas contractor.
  - TOP Prime/TOP Prime Remote enrollees are reimbursed 100% of billed charges.
  - All others pay applicable TOP Standard cost-shares and deductibles.

9.0 TRICARE and Medicare Part D

- TRICARE for Life (TFL) beneficiaries are covered under the TRICARE Pharmacy Benefits Program. Requirements and costs are based on how and where prescription services are received (i.e., MTF, home delivery, retail, non-network; stateside/U.S. territories or overseas).
- Medicare has a prescription drug option referred to as Medicare Part D. It is only available in the United States and U.S. territories.
  - **Note:** Medicare eligible beneficiaries aren't required to purchase Medicare Part D to have prescription drug coverage under the TRICARE Pharmacy Benefits Program. TRICARE is considered creditable coverage (i.e., equal to) Medicare Part D coverage for Medicare purposes.
  - If a TFL beneficiary shows as having Medicare Part D but isn't enrolled or disenrolled, the beneficiary should contact DEERS to get their record corrected.
    - Phone: 1-800-538-9552 (worldwide) or 1-866-363-2883 (TTY/TDD)
    - In person: To find a DEERS office visit www.dmdc.osd.mil/rsl
- TFL beneficiaries who live overseas may contact the pharmacy contractor with questions. Overseas contact information is available in Section 12.0 of this module.

10.0 Pharmacy Benefits with Other Health Insurance (OHI)

- For beneficiaries with OHI and TRICARE pharmacy coverage, federal law requires the OHI be the primary payer. TRICARE is the last payer.
  - Between the two payers, most medication expenses are covered.
- TRICARE is the primary payer for TRICARE-covered medications not covered by the beneficiary's OHI or when the beneficiary reaches the OHI plan's pharmacy benefit cap.
- Those with prescription OHI coverage cannot use TRICARE's home delivery, unless:
  - The medication isn't covered under the OHI; or
  - The beneficiary has exceeded his/her OHI dollar coverage limit for the current year
- At retail pharmacies, TRICARE beneficiaries who have OHI with prescription coverage must show both their OHI and uniformed services ID cards.
- Beneficiaries should use their OHI's home delivery or retail pharmacy benefit, pay the OHI's copayment, and then submit a claim to the TRICARE pharmacy or overseas contractor for reimbursement.
- Stateside beneficiaries with OHI select a pharmacy that is in both their OHI's and TRICARE's network. (Otherwise the beneficiary may have to pay non-network retail pharmacy cost-shares or POS charges if enrolled in TRICARE Prime.)
- Many TRICARE network retail pharmacies can coordinate benefits electronically, which allows the pharmacy to process TRICARE's payment before the beneficiary leaves the pharmacy. This is how it works:
  - The beneficiary goes to a pharmacy that accepts their OHI and is also a TRICARE network retail pharmacy.
  - The beneficiary shows proof of OHI and TRICARE (enrollment and ID cards).
  - The pharmacy submits the claim to the OHI.
  - The pharmacy then submits a second transaction to TRICARE.
  - TRICARE's claims system reviews the unpaid portion of the claim and pays up to the TRICARE-allowable amount.
  - The beneficiary pays any remaining costs after both plans process the claim.

Note: Medicaid, TRICARE supplements, and Indian Health Services plans aren't considered OHI.

11.0 Pharmacy Claims

- To get reimbursed for prescription costs when using non-network pharmacies stateside or overseas, beneficiaries must complete a *TRICARE DoD/CHAMPUS Medical Claim–Patient's Request for Medical Payment* (DD Form 2642).
  - Forms are available at www.tricare.mil/forms
  - **Note:** Guard/Reserve members with an approved Line of Duty or Notice of Eligibility (LOD/NOE) condition always pay out of pocket for prescription medications and complete a *DD Form 2642* to get reimbursed. See the *National Guard and Reserve* module for more information on LOD/NOE pharmacy claims.
- Beneficiaries must include the following information with their claim:
  - Patient's name
  - Drug name, strength, date filled, recommended dose, quantity dispensed, and price of each drug
  - National Drug Code for each drug, if available
  - Prescription number of each drug
  - Name and address of the pharmacy
  - Name and address of the prescribing physician

Note: Billing statements showing only total charges, canceled checks, or cash register and similar types of receipts are not acceptable as itemized statements, unless the receipt provides the detailed information listed above. Beneficiaries with OHI include a copy of the Explanation of Benefits (EOB) from their primary insurance.

- Claims for medications dispensed in a provider's office or by a home health care agency or specialty pharmacy are the responsibility of the regional contractor (not the pharmacy contractor).
- Beneficiaries in overseas areas, excluding U.S. territories, must file their prescription claims with the overseas claims processor and include proof of payment with their claims.
- Claims for prescriptions filled in the United States and Puerto Rico must be received and entered in the claim processor's system within one year of the date of service.
- Claims for prescriptions filled in overseas locations (including all U.S. territories except Puerto Rico) must be submitted for processing within three years of the date of service.
- Pharmacy claims filing addresses can be found in Appendix B of this module.

11.1 Appealing a Denied Claim

- Beneficiaries can appeal a denied pharmacy claim. The appeal must be in writing, signed, and postmarked or received by the pharmacy contractor within 90 calendar days from the date the claim was initially denied. A copy of the denial decision must be submitted with the appeal. The appeal must state what the beneficiary disagrees with.
    - Stateside and U.S. territory appeals are sent to:

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

    - Overseas appeals are sent to the overseas claims processor. See the *Claims and Appeals* module for overseas appeals filing addresses.
- Beneficiaries may send additional documentation to support their appeal. However, they must meet the 90-day time frame and indicate in their initial appeal package that additional documentation will be sent later.

Module Objectives

Summary:

- **Describe the TRICARE Pharmacy Benefits Program**
- **Identify who is eligible for TRICARE Pharmacy Benefits**
- **Compare the TRICARE pharmacy options**
- **List TRICARE pharmacy costs**

Appendix A: Home Delivery and the Overseas Deployment Prescription Program

- Deploying service members should register for a home delivery account and receive an initial 180-day supply of maintenance medications prior to deployment, per current theater guidance.
- The MTF pharmacy or deployment processing center forwards a deployment prescription form via mail, fax, or through the secure DoD PharmacoEconomic Center website (www.pec.ha.osd.mil) to the TMA Pharmacy Operations Center for future processing of the service member's medications while deployed.
- The TMA Pharmacy Operations Center reviews the deployment prescriptions, processes them per DoD policy, and forwards them to the pharmacy contractor.
- After deploying, service members receive an e-mail from the pharmacy contractor asking them to update their online account with their current mailing address (APO/FPO/DPO).
    - Service members who do not receive an e-mail 60 days after deploying should contact the TMA Pharmacy Operations Center at:
        - Phone: 1-866-275-4732 (stateside or overseas) or 1-210-221-8274
        - DSN: 471-8274
        - E-mail: pdts.ameddcs@amedd.army.mil
- Prescription(s) are on hold until refills are available.
- When the medication reaches the refill date, the pharmacy contractor sends an e-mail reminding service members to order the refill.
    - Service members should then log in to their home delivery account.
    - **Note:** Deployment prescription refills ***are not*** automatically sent since a service member's deployment status could change unexpectedly.
- It's very important for service members to keep their e-mail and mailing address information updated. If service members have questions or experience problems, they should contact the pharmacy contractor or the TMA Pharmacy Operations Center.
    - When service members don't update their contact information or request refills, the prescription remains on hold until it expires, which is one year from the date the prescription was written.
    - Service members with questions about the Deployment Prescription Program can contact the TMA Pharmacy Operations Center at:
        - Phone: 1-866-275-4732 (stateside or overseas) or 1-210-221-8274
        - DSN: 471-8274
        - E-mail: pdts.ameddcs@amedd.army.mil
- Delivery overseas may take anywhere from 2–4 weeks from the date shipped.

Appendix B: Pharmacy Contact Information

Pharmacy Benefit Contractor Contact Information for Home Delivery and Retail (Stateside and U.S. Territories)	
General Correspondence	**Phone:** 1-877-363-1303 **Online:** www.express-scripts.com/tricare **Mail:** Express Scripts, Inc. PO Box 52150 Phoenix, AZ 85072
International Toll-Free Access	Dial the in-country access code listed below **Germany:** 00+800-3631-3030 **Italy:** 00+800-3631-3030 **Japan—IDC:** 0061+800-3631-3030 **Japan—Japan Telecom:** 0041+800-3631-3030 **Japan—KDD:** 010+800-3631-3030 **Japan—Other:** 0033+800-3631-3030 **South Korea:** 002+800-3631-3030 **Turkey:** 0811-288-0001 (once prompted, input 877-363-1303) **United Kingdom:** 00+800-3631-3030 **Note:** Beneficiaries residing overseas located in areas outside of these six countries should call their local point of contact number, which will provide access to the Express Scripts Contact Center.
Pharmacy Operations Center	**Phone:** 1-866-ASK-4PEC/1-866-275-4732 (For specific in-country, toll-free service, where established) **Online:** www.pec.ha.osd.mil
Pharmacy Claim Filing Information	**Phone:** 1-877-363-1303 **Online:** www.tricare.mil/pharmacy/claims

<table>
<tr><th colspan="2">Pharmacy Claims Contact Information</th></tr>
<tr><th>United States and U.S. Territories</th><th>Overseas Areas, Excluding U.S. Territories</th></tr>
<tr><td rowspan="4">Express Scripts, Inc.
P.O. Box 52132
Phoenix, AZ 85082

1-877-363-1303

www.express-scripts.com/TRICARE</td><td>Active Duty Service Members
TRICARE Active Duty Claims
P.O. Box 7968
Madison, WI 53707-7968

Eurasia-Africa: 1-877-678-1207
Latin America and Canada: 1-877-451-8659
Pacific: 1-877-678-1208 (Singapore)
1-877-678-1209 (Sydney)

www.tricare-overseas.com/beneficiaries.htm</td></tr>
<tr><td>All Other Beneficiaries—Eurasia-Africa
TRICARE Overseas Program
P.O. Box 8976
Madison, WI 53708-8976

1-877-678-1207

www.tricare-overseas.com/beneficiaries.htm</td></tr>
<tr><td>All Other Beneficiaries—Latin America and Canada
TRICARE Overseas Program
P.O. Box 7985
Madison, WI 53707-7985

1-877-451-8659

www.tricare-overseas.com/beneficiaries.htm</td></tr>
<tr><td>All Other Beneficiaries—Pacific
TRICARE Overseas Program
P.O. Box 7985
Madison, WI 53707-7985

Singapore: 1-877-678-1208
Sydney: 1-877-678-1209

www.tricare-overseas.com/beneficiaries.htm</td></tr>
</table>

TRICARE Fundamentals Course

Dental

8

Participant Guide

References

10 USC
32 CFR §§ 199.13, 199.22
TRICARE Operations Manual, Chapter 24, Section 10; Chapter 16, Addendum B
TRICARE Dental Program Benefit Booklet
www.trdp.org
www.addp-ucci.com

Brainteasers

What phrase is represented below?

Riddle

What can run, but not walk?

Module Objectives

- **Describe active duty dental coverage**
- **Explain the TRICARE Dental Program (TDP) and who is eligible**
- **Explain the TRICARE Retiree Dental Program (TRDP) and who is eligible**
- **State how premiums are determined for the TRICARE Retiree Dental Program (TRDP)**

1.0 Introduction

TRICARE covers dental care based on the scope of the dental contract:

- Active Duty Dental Coverage:
  - The Active Duty Dental Program (ADDP)
  - Active Duty Dental Care Overseas
- The TRICARE Dental Program (TDP)
- The TRICARE Retiree Dental Program (TRDP)

2.0 Active Duty Dental Care

- Most active duty service members (ADSMs) receive dental care at uniformed service dental treatment facilities (DTFs). Prior authorization is required before seeking care from a civilian/host nation dental provider when:
  - The DTF can't provide the required care.
  - They are stationed, on temporary duty, or traveling in remote locations stateside or overseas
- The Active Duty Dental Program (ADDP) provides ADSMs stateside private sector/civilian dental care to ensure dental health and deployment readiness.
  - The ADDP service area includes the United States, U.S. Virgin Islands, Guam, Puerto Rico, American Samoa, and the Northern Mariana Islands.
- Overseas (all other overseas locations)
  - Some non-remote overseas locations have fixed uniformed service DTFs. Non-remote countries with fixed DTFs currently include: the Azores, Bahrain, Belgium, Diego Garcia, Germany, Iceland, Italy/ Sardinia, Japan, Portugal, South Korea, Spain, and Turkey.
  - The TRICARE Overseas Program (TOP) health care contractor supports dental care services for ADSMs assigned to, on temporary or limited duty, or traveling to a designated remote location overseas (those without fixed DTFs).

Note: Throughout this module the TOP overseas health contractor is referred to as the "overseas contractor."

2.1 Active Duty Dental Care Eligibility

- Active duty service members eligible for dental care include:
  - U.S. Army
  - U.S. Marine Corps
  - U.S. Navy
  - U.S. Air Force
  - U.S. Coast Guard
  - National Oceanic and Atmospheric Administration (NOAA)
  - Guard/Reserve members called or on written federal orders for more than 30 consecutive days; those who receive delayed-effective-date active duty orders
  - Certain members eligible under the Transitional Assistance Management Program (TAMP)
  - Line of Duty/Notice of Eligibility (LOD/NOE) Service Members
    - Guard/Reserve members with a dental illness or injury received during active duty status are only eligible for MTF/civilian dental care with a valid LOD/NOE determination by their service.

2.1.1 Active Duty Dental Program (ADDP)

All eligible service members residing stateside or in U.S. territories are covered under the ADDP, which includes:

- DTF-referred care (for ADSMs who live and work within 50 miles of a DTF)
- Remote ADDP (R-ADDP), which covers service members when they:
  - Live in an ADDP remote location and are enrolled in TRICARE Prime Remote
  - Live within 50 miles of a military treatment facility (MTF), but there is no DTF available within the 50-mile radius
  - Are TAMP-eligible Guard/Reserve members separating from a period of active duty that was more than 30 consecutive days in support of a contingency operation (as of January 27, 2012)
    - All orthodontics, implants, and certain complex treatments require prior authorization and must be able to be completed within the TAMP period
  - Are eligible for benefits during their early eligibility period
  - Are in the NOAA
- The Defense Manpower Data Center (DMDC) mails R-ADDP eligibility letters and enrollment cards based on the service member's duty location.

2.1.2 Overseas Active Duty Dental Care

ADSMs assigned to remote locations overseas are responsible for obtaining dental care from either a DTF or the overseas contractor via their Regional or Country-specific Call Centers.

2.2 Dentists

ADDP	Overseas
● ADSMs are required to use a network dentist ○ If a network dentist is not available, the ADSM or the DTF must contact the ADDP contractor to receive authorization to use a non-network dentist. ○ ADSMs who use a non-network dentist without proper authorization must pay for all dental care received. ● A list of network dentists is available: ○ Online: www.addp-ucci.com ○ Phone: 1-866-984-2337/ADDP ○ E-mail: addpdcf@ucci.com	● ADSMs are required to use host nation dental providers. ● For assistance in finding a host nation dental provider, ADSMs should contact their Regional or Country-specific Call Center. Contact information may be found at: www.tricare-overseas.com.

2.3 ADDP Dental Treatment Facility (DTF)-Referred Care (Stateside and Territories)

DTF-referred care authorizes ADSMs to receive care from a civilian dentist when the DTF is unable to provide the required care.

2.3.1 ADSM Dental Emergencies

- DTF emergency dental care policies and procedures apply to all non-remote ADSMs (i.e., those who live within 50 miles of the DTF). Non-remote ADSMs who are traveling (leave, duty-related) and are not within 50 miles of a DTF may receive emergency treatment from any civilian (including non-network) dentist. (See Section 2.4.1 of this module for authorization information.)
  - Non-remote ADSMs are encouraged to use an ADDP network dentist for emergency dental care because they will not be authorized to use a non-network dentist for follow-up care.

2.3.2 DTF Referrals to a Civilian Dentist

- ADSMs may only receive the services listed on the DTF referral or ADDP's contractor's authorization.
    - If the civilian dentist determines the service member needs additional services, the dentist must contact the DTF to modify the referral. If approved, the DTF submits the modified referral to the ADDP contractor.

2.3.3 Managing DTF-Referred Care Under the ADDP

- The DTF completes a referral request form online at www.addp-ucci.com, which populates a referral number and the required appointment control number (ACN).
    - The DTF prints a referral request confirmation page for the ADSM to take to the civilian dental appointment; this page displays the ACN and the procedures required/authorized.
- Once the ADDP contractor receives the referral, the appointment is scheduled by the ADDP contractor or the ADSM.
    - The ADSM is then scheduled to be seen within 21 days for routine care and 28 days for specialty care.
    - If the ADSM needs an immediate appointment, the DTF or ADSM must contact the ADDP contractor to get an ACN.
        - Immediate appointments can be made by calling the ADDP contractor's Dental Care Finder.

2.3.4 Cancelled and Missed Appointments Under the ADDP

- ADSMs should cancel civilian dentist appointments as soon as possible or within 24 hours of the appointment.
- ADSMs must notify the ADDP contractor of missed/cancelled appointments to reschedule. The ADSM should also inform the ADDP contractor if they receive a bill from the civilian dentist for the missed appointment.

2.4 Dental Care for Active Duty in Remote Locations

- Remote active duty dental care is provided through:
    - ADDP contractor through its Remote-Active Duty Dental Care Program (R-ADDP) (stateside)
    - The overseas contractor
- ADSMs in remote locations must have civilian dentists complete and submit an authorization request form listing the treatment(s) that match the procedure and cost criteria listed below.
    - Dental care greater than $750 per procedure or appointment ($500 per procedure or episode in overseas areas)
    - Dental care with a cumulative total of more than $1500 per treatment plan
    - Specialty care (e.g., crowns, bridges, dentures, periodontal treatment)
    - Dental care from a non-network dentist (stateside only)
- All overseas routine care is scheduled through the overseas contractor.
- ADSMs must make sure the care is authorized before getting services, otherwise they may be responsible for payment.
- Prior-authorization is obtained from either the ADDP contractor (stateside or U.S. territories) or from the overseas contractor's Regional or Country-specific Call Centers (who coordinates care authorization with the appropriate TAO Dental Consultant).

2.4.1 Managing Remote Dental Care—Routine and Specialty Care

Stateside Routine and Specialty Care

- Routine care:
  - ADSMs must fill out an appointment request form online at www.addp-ucci.com to coordinate getting a civilian dental appointment. The appointment request form provides two options for appointment scheduling: ADSMs may make their own appointment (preferred) or let the ADDP contractor's Dental Care Finder make the appointment. An ACN is required before seeking services. Information on making appointments can be found at: https://secure.addp-ucci.com/ddpddw/adsm/care-remote.xhtml.
- Speciality care:
  - Specialty dental care requires prior authorization from the ADDP contractor.
  - ADDP network dentists download the prior authorization request form from the ADDP contractor's website, complete it, and send it in a single package to:

    United Concordia Companies, Inc
    ADDP Authorization Requests
    P.O. Box 69431
    Harrisburg, PA 17106-9431
  - When approved, the contractor assigns an ACN and notifies the ADSM and the specialty dentist that an appointment can be scheduled; the ADSM then schedules the appointment.
  - ADSMs requesting dental implant or orthodontic services must have a command memorandum form signed by their unit commander or designated representative.
    - The command memorandum form can be downloaded from https://secure.addp-ucci.com/ddpddw/adsm/forms.xhtml.
    - The civilian dentist completes and submits the signed command memorandum authorization request to the contractor.
    - Civilian dentists can e-mail the command memorandum form to addpdcm@ucci.com, or mail it to the address provided above.

Note: Coast Guard members should contact 1-800-942-2422 (1-800-9HBA-HBA) for information about their dental benefits.

Overseas Routine and Specialty Care

- Routine care:
  - TOP Prime Remote enrolled ADSMs must contact the Regional Country-specific Call Center before seeking routine dental care. This ensures a cashless, claimless episode of care for the member.
  - The overseas contractor also provides access to urgent dental care services to non-enrolled ADSMs who require urgent care while on Temporary Additional Duty/Temporary Duty (TAD/TDY).
- Specialty care:
  - ADSMs should contact their Regional or Country-specific Call Centers if they, or an Embassy provider, feels they have a dental condition that needs attention, are referred for specialty care by a civilian host nation dental provider, or seek services that require prior authorization.
  - Call Center staff coordinate with the ADSM on setting up an appointment with a host nation dental provider; claims are denied when ADSMs seek care without prior authorization.
  - Call Center staff send an authorization to the host nation dentist for use in filing the claim.
- Orthodontic care (extremely limited):
  - All orthodontic care, evaluation, and treatment must have a predetermination decision; this decision is coordinated through the TOP contractor.

2.5 Payment and Claims Filing

ADDP
● Network dental providers submit claims to and are paid by the ADDP contractor. ● When ADSMs seek emergency dental services or obtain services from a non-network provider, they may have to pay up front and file the claim with the ADDP contractor. ○ If the ADSM files the claim, he/she needs to find and submit documentation (when the provider doesn't give the ADSM an American Dental Association claim form). ○ If needed, direct payments to non-network dentists must be approved by the contractor. If not approved, payment goes to the ADSM, who is required to pay the dentist. ● Claims can be filed on any standard dental claim form of the American Dental Association or on the ADDP claim form. ○ The ADDP claim form can be completed online at www.addp-ucci.com, printed, and mailed to the contractor at: United Concordia Companies, Inc. ADDP Claims P.O. Box 69429 Harrisburg, PA 17106-9429 ● Claims are paid at the network rate.

Overseas
● ADSMs should coordinate all dental care through their Regional or Country-specific Call Centers. If dental care is provided by a host nation dentist, ADSMs may have to pay up front and file a claim for reimbursement. ● Claims should be filed on a *CHAMPUS Claim Patient's Request for Medical Payment* (DD Form 2642) with copies of documents reflecting all the information required as noted above. Dental claims may be submitted by the TOP Points of Contact on behalf of ADSMs. ● When filing a claim, the ADSM must submit the following documentation with the *DD Form 2642*: ○ Date(s) of service ○ Specific dental problem ○ Procedure Code(s) ○ Specific tooth/teeth treated for each service performed ○ A complete description of the service performed, including applicable tooth/teeth numbers, if a procedure code is not provided ○ Total charges ○ A dentist's bill or statement of charges if the specific service(s) provided are not found on the claim form ○ LOD/NOE documentation, when applicable ○ **Note:** Guard/Reserve members on orders for less than 30 days may not appear eligible in DEERS. Claims for these beneficiaries must be accompanied by proof of eligibility (orders, roster). ● Claim payment is based on billed charges.

- If dental claims are not in processing within the following timelines, the claim will be denied:
  - ADDP: within one year from the date of service
  - Overseas: within three years from the date of service

3.0 TRICARE Dental Program (TDP)

3.1 Purpose

- The TRICARE Dental Program (TDP) provides worldwide dental coverage to enrolled beneficiaries.
- It's a voluntary, premium-based dental insurance plan administered and underwritten by the TDP contractor.
- TDP has two service areas:
  - Stateside: 50 states, District of Columbia, Puerto Rico, Guam, and U.S. Virgin Islands
  - Overseas: All other overseas locations and covered services provided on a ship or vessel outside territorial waters (regardless of the dentist's office address)

3.2 Eligibility

- The following may purchase TDP coverage:
  - Eligible **family members** of active duty and activated Guard and Reserve service members (as determined by their Service)
  - Inactive Guard or Reserve members and their families
- To be TDP eligible, the sponsor must have at least 12 months remaining on his or her service commitment at the time of enrollment.
  - In some circumstances, the TDP contractor may waive this requirement for family members of Guard/Reserve and Individual Ready Reserve (IRR) whose sponsors are activated in support of certain contingency operations.
- The TDP contractor verifies eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

3.3 TDP Enrollment

- Enrollment is required.
  - After 12 months, enrollment may be continued on a month-to-month basis. Enrollees must have a valid reason to be considered and approved for disenrollment before the end of the initial 12-month commitment period.
- There are two enrollment plans:
  - Single Plan: (one covered individual); includes one active duty family member (ADFM), one Guard or Reserve family member, or one inactive Guard or Reserve sponsor
  - Family Plan: (two or more covered individuals); includes two or more eligible ADFMs or eligible Guard/Reserve family members
- Coverage is effective on the date on the TDP enrollment card. The 20th of the month rule applies.

Note: Two sponsors cannot enroll the same family member(s), and the service members must decide under which sponsor the children are enrolled. When both husband and wife are service members, neither sponsor can be enrolled in the TDP as a family member.

3.3.1 Special Types of Enrollment

Under TDP family enrollment, all eligible family members must be enrolled, except in the following situations:

- **Guard and Reserve Sponsors** must enroll independent of family members.
- If the sponsor enrolls, he or she must submit a separate, single enrollment form.
  - May enroll their family members, but are not required to be enrolled themselves
  - If called to active duty on federally funded orders for more than 30 consecutive days, the sponsor is automatically disenrolled and re-enrolled upon deactivation. (See the chart later in this module for more information.)

- **Note:** All members of the Guard and Reserve are required to have an annual dental examination.
  - TDP-participating dentists complete the *DoD Active Duty/Reserve Forces Dental Examination* form (DD Form 2813) at no cost to TDP enrollees (form is available at https://mybenefits.metlife.com/tricare).
  - Guard and Reserve members are responsible for reporting their dental readiness status to their service.

- **Children under age 4** may be voluntarily enrolled at any time, but are automatically enrolled on the first day of the month following the month they turn 4, as long as other family members are enrolled. The premium rate may change from a single to a family plan.
- **Split Enrollment:** If family members reside in two or more locations, (e.g., in the case of children who are attending college away from home or living with a divorced spouse) the sponsor may choose who to enroll. Not all family members are required to be enrolled.
- **Split Enrollment for Active Duty Family Members Only**: When a family member requires a hospital or special treatment environment (due to medical, physical handicap, or mental condition) for dental care covered by the TDP, the family member may be disenrolled and receive care from a military treatment facility.
  - Before seeking services, the sponsor must provide documentation, such as a signed letter or memorandum from the MTF provider or administrator to the TDP contractor, verifying this requirement for a hospital or special treatment environment.

3.3.2 TDP Survivor Coverage

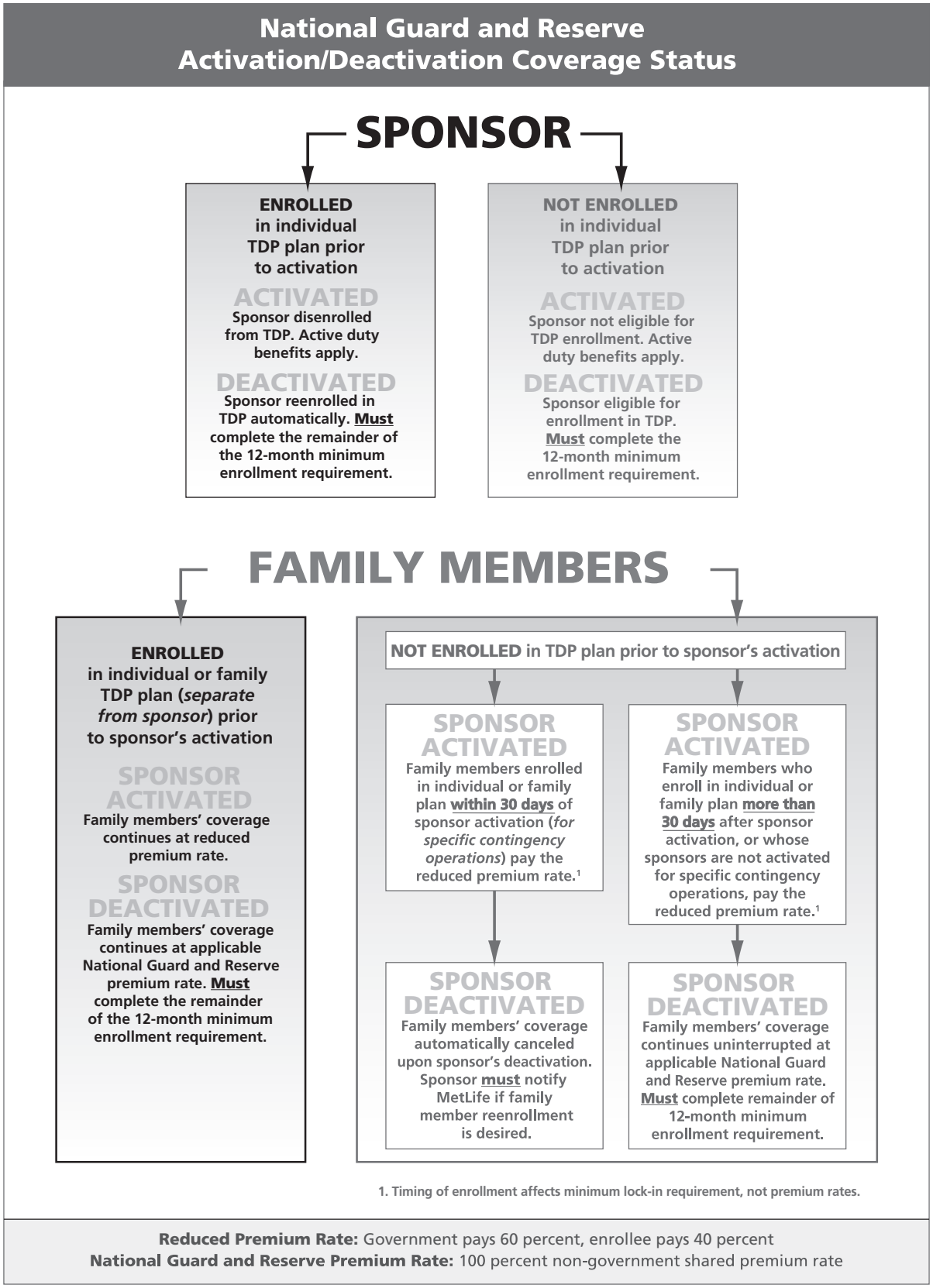
- The TDP survivor benefit entitles surviving spouses and child(ren) to receive TDP benefits, regardless of whether they were previously enrolled in the TDP.
  - The TDP survivor benefit also applies to surviving enrolled family members of the Selected Reserve (Guard or Reserve) and the IRR (special mobilization only), regardless of whether the sponsor was on active duty orders or enrolled in the TDP at the time of the sponsor's death.
- The government pays 100 percent of the TDP premium for survivors.
  - Children of the deceased sponsor are covered until they lose eligibility.
  - The benefit expires for a spouse three years from the month following the sponsor's death.
  - Family members are responsible for TDP cost-shares.
- Eligible surviving family members enrolled at the time of their sponsor's death are automatically disenrolled from TDP and enrolled in the TDP Survivor Benefit Plan. The TDP contractor notifies survivors of the disenrollment and the terms of the TDP survivor benefit.
- **Note:** The TRDP also may be available to surviving family members who do not qualify for the TDP Survivor Benefit—for specifics, check with the TRDP contractor.

3.3.3 Enrollment Methods

- **Online:** Complete the *TDP Enrollment Authorization* document on the Beneficiary Web Enrollment website at http://dmdc.osd.mil/appj/bwe and make the initial payment using a credit or debit card. A DS Logon, Defense Finance and Accounting Services (DFAS) myPay account, or Common Access Card (CAC) is required to access the Beneficiary Web Enrollment (BWE) website.
- **By Phone:**
  - Stateside: 1-855-MET-TDP1 (1-855-638-8371)
    Overseas: 1-855-MET-TDP2 (1-855-638-8372)
    TDD/TTY for the hearing impaired: 1-855-MET-TDP3 (1-855-638-8373)
- **By Mail:** Complete the *TDP Enrollment Authorization* document (available on www.tricare.mil/forms) and mail it with the initial premium payment by check or money order to:

  MetLife TRICARE Dental Program
  Enrollment and Billing Services
  P.O. Box 14185
  Lexington, KY 40512

The following chart reflects how enrollment and premium costs shift as Guard/Reserve members are activated and deactivated.



3.3.4 Disenrollment

- To disenroll, TDP enrollees must complete a new *TDP Enrollment Authorization* document. The 20th-of-the month rule applies for the disenrollment effective date.
    - **Note:** If received after the 20th of the month, the cancellation is processed for the first day of the second month and premiums are due for the one month in between.

Cancellation Example: If a beneficiary decides to cancel their TDP coverage for December, they must submit a *TDP Enrollment Authorization* document by November 20 for the cancellation to be processed December 1. The beneficiary is responsible for November's payment. If the *TDP Enrollment Authorization* document is received after November 20, the cancellation is effective January 1. The beneficiary is responsible for payments in the months of November and December.

There are certain circumstances that allow disenrollment before the 12-month initial commitment is completed; specific information is available from the TDP contractor.

3.3.5 Exceptions to Early Disenrollment Rule

Disenrolling Before Completing the Initial 12-month Enrollment Period	
Situation	**Description**
Loss of eligibility	Sponsor or family member loses eligibility for the TDP due to death, divorce, marriage, age limit of the child, or end of entitlement.
Sponsor and family are relocated to the stateside service area	Sponsor may choose to disenroll and/or disenroll his or her family members from the TDP within 90 calendar days of the transfer; the date of the relocation must be included on the disenrollment request. The disenrollment is processed based on the date the *TDP Enrollment Authorization* document is received.
Active duty sponsor receives permanent change of station orders	When an active duty sponsor transfers with TDP-enrolled family members to a duty station where space-available dental care is available at the uniformed service DTF, the sponsor may elect to disenroll his or her family within 90 calendar days of the transfer. The disenrollment is processed based on the date the *TDP Enrollment Authorization* document is received.
Guard or Reserve sponsor deactivation (sponsor previously activated more than 30 consecutive days in support of specific contingency operations)	Family members will be disenrolled before the end of the mandatory 12-month initial enrollment period if initially enrolled within 30 days of sponsor activation (unless the sponsor requests re-enrollment).
Transfer to standby or retired reserve	A Guard or Reserve member will be disenrolled before the end of the mandatory 12-month enrollment period if the member is transferred to the Standby Reserve or Retired Reserve.

3.4 TDP Premiums

- TDP premiums are based on the TDP enrollment plan (single or family) and the military status of the sponsor.
- The benefit year is May 1–April 30.
- Premiums change every February (since the TDP is a pay-ahead program, changes show up in January).
- For information about current premiums and cost-shares, visit www.tricare.mil/costs.
- Enrollment lockout: TDP enrollees who fail to pay monthly premiums will be disenrolled and not allowed to re-enroll ("locked out") for 12 months from the date the last premium was paid.

3.4.1 Initial Payments

- Credit or debit card payments for initial enrollments may be completed online via BWE, by phone, or by mail.
- If necessary, TDP enrollees may mail their initial premium payment by check or money order with their *TDP Enrollment Authorization* document.

3.4.2 Ongoing Payments

- If the sponsor has a military payroll account the government collects the premium through a uniformed services finance center.
    - If the TDP contractor can't collect the requested premium payment from the payroll account, the premium collection transfers from the finance center payroll allotment or deduction to direct billing by the TDP contractor.
    - Premium payments for non-active duty Guard and Reserve family members are paid directly to TDP contractor.
        - Ongoing payments for Guard/Reserve members and their eligible family members may be made with a credit card, electronic fund transfer, or allotment.

3.5 TRICARE Dental Program Covered Services and Cost-Shares

3.5.1 Benefits Overview

- Services must be necessary and meet accepted standards of dental practice.
- There are coverage benefits, time and frequency limitations, and exclusions, which can be found on the TDP contractor's website.

3.5.2 Cost-Shares

- Cost-shares are the percentage a TDP-enrollee is required to pay for covered dental services. The government and enrollee percentages are based on the treatment provided.
    - Cost-share payments are based on the established allowable charge.
- **Note:** For a complete list of cost-shares, visit www.tricare.mil/costs.

3.5.3 Provider Types and Cost-Shares

Stateside	Overseas
TDP enrollees residing in the service area may visit any licensed civilian dentist. However, visiting a preferred dentist can reduce time and costs. **Preferred Dentist Program (PDP) Dentists** ● A PDP dentist signs a contractual agreement with the TDP contractor to follow TDP rules for providing care and accepting payment to include filing claims for enrollees. ● The TDP access standards are that a PDP general dentist is located within 35 driving miles of an enrollee's home and that enrollees can get an appointment within 21 days of their call to the PDP's office. ● Enrollees can find a PDP dentist by calling the TDP contractor. (See Section 6.0 of this module for contact information.) ● Enrollees should ask PDP dentists to submit predetermination requests for high cost services. **Non-PDP Dentists** ● If enrollees use a non-PDP (non-contracted) dentist, they are responsible for paying the difference between what the TDP contractor may pay for the service and the amount charged by the non-network dentist, in addition to their cost-share percentage. ● Non-network dentists may or may not submit claim forms for TDP enrollees. ● Enrollees must sign an assignment of benefits statement on the claim to have payment go directly to the non-network provider. If not signed, the payment goes to the enrollee, who is responsible for paying the dentist.	Enrollees are free to see any licensed and authorized dentist; however, it's recommended they use a TRICARE OCONUS (overseas) Preferred Dentist (TOPD). The TDP contractor maintains a directory of TOPDs at http://mybenefits.metlife.com/tricare ● TOPDs agree to: ○ Not require enrollees to pay their full charge at the time of service, only the applicable cost-share, if any ○ Complete and submit claim forms on an enrollee's behalf ● Enrollees should ask TOPDs to submit predeterminations for procedures with a cost-share or complex and costly services exceeding $1,300 U.S. dollars. ● Enrollees using a non-TOPD provider may have to pay up front for services before receiving care and submit their own claim and other required documentation. ● For orthodontic services, all enrollees may see any licensed and authorized orthodontist. A *Non-Availability and Referral Form (NARF)* for orthodontic services is required. **Note:** Access standards for the location of a dentist are not applicable for TDP enrollees living in overseas areas.

3.5.4 Overseas Cost-Share Information

- The government pays up to the billed amount, except for Guard and Reserve family members (in the Selected Reserve), Individual Ready Reserve family members, and ADFMs who are not command-sponsored.
  - Non-command sponsored family members pay enrollee cost-shares; the government doesn't cover the entire bill.
- Command-sponsored TDP enrollees who reside in overseas areas pay stateside cost-shares when they receive services stateside.

3.5.5 Annual and Lifetime Maximum Benefit

The annual and lifetime maximums are the most the government will pay for specific services. The enrollee is responsible for his/her cost shares.

Maximum	Description
Annual Maximum Benefit	● The annual maximum is $1,300 per enrollee per plan year (May 1–April 30). ○ The government will not pay for any services once the maximum is reached. ● Payments for certain diagnostic and preventive services do not apply towards the annual maximum.
Accidental Annual Maximum	● Accidental annual maximum benefit is $1,200 per enrollee. (This is in addition to the $1,300 annual maximum benefit.) ○ An accident is defined as an injury that results in the physical damages or injury to the teeth and/or supporting hard or soft tissue from external oral blunt forces; this does not include chewing or biting forces.
Orthodontic Lifetime Maximum	● Maximum orthodontic lifetime benefit per enrollee is $1,750. ● Orthodontic diagnostic services are applied to the $1,300 annual maximum, not the orthodontic maximum.

3.6 TDP Claims

3.6.1 Stateside

- The provider type determines who is responsible for filing a TDP claim—either a PDP dentist (in the TDP network) or non-participating (outside of the TDP network).

Provider	Who Submits Claim	TDP Contractor Pays
Participating Dentist	Dentist	Dentist
Non-participating Dentist	Enrollee	Enrollee

- Non-participating dentists may leave it up to TDP enrollees to file their own claims since non-participating dentists aren't required to file for the enrollee. In this case, enrollees are responsible for paying the dentist and the TDP contractor reimburses enrollees directly, minus the enrollee's cost-share. The TDP contractor pays non-participating dentists directly when TDP enrollees indicate on the claim form that the dentist is to receive the payment (referred to as "assignment of benefit" on the claim form).

3.6.2 Overseas

- For the TDP contractor to process an overseas claim the following needs to be submitted:
  - A completed claims form (*DD Form 2642*)
  - A dentist bill or statement of charges. If the specific service(s) provided is repeated on the claim form, a separate office bill is not needed. (See the table in Section 3.6.3 of this module for more information.)
    - TDP enrollees who receive dental care in overseas areas should obtain a detailed receipt from the dentist.
- A *Non-availability Referral Form (NARF)* for orthodontia indicates services aren't available through the uniformed services. A *Non-availability Referral Form (NARF)* is issued by the TRICARE Area Office, overseas dental treatment facility, or overseas POCs.

- Additional overseas claim payments information:
  - Enrollees typically pay up front for covered services and submit a claim.
  - The TDP contractor issues a Dental Explanation of Benefits (DEOB) to the dentist or enrollee, depending on which party sent the claim.
    - If the TDP contractor can't determine which party forwarded the claim, the contractor pays the dentist.
    - Payments issued to overseas dental providers are paid in foreign currency (if the currency is available through recognized U.S. banking institutions). One exception is Turkey, where claims are paid in U.S. dollars.
    - TDP pays all claims submitted by enrollees in U.S. dollars, based on the exchange rate on the date of service, unless the enrollee requests payment in local currency.

3.6.3 Claims: Finding and Submitting Forms

Note: For information on where to send claims see Section 6.0 of this module.

Stateside	Overseas
● The TDP contractor accepts claims submitted on any standard American Dental Association claim form. ● A separate claim form must be submitted for each TDP enrollee receiving services. For example, if a family of four is treated by the same dentist on the same day, four separate claim forms should be submitted. ● Submission documents and instructions may be found on www.tricare.mil/tdp.	● The TDP claim submission document may be found on the TDP contractor's website. ● Claim forms are also available from TRICARE Area Office (TAO), overseas dental treatment facility (ODTF), designated overseas TRICARE points of contact (POCs), or by calling the TDP contractor. ● Claims documents should include the following if an American Dental Association claim form is not used: ○ Date(s) of service ○ Provider name, address, and phone number ○ Specific problem encountered ○ Procedure code(s) (If a procedure code is not provided on the claim form, a complete description of the service performed, including applicable tooth number(s), must be provided.) ○ Specific tooth/teeth treated for each, where appropriate ○ Total charges

3.6.4 Deadline for Filing Claims

Claims should be filed as soon as possible after the dental service. Stateside claims must be submitted within one year of the date of service and overseas claims must be submitted within three years of the date of service.

3.6.5 Claim Denial

- In general, a claim may be denied if:
  - Premiums are not up to date
  - The claim isn't timely filed
  - Charges are for non-covered services
  - Claims submission forms or packages are incomplete

Note: This list does not cover all specific situations. For detailed information, view the *TRICARE Dental Program Benefit Booklet*, available at www.tricare.mil/dental.

3.6.6 Dental Explanation of Benefits (DEOB)

The TDP contractor issues DEOBs to the beneficiary explaining how a dental claim processed. It reflects what services were provided, which were covered, and the government's and beneficiary's cost-shares.

3.7 Exercise

Use the DEOB below to answer the following questions:

Q1. How many procedures did the dentist perform on 05/15/11?

Q2. What is the procedure code for comprehensive evaluation?

Q3. How much did the dentist charge for the procedure?

Q4. What are the TDP allowable charges for the procedure performed?

99995 99986 00000146001201307515990 -006

MetLife®

Explanation of Dental Benefits

GROUP # 146001 TRICARE DENTAL PROGRAM CLAIM YEAR: 2011 08

This is not a bill. It is an explanation of how MetLife computed the payment for your recent dental services.

SPONSOR'S NAME	SPONSOR'S ID	SERVICES RENDERED BY
FIDEL BISHOO SR	XXXXXXXXXXX	DR. HARRY JONES

BENEFICIARY/PATIENT NAME	RELATIONSHIP	DATE PROCESSED	FILE REFERENCE
STELLA BISHOO	DEPENDENT	FEBRUARY 1, 2012	2013075159 9 DCN: 120130075160

DATE SERVICE PERFORMED	TOOTH # /AREA	PROCEDURE CODE	FEE CHARGED	PDP FEE (If Applicable)	COVERED EXPENSE	PLAN BENEFIT	DESCRIPTION OF SERVICE/ COMMENTS
05/15/11		D0150	80.00	35.00	35.00 100%	35.00	COMPREHENSIVE ORAL EVALUATION
	TOTALS		80.00	35.00	35.00	35.00	

METLIFE DENTAL CLAIM FORMS ARE AVAILABLE THROUGH THE FOLLOWING SOURCES:
1) 1-855-638-8371, 2) www.metlife.com/dental

YOUR GROUP PARTICIPATES IN METLIFE'S PREFERRED DENTIST PROGRAM (PDP). AS A PARTICIPATING PDP PROVIDER, YOUR DENTIST HAS AGREED TO ACCEPT A MAXIMUM ALLOWABLE CHARGE FOR EACH SERVICE. THIS "PDP FEE" IS TYPICALLY LESS THAN THE NORMAL "FEE CHARGED" BY THE DENTIST AND YOU SHOULD BE BILLED ONLY THE DIFFERENCE BETWEEN THE "PDP FEE" FOR ACTUAL SERVICES PROVIDED AND YOUR "PLAN BENEFIT".

TO RECEIVE A LISTING OF PDP DENTISTS IN YOUR ZIP CODE AREA, OR TO OBTAIN A DENTAL CLAIM FORM, CALL 1-855-MET-TDP1 OR 1-855-MET-TDP3 TDD/TTY.

YOU AND YOUR PLAN SAVED $45.00 BY UTILIZING A DENTIST IN THE PDP NETWORK.

$35.00 WILL BE PAID TO HARRY W JONES DDS ON 02/08/12

FIND INFORMATION ON YOUR AVAILABLE DENTAL BENEFITS, CLAIMS DETAILS AND MORE ONLINE AT WWW.TRICARE.MIL OR HTTP://MYBENEFITS.METLIFE.COM/TRICARE
IF YOU HAVE ANY QUESTIONS ABOUT THIS CLAIM PLEASE CALL 1-855-MET-TDP1 (1-855-638-8371) OR 1-855-MET-TDP3 (1-855-638-8373) TDD/TTY.
CUSTOMER SERVICE HOURS ARE SUNDAY 6PM TO FRIDAY 10PM EST.

3.8 TDP Appeals

There are three levels of appeal for denial of TDP claims: reconsideration, formal review, and hearing. All initial denials and appeal denials explain how, where, and by when to file for the next level of review.

3.8.1 Reconsideration

- Enrollees and dentists may formally request that the TDP contractor review an initial payment determination to evaluate whether the initial payment decision was correct.
    - The request should include the reason for reconsideration, supporting documentation, and a copy of the initial determination.
- The request must be in writing and must be postmarked or received by the TDP contractor within 90 calendar days of the DEOB issue date. If supporting records will be submitted later, the appeal letter should contain the expected date of submission.
- The instructions and timelines for filing an appeals are on the DEOB. Requests for reconsiderations must be submitted separately from dental claim forms.
- The reconsideration may result in full or partial approval of the claim or support the initial denial determination. A decision is delivered within 60 days of receipt of the reconsideration request.
- The reconsideration requests must be submitted to:

	Stateside	**Overseas**
For dates of service ***on or after*** May 1, 2012	MetLife TRICARE Dental Program Appeals P.O. Box 14183 Lexington, KY 40512 Fax: 1-855-763-1335	MetLife TRICARE Dental Appeals P.O. Box 14183 Lexington, KY 40512
For dates of service ***before*** May 1, 2012	United Concordia TDP Customer Service P.O. Box 69410 Harrisburg, PA 17106-9410	United Concordia TDP OCONUS Dental Unit P.O. Box 69418 Harrisburg, PA 17106-9418 USA

3.8.2 Formal Review

- Enrollees may request a formal review from the TRICARE Management Activity (TMA) if they disagree with the TDP contractor's reconsideration decision and if the amount remaining in dispute is $50 or more.
- The formal review process is the same as the Factual Determination appeal process for medical claims.

3.8.3 Hearing

- Enrollees may request a hearing with TMA if they disagree with the formal review decision from TMA and the amount in dispute is $300 or more.
- The hearing process is the same as the Factual Determination appeal process for medical claims. See the *Claims and Appeals* module for more information.

4.0 TRICARE Retiree Dental Program (TRDP)

- The TRDP offers premium-based, voluntary group benefit dental coverage. It is a fee-for-service/preferred provider program offers enrollees access to any licensed dentist. Dental coverage is offered through the following group plans:
    - Enhanced TRDP (group plan #4601)—Covers services provided within the service area (all the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada). If traveling outside the Enhanced TRDP service area, enrollees are only covered for emergency dental care.
    - Enhanced-Overseas TRDP (group plan #4602)—Covered services are available worldwide; available for purchase by beneficiaries whose permanent address (in DEERS) is outside the Enhanced TRDP service area.
    - Basic Program (group plan #4600)—There is a separate benefit booklet for this program, which closed to new enrollees in 2000. Information is available through the TRDP contractor.

4.1 Eligibility

TRDP purchase is voluntary and open to the following:

- Former members of the uniformed services who are entitled to uniformed services retired pay, includes those who are 65 years of age or older, and their eligible family members
- Guard and Reserve Retired Reserve (includes those who are not yet 60 years old, aka “Gray-Area Retired Reservists”) and their eligible family members
- An unremarried surviving spouse or eligible child of a deceased member who: (a) died on retired status; or (b) died while on active duty for a period of more than 30 days and whose eligible family members are no longer eligible for dental benefits under the TRICARE Dental Program (Surviving spouses who remarry are not eligible.)
- Medal of Honor (MOH) recipients and their eligible family members, or an unremarried surviving spouse and eligible family members of a deceased MOH recipient
- Current spouses and/or eligible children of certain non-enrolled members (They must have documented proof the non-enrolled member is: [a] eligible to receive ongoing comprehensive dental care from the Department of Veterans Affairs; [b] enrolled in a dental plan through employment but the plan is not available to family members; or [c] unable to obtain benefits through the TRDP due to a current and enduring medical or dental condition.)

Note: Those not eligible are former spouses of eligible sponsors, remarried surviving spouses of deceased service members, and family members of non-enrolled retirees who don’t meet the above criteria.

4.2 Enrollment

- New enrollees must commit to an initial 12-month enrollment period; after that, enrollment is continued automatically on a month-to-month basis.
- Types of plans available: single-person, two-person, and family (three or more persons)
- Beneficiaries may enroll:
    - Online: www.trdp.org (may use a major credit card)
        - “Family member(s) only” enrollment applications are not accepted online. Applications are submitted by mail because specific documentation is required.
    - By phone: 1-888-838-8737, option #2
    - By mail: Download application from www.trdp.org/pro

Delta Dental of California
Federal Government Programs
P.O. Box 537008
Sacramento, CA 95853-7008
United States of America

4.3 Premiums

- Premiums are based on where the enrollee lives (residential zip code) and the number of family members enrolled.
- Premiums are adjusted on October 1 of each benefit year (October 1 through September 30) and are accepted in U.S. dollars only.
- To view the premium rate for a specific region, visit the TRDP website at www.trdp.org/pro/premiumSrch.html and enter a five-digit zip code.
    - Beneficiaries living in Canada should enter “99999” as their zip code.
    - Beneficiaries living outside of the United States and Canada who do not have a U.S. postal code should enter “00000” as their zip code.
- Enrollees can also get premium information by calling the TRDP customer service toll-free number at 1-888-838-8737.
- As mandated, the TRDP collects premium payments through retired pay allotment. Enrollees must send in a two-month pre-payment with their application to cover their premiums until the allotment is established.
    - The TRDP contractor refunds any unused prepayment portion if the allotment goes into effect before the third month. If there aren’t enough funds for an automatic allotment, the TRDP contractor notifies the enrollee about other payment options.

4.4 Disenrollment and Lockout

- A 30-day grace period for TRDP disenrollment begins on the coverage effective date.
    - During the grace period, enrollees may voluntarily end their enrollment as long as they didn’t receive dental benefits during that time.
- If TRDP enrollees want to be disenrolled at the end of their 12-month commitment, the TRDP contractor needs to receive their disenrollment request no less than 30 days before the first day of the 13th month.
    - For example, for a 12-month commitment of March 1 to April 30, the enrollee must request disenrollment no later than March 31 for an effective end date of May 1.
- Once on a month-to-month enrollment status, the TRDP contractor needs to receive the enrollee’s disenrollment request 30 days before the month coverage is to end.
    - For example, if the disenrollment request is received June 15, disenrollment is effective August 1.
- Enrollees who fail to complete their initial 12-month commitment are locked out for 12 months before they can re-enroll.

4.5 New Retiree Enrollment Opportunity in TRDP

- ADSMs and eligible family members may send in an enrollment form during the month before the sponsor’s retirement effective date.
- Retirees, including retired Guard and Reserve members and eligible family members, who enroll within four months of their retirement date are eligible for a waiver of the 12-month waiting period for the full scope of benefits.
    - They must submit a copy of their retirement orders with the enrollment form.

4.6 Covered Services

- Coverage begins the first day of the month after the TRDP contractor processes a complete enrollment package.
- TRDP covers services that are necessary, appropriate, and provided by a licensed dentist within the Enhanced TRDP service area.
- Some TRDP services are subject to a 12-month waiting period. For a listing of these services, covered services, and cost-shares visit www.tricare.mil/costs.

- The maximum benefit amount is the dollar limit the TRDP can pay towards covered services.
    - When an enrollee uses any or all of the maximum benefit for orthodontics allowed under the TDP, he or she may still receive up to the maximum benefit available under the TRDP for in-progress orthodontic treatment.

Maximum	Description
Annual Deductible* (per benefit year, October 1–September 30)	$50 per individual, not to exceed $150 for the family
Annual Maximum Benefit	$1,200 per enrollee—The maximum amount TRDP pays per enrollee per benefit year
Accidental Annual Maximum	$1,000 per enrollee—The maximum TRDP pays for procedures as the result of a dental accident
Lifetime Maximum Orthodontic for Procedures	$1,500 per enrollee (includes children and adults)—The maximum TRDP pays per enrollee per lifetime for covered orthodontic procedures

* *Diagnostic, preventive, orthodontic, and dental accident procedures don't apply to the deductible.*

4.7 TRDP-Dental Providers

- Enrollees may receive care from any licensed dentist in their local service area; they're encouraged to seek treatment from a TRDP network dentist.
    - Only emergency care is covered when received from host nation dentists by stateside TRDP enrollees.
- The Enhanced TRDP encourages enrollees to seek treatment from Delta Dental Select and Delta Dental PPO/DPO network dentists.

4.8 TRDP-Network Providers

- Network dentists:
    - Are responsible for submitting claims for TRDP enrollees
    - Have payments sent directly to their office
    - Are reimbursed based on local TRDP negotiated reimbursement rates
    - Cannot charge TRDP enrollees the difference between the negotiated fees and billed charges
    - Agree to adhere to the processing policies for TRDP covered services

4.9 Non-Network Providers

- Non-network dentists:
    - Are U.S. dentists who do not belong to a Delta Dental network, and includes those who practice outside the 50 United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada.
    - Are allowed to collect payment in full, up to the billed charge, from the enrollee at the time services are rendered.
    - The TRDP sends payment to the enrollee, who is responsible for paying the dental provider.
    - The TRDP contractor pays the same percentage for covered services as if the enrollee had gone to a network dentist. The TRDP enrollee remains responsible for the difference between the TRDP-allowed amount and billed charges (if applicable).

4.10 Overseas Dentists

- Under the Enhanced Overseas TRDP, enrollees may use any host nation or stateside network or non-network dentist.
- To locate an overseas dentist, enrollees should call the TRDP international referral service toll-free number from inside the United States at 1-888-558-2705 or collect anywhere in the world at 1-312-356-5971. (Dial the international country code, then the country code for the United States [1], and then the collect number.) Multilingual customer service staff are available 24/7.
- There is a host nation dental provider listing on the web at www.trdp.org.

4.11 TRDP Claims

- An advantage of using a network dentist is that he/she submits the claim and receives payment directly from the TRDP contractor (less the enrollee's copayment/cost-share).
- Non-network dentists (non-Delta or non-participating) may, but are not required to file a claim. Instead, they may give the enrollee a standard dental claim form to complete and submit.
    - Claims may be completed using any standard dental claim form; enrollees can download a dental claim forms at www.trdp.org.
- Mail a TRDP claim form to:

Delta Dental of California
Federal Government Programs
P.O. Box 537007
Sacramento, CA 95853-7008
United States of America

- Claims must be in processing within one year from the date of service or will be denied.
- An enrollee who files the claim receives the claim payment; however, the enrollee can choose to authorize payment directly to the dentist on the claim form.
- Enrollees needing assistance with completing the claim form may contact customer service staff at 1-888-838-8737 or international toll-free at +866-721-8737.
- Beneficiaries can review their benefits, verify deductibles, and check on the status of claims by visiting the self-service Customer Toolkit at www.trdp.org.

4.11.1 Dental Explanation of Benefits (DEOB)

The TRDP contractor sends a DEOB to the enrollee to show how a claim processed. Services covered and enrollees cost-share/copayment DEOBs are sent to network providers.

4.12 TRDP Appeals

There are two levels of appeal for denied claims: reconsideration and formal review. There must be a disputed question of fact, which, if resolved in favor of whomever is filing the appeal, would result in the authorization of dental benefits. All initial denials and appeal denials explain how, where, and by when to file for the next level of review.

- Benefits are services determined to be necessary and furnished in a manner consistent with generally acceptable standards of practice.
- Requests must be in writing, state the issue in dispute, include a copy of all supporting documentation necessary for the review, and may include the DEOB (though this is not required).

4.12.1 Reconsideration

- The appealing party must file the request within 90 calendar days after the date on the notice of the initial denial determination, usually the dental explanation of benefits.

4.12.2 Formal Review

- Enrollees may request a formal review from the TRICARE Management Activity (TMA) if they disagree with the TRDP contractor's reconsideration decision and the amount remaining in dispute is $50 or more, or there is a question of dental necessity.
- The formal review process is the same as the factual determination appeal process for medical claims. See the *Claims and Appeals* module for more information.

5.0 General Anesthesia for Dental Treatment

- General anesthesia is a TDP/TRDP-covered benefit when administered by a dental provider. In these instances, the enrollee has a cost-share.
- The TRICARE medical benefit covers general anesthesia services for dental treatment provided to beneficiaries with developmental, mental, or physical disabilities and to children age 5 or under. Although this relates to dental procedures, it's administered through the TRICARE **medical** benefit.
    - Payment for general anesthesia and institutional costs are based on the beneficiaries' selected TRICARE program option and paid by the regional or overseas claims processor. If beneficiaries qualify to use their medical benefit for anesthesia services, costs are not counted against their TRDP $1,200 annual maximum benefit. Qualifying beneficiaries should contact their regional contractor for authorization before seeking anesthesia services associated with dental services.

6.0 Resources

6.1 Active Duty Dental Program Resources

United States and U.S. Territories	Overseas
● Website: www.addp-ucci.com ● E-mail: addpdcf@ucci.com ● Phone: 1-866-984-ADDP (1-866-984-2337) ● Mail: United Concordia Companies, Inc. ADDP Unit P.O. Box 69430 Harrisburg, PA 17106-9430	● Contact the overseas contractor Regional or Country-specific Call Center for assistance. ● For contact information, see Section 6.2 below.

6.2 TRICARE Overseas Program Contractor Regional Call Centers

Eurasia-Africa	Latin America and Canada	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 1-877-678-1207 (stateside) +44-20-8762-8384 (overseas) tricarelon@internationalsos.com	**TOP Regional Call Center** 1-877-451-8659 (stateside) 1-215-942-8393 (overseas) tricarephl@internationalsos.com	**TOP Regional Call Centers** Singapore: 1-877-678-1208 (stateside) +65-6339-2676 (overseas) sin.tricare@internationalsos.com Sydney: 1-877-678-1209 (stateside) +61-2-9273-2710 (overseas) sydtricare@internationalsos.com

* *For toll-free and country-specific contact information, visit www.tricare-overseas.com. Toll-free lines may not be available for all mobile phone carriers overseas.*

6.3 TRICARE Dental Program Resources (for Dates of Service After May 1, 2012)

Stateside	Overseas
Customer Service Phone: 1-855-MET-TDP1 (1-855-638-8371) TDD/TTY: 1-855-MET-TDP3 (1-855-638-8373) Sunday 6 PM to Friday 10 PM, Eastern Time Representatives are available to assist members in English, German, Italian, Korean, Japanese, and Spanish Online: http://mybenefits.metlife.com/tricare	**Customer Service** Phone: 1-855-MET-TDP2 (1-855-638-8372) TDD/TTY: 1-855-MET-TDP2 (1-855-638-8372) Sunday 6 PM to Friday 10 PM, Eastern Time Representatives are available to assist members in English, German, Italian, Korean, Japanese, and Spanish Online: http://mybenefits.metlife.com/tricare
Claims MetLife TRICARE Dental Program P.O. Box 14181 Lexington, KY 40512 Phone: 1-855-638-8371 Fax: 1-855-763-1333	**Claims** MetLife TRICARE Dental Program P.O. Box 14182 Lexington, KY 40512 Phone: 1-855-638-8372 E-mail: OCONUSDentalClaims@metlife.com Fax: 1-855-763-1334

6.4 TRICARE Dental Program Resources (for Dates of Service Before May 1, 2012)

Stateside (Before May 1, 2012)	Overseas (Before May 1, 2012)
Claims TDP Claims Processing P.O. Box 69411 Harrisburg, PA 17106-9411	**Claims** TDP OCONUS Dental Unit P.O. Box 69418 Harrisburg, PA 17106-9418

6.5 TRICARE Retiree Dental Program Resources

- Online: www.trdp.org
- Phone: 1-888-838-8737 or international toll-free at +866-721-8737 (24 hours a day)
- Mail written inquiries (stateside or overseas) to:

Delta Dental of California
Federal Government Programs
P.O. Box 537008
Sacramento, CA 95853-7008
United States of America

Module Objectives

Summary:

- **Describe active duty dental coverage**
- **Explain the TRICARE Dental Program (TDP) and who is eligible**
- **Explain the TRICARE Retiree Dental Program (TRDP) and who is eligible**
- **State how premiums are determined for the TRICARE Retiree Dental Program**

TRICARE Fundamentals Course

National Guard and Reserve

9

Participant Guide

References

10 USC

32 CFR § 199.20

2002 TRICARE Operations Manual, Chapter 24

2008 TRICARE Operations Manual, Chapter 22

www.tricare.mil/mmso

www.dol.gov/elaws/userra.htm

DoD Instruction 1241.03

Brainteaser

Each of the eight items below is a separate puzzle.

How many can you figure out?

1. DOX DOX	2. ##### wait	3. polmomice	4. B BA BACK
5. STEP PETS PETS	6. k c u t s	7. DDDWESTDDD	8. b bow w

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

- **Define line of duty determinations and their use**
- **Explain TRICARE coverage for Guard/Reserve members on active duty for more than 30 consecutive days**
- **Describe how delayed-effective-date active duty orders are used**
- **Describe TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR)**
- **Define USERRA and how it impacts Guard/Reserve members**

1.0 Introduction

The seven U.S. Uniformed Services National Guard and Reserve components are:

- Army National Guard
- Army Reserve
- Marine Corps Reserve
- Naval Reserve
- Air Force Reserve
- Air National Guard
- Coast Guard Reserve

TRICARE options available to Guard/Reserve members vary based on the sponsor's status. When on federal orders written for more than 30 consecutive days, Guard/Reserve members have the same health care benefits as active duty service members (ADSMs). When serving on active duty for 30 days or less, Guard/Reserve members are covered under line of duty care.

2.0 Coverage While on Active Duty for 30 Days or Less

When Guard/Reserve members are on active duty for 30 days or less (e.g., drilling on weekends, training during the summer), they're covered for any injury, illness, or disease incurred or aggravated in the line of duty; this includes traveling directly to or from their place of duty. They don't show as eligible in the Defense Enrollment Eligibility Reporting System (DEERS), but may receive care based on a Line of Duty (LOD)/Notice of Eligibility (NOE) determination.

Potential Coverage	Sponsor Coverage	Family Coverage
Line of Duty (LOD) Care	LOD/NOE care covers treatment of an injury, illness, or disease incurred or aggravated in the line of duty. (See Section 2.1 of this module for more information on LOD/NOE care.)	Guard/Reserve family members are not eligible for LOD/NOE care
TRICARE Reserve Select (TRS)	Qualified members may purchase TRS member-only or TRS member-and-family coverage. (See Section 7.0 of this module for more information on TRS.)	Eligible family members may be included in TRS member-and-family coverage.
TRICARE Dental Program (TDP)	Eligible sponsors may purchase TDP sponsor coverage, which is separate from TDP family coverage. (See the *Dental* module for more information on TDP.)	Sponsors may purchase TDP coverage for eligible family members, which is separate from sponsor coverage.

2.1 Line of Duty/Notice of Eligibility Determination (LOD/NOE)

- The Services use an LOD determination to document, establish, manage, and request authorization for civilian health care for Guard/Reserve members if injury or illness occurs in the line of duty. The Coast Guard refers to an LOD as NOE.
- Guard/Reserve members who live or are stationed within a military treatment facility's (MTF's) Prime Service Area should seek LOD/NOE care from that MTF. The Guard/Reserve member's command or medical unit should contact the MTF's patient administration office for assistance.
- If MTF care isn't available locally, the Guard/Reserve member's command or medical unit may request an authorization for civilian medical care by submitting a LOD/NOE determination to the Military Medical Support Office (MMSO).

- MMSO is responsible for authorizing civilian health care for Guard/Reserve members **not** in a Prime Service Area.
  - The unit medical representative submits the LOD/NOE, copy of orders or drill attendance sheet, along with the MMSO *Medical Eligibility Verification* form, which can be found at: www.tricare.mil/tma/mmso/pdf/mmsoformmedicaleligibility.pdf.
  - Once MMSO receives and reviews all the documentation, they issue an authorization determination.
- The member doesn't need prior authorization for an initial emergency room visit. However, if the member is admitted to a hospital/facility or needs additional care for the LOD/NOE condition, the member must obtain prior authorization from MMSO or the MTF.
- Overseas Guard/Reserve members must use their respective service component's procedures for LOD/NOE care. MMSO isn't involved in LOD/NOE care in any overseas location other than the U.S. Virgin Islands.
  - For information on LOD/NOE care in the U.S. Virgin Islands, unit medical representatives should call the MMSO at 1-888-647-6676, option 4.

2.2 LOD/NOE Coverage after Release from Active Duty

Guard/Reserve members are also covered for LOD/NOE conditions after release from qualified active duty as long as they remain a Guard/Reserve member, the condition needs continued treatment, and the care is authorized.

To obtain follow-up care after release from active duty, members should ensure they and their command or medical unit receive and retain the official LOD/NOE document before the Guard/Reserve member's release from active duty. For more information, refer to the MMSO website at www.tricare.mil/mmso.

2.3 Guard or Reserve Members and Line of Duty or Notice of Eligibility Retail Pharmacy Claims

- Guard or Reserve members with an approved Line of Duty or Notice of Eligibility (LOD/NOE) condition must pay out of pocket for prescription medications as they don't show as TRICARE eligible in the DEERS.
- These members must complete a *TRICARE DoD/CHAMPUS Medical Claim–Patient's Request for Medical Payment* (DD Form 2642) and mail or fax it, along with a copy of the LOD document and the civilian/host nation pharmacy's payment receipt or invoice, to the Military Medical Support Office or overseas claims processor using the following steps:

	Care Rendered Stateside and in the U.S. Virgin Islands	**Care Rendered in All Other Overseas Locations**
Step 1	The Guard/Reserve members submit the *DD Form 2642*, claims receipts, and LOD documents (if not already sent or on file) to: Military Medical Support Office (MMSO) Attn: RC Retail Pharmacy Reimbursement P.O. Box 886999 Great Lakes, IL 60088-6999 Fax: 1-847-688-6460	The Guard/Reserve members submit the *DD Form 2642*, claims receipts, and LOD documents (if not already sent or on file) to: Overseas Active Duty Claims TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968
Step 2	Once the information is received and verified, MMSO faxes the *DD Form 2642* and the receipt or invoice to the pharmacy contractor for payment.	Once the information is received and verified, the overseas contractor's claims processor reviews, verifies, and processes the claim.
Step 3	The pharmacy contractor mails the reimbursement check directly to the Guard/Reserve member.	The overseas contractor's claims processor mails the reimbursement check directly to the Guard/Reserve member.

3.0 Coverage for Guard/Reserve Members With Early Eligibility

- When Guard/Reserve members receive delayed-effective-date active duty orders to serve for more than 30 consecutive days in support of a contingency operation, they and their eligible family members may become TRICARE eligible on the date the delayed-effective-date order is issued or 180 days prior to being called to active duty, whichever is later. This benefit is known as "early eligibility."
  - The coding of "early eligibility" in DEERS is a service responsibility and may need to be addressed by the Guard/Reserve member's unit. (The personnel office will provide notification of eligibility.)
- When the early eligibility benefit begins, TRS coverage automatically ends for the sponsor and his/her family members.
- Sponsors with early eligibility may either:
  - Enroll in TRICARE Prime at the MTF (if they live within 50 miles or about one hour from an MTF)
  - Seek covered primary care from a TRICARE-authorized provider (speciality care requires prior authorization from the regional contractor)
- Family members are automatically covered under TRICARE Standard/Extra when shown as eligible in DEERS.
- Family members may choose to enroll in an available TRICARE Prime option, including TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Overseas Program (TOP) Prime, TOP Prime Remote, and the US Family Health Plan.

3.1 Guard/Reserve Early Eligibility Scenarios

Scenario 1: On January 1, a Guard/Reserve member receives delayed-effective-date active duty orders to serve for 180 consecutive days, with a reporting date of July 2. On January 1, TRICARE coverage begins for the Guard/Reserve member and their eligible family members.

Scenario 2: On January 1, a Guard/Reserve member receives delayed-effective-date active duty orders to serve for 180 consecutive days, with a reporting date of July 2. On January 1, TRICARE coverage begins for the Guard/Reserve member and their eligible family members. On February 1, the Guard/Reserve member's orders are cancelled. As a result, the member and their family's TRICARE coverage ends on the same day, February 1.

4.0 Coverage Available While on Active Duty for More Than 30 Days

Potential Coverage	Sponsor Coverage	Family Coverage
Medical Coverage (during active duty)	● Members who had early eligibility coverage should not enroll or reenroll in a TRICARE Prime program while travelling to their final duty location (e.g., at training or mobilization location). ● After arriving at their final duty location, members should follow their command's guidance regarding TRICARE Prime option enrollment.	● Family members are automatically covered under TRICARE Standard/ Extra unless already enrolled in TRICARE Prime or TPRADFM during the early-eligibility period. ● Family members may choose to enroll in an available TRICARE Prime option.
Dental Coverage	● If enrolled, TDP coverage automatically ends. ● Most dental care is provided through military dental treatment facilities or through the Active Duty Dental Program.	● If already enrolled, TDP coverage continues at a reduced premium rate. ● New TDP coverage is available for purchase by eligible family members at the reduced premium rate.

5.0 Coverage Available After Separating from Active Duty

Potential Coverage	Sponsor Coverage	Family Coverage
Transitional Assistance Management Program (TAMP)*	● TAMP provides 180 days of transitional TRICARE coverage for eligible sponsors. (See the *Transitional Benefits* module for more information on TAMP.) ● Eligible sponsors may enroll (or reenroll) in TRICARE Prime or TOP Prime, or use TRICARE Standard and TRICARE Extra. (TPR and TOP Prime Remote are not available during TAMP.) ● Certain sponsors are covered under the Active Duty Dental Program during TAMP. Others may qualify to resume or purchase TDP when TAMP coverage ends.	● TAMP provides 180 days of transitional TRICARE coverage for eligible family members. ● Family members are automatically covered under TRICARE Standard/ Extra and may choose to enroll or reenroll in TRICARE Prime, if available. (TPRADFM and TOP Prime Remote are not available during TAMP.) ● May qualify to resume or purchase TDP at the appropriate premium rate (based on sponsor's status).
TRICARE Reserve Select (TRS)	● Qualified Selected Reserve sponsors may purchase TRS to begin after active duty benefits or TAMP coverage ends, whichever is later. ● To avoid a break in TRICARE coverage, TRS must be purchased within 30 days of the last day of TRICARE coverage (e.g., active duty benefits, TAMP).	● Eligible family members may be included in TRS member-and-family coverage. ● Family members may only receive TRS coverage through their sponsors.
Continued Health Care Benefit Program (CHCBP)	● CHCBP provides up to 18 months of premium-based health coverage. (See the *Transitional Benefits* module for more information on CHCBP.) ● Eligible sponsors may purchase CHCBP within 60 days of the end of TRICARE eligibility or TAMP coverage, whichever is later. ● If Selected Reserve status or TRS coverage ends, sponsors must enroll in CHCBP within 30 days of the end of TRS coverage.	● Qualifying dependent spouses, dependent children, unremarried former spouses, and unremarried surviving spouses may be eligible for CHCBP coverage for up to 36 months. ● Certain unremarried former spouses may qualify for CHCBP coverage beyond 36 months.
TRICARE Dental Program (TDP)	● Sponsors who are not TAMP eligible and were enrolled in the TDP before activation are automatically reenrolled. ● Sponsors who are not TAMP eligible and were not previously enrolled may purchase TDP sponsor coverage.	● Eligible family members may purchase or continue TDP family coverage. ● If previously enrolled, premiums will increase to the appropriate family-member rate, depending on the sponsor's status.

* *Activated National Guard and Reserve personnel must be on active duty status for more than 30 consecutive days in support of a contingency operation to qualify for TAMP coverage.*

6.0 Coverage Available When Retired

Potential Coverage	Sponsor Coverage	Family Coverage
TRICARE Retired Reserve (TRR)	● Members of the Retired Reserve may qualify to purchase TRR until they reach age 60 and qualify for full retiree benefits. (See Section 7.0 of this module for more information on TRR.)	● Eligible family members may be included in TRR member-and-family coverage purchased by their sponsors. ● If a qualified member of the Retired Reserve dies during a period of TRR coverage, the sponsor's eligible family members may purchase new or continue existing TRR coverage until the date the deceased sponsor would have turned 60.
TRICARE Retiree Dental Program (TRDP)	● Eligible sponsors may purchase coverage under the TRDP. (See the *Dental* module for more information on TRDP.)	● Eligible family members may purchase coverage under the TRDP. ● Former spouses and remarried surviving spouses are not eligible to purchase coverage.

7.0 TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR)

- TRS and TRR are premium-based health plans available for purchase worldwide. They both deliver the TRICARE Standard/Extra or TRICARE Overseas Program (TOP) Standard benefit, depending on where the covered individuals live.
- TRS and TRR are available overseas.
  - The TOP contractor handles overseas enrollments, premium payments, billing, and customer support services.
  - TRICARE Area Offices can also provide information about accessing health care in overseas locations.

7.1 Eligibility

- TRS is available for purchase by qualified members of the Selected Reserve for themselves and their eligible family members.
- TRR is available for purchase by qualified Retired Reserve members and their eligible family members. This population of Guard/Reserve retirees is commonly referred to as "Gray-area retirees."

7.2 Types of Coverage

TRS and TRR offer two types of coverage:

- Member-only coverage
- Member-and-family coverage

7.3 Qualifying for Coverage

7.3.1 Qualifying for TRS Coverage

- Each Guard/Reserve component is responsible for validating a member's qualification to purchase TRS.
- Members must not be enrolled or eligible to enroll in the Federal Employees Health Benefits (FEHB) Program.
- To qualify to purchase TRS coverage, Guard/Reserve members must be in the Selected Reserve of the Ready Reserve throughout the entire coverage period.

7.3.2 Qualifying for TRR Coverage

- Each Guard/Reserve component is responsible for validating a member's qualification to purchase TRR.
- Members must not be enrolled or eligible to enroll in the Federal Employees Health Benefits (FEHB) Program.
- To qualify to purchase TRR coverage, retired Guard/Reserve members must be:
  - A member of the Retired Reserve of a reserve component who is qualified for non-regular retirement under 10 USC, Chapter 1223
  - Under age 60

7.3.3 Verifying Qualification for TRS or TRR

- To verify qualification for either TRS or TRR, members should log on to the DMDC *Reserve Component Purchased TRICARE Application* at www.dmdc.osd.mil/appj/reservetricare. Members need a DoD Self-Service Logon (DS Logon), DFAS myPay account, or DoD Common Access Card (CAC) to access the application
  - Members can obtain a DS Logon either online or in-person:
    - Online: Visit https://myaccess.dmdc.osd.mil/identitymanagement and click "Request an Account"
    - In-person: Visit the nearest TRICARE Service Center (TSC) or select VA Regional Hospitals.

7.4 Purchasing TRS and TRR Coverage

- If members qualify, they use the *Reserve Component Purchased TRICARE Application* to print the *Reserve Component Health Coverage Request* form (DD Form 2896-1). They then submit the completed and signed form and two-month initial premium payment to the regional or overseas contractor.
- The effective date of TRS and TRR coverage varies based on how and when coverage is purchased.

7.4.1 General Enrollment

- Qualified members may purchase TRS or TRR coverage to begin any month of the year.
- Deadline: The application form must be postmarked or received no later than the last day of the month before coverage is to begin.
- Effective date: TRS or TRR coverage begins on the first day of the first or second month, whichever is selected on the form.

7.4.2 Loss of Other TRICARE Coverage

- Eligible members losing coverage under another TRICARE health care plan may purchase TRS or TRR with no break in TRICARE coverage in the following circumstances. This only applies to:
  - A Selected Reserve member who qualifies for TRS; retired reserve Guard/Reserve member who qualifies for TRR
  - A Guard/Reserve member who was activated, deactivated, and TAMP coverage is ending
- Deadline: The application form must be postmarked or received no later than 30 days after the loss of other TRICARE coverage.
- Effective date: TRS or TRR coverage begins on the day after the loss of prior TRICARE coverage.
- Members who qualify may apply up to 60 days before the end of their other TRICARE coverage.

7.4.3 Change in Family Composition

- When the composition of the sponsor's immediate family changes through qualifying life events such as marriage, birth, adoption, or death, their TRS or TRR coverage needs (member-only or member-and-family) may change. If so, a new application is required. Family members must be listed in DEERS.
    - Deadline: The new application must be postmarked or received no later than 60 days after the qualifying life event. It must be submitted when going from single to family or vice versa (i.e., each time a new family member is added or removed).
    - Effective date: TRS or TRR coverage effective date is the same as the date of the qualifying life event.

7.4.4 Survivor Coverage

- If TRS or TRR coverage (member-and-family or member-only) is in effect when the sponsor passes away, qualified survivors may purchase or continue coverage as follows:
    - TRS: For up to six months beyond the sponsor's date of death
    - TRR: Until the day the sponsor would have become eligible for retiree benefits (typically age 60)
- If TRS or TRR member-and-family coverage is in effect at the time of death:
    - DEERS automatically converts coverage to TRS or TRR survivor coverage (Advise beneficiaries to verify status changes in DEERS.)
    - If survivors don't want TRS or TRR survivor coverage, they must submit a written letter or a *DD Form 2896-1* no later than 60 days after the date of the sponsor's death. Premiums are refunded if there were no claims for health care submitted during the 60 days.
- If TRS or TRR member-only coverage is in effect at the time of death:
    - Eligible survivors may qualify to purchase TRS or TRR survivor coverage.
    - See Section 7.4.3 of this module if the survivor wants coverage to coincide with the date of the sponsor's death as a qualifying life event.
    - Surviving family members who are eligible in their own right for or are enrolled in the FEHB program may still purchase TRS or TRR.
- If a sponsor was not enrolled in TRS or TRR at the time of death, surviving family members do not qualify to purchase coverage under either plan.

7.5 Receiving Care Under TRS and TRR

- TRS and TRR coverage is handled like TRICARE Standard/Extra or TOP Standard.
- Pharmacy benefits are administered by the pharmacy contractor stateside and by the overseas contractor in countries other than U.S. territories.

7.6 TRS and TRR Costs

- TRS: TRICARE Standard/Extra cost-shares, deductibles, and catastrophic caps that apply to active duty family members (ADFMs) apply to all TRS-covered individuals (including the Guard/Reserve member).
- TRR: TRICARE Standard/Extra cost-shares, deductibles, and catastrophic caps that apply to regular retirees apply to all TRR-covered individuals.
- See the *TRICARE Options* Module for more information on Standard/Extra cost-shares, deductibles, and catastrophic caps.

7.6.1 TRS and TRR Monthly Premiums

- TRS and TRR premiums are adjusted on an annual basis, effective January 1.
- The most recent premiums are available at www.tricare.mil/costs.
- After the initial premium payment (included with the request form), the regional or overseas contractor bills the TRS or TRR member, family member, or survivor by the 10th of each month.
- TRS and TRR premium payments are due in advance of the month of coverage; payment is due no later than the 30th.
  - Members may schedule recurring monthly credit card payments when they submit the initial payment.
  - Members may set up electronic funds transfers by contacting their regional or overseas contractor after they receive their first bill.

7.7 Loss of TRS or TRR Coverage

7.7.1 Loss of TRS or TRR Eligibility

Members, families, and survivors lose eligibility/coverage in the following situations:

TRS	TRR
● Failure to pay monthly premiums (See Section 7.7.3 of this module for more information.) ● The sponsor: ○ Separates from the Selected Reserve ○ Is called to active duty ○ Retires from the Selected Reserve ○ Becomes eligible for FEHB coverage ▪ Typically, when starting a new job that offers FEHB, eligibility for FEHB doesn't begin until the first day of the second pay period. TRS members should keep this in mind when selecting their TRS disenrollment date to ensure continuous health care coverage	● Failure to pay monthly premiums (See Section 7.7.3 of this module for more information.) ● The sponsor: ○ Turns 60, or becomes eligible for health benefits as a retiree per his/her Service ○ Becomes eligible for FEHB coverage ▪ When the TRR sponsor becomes eligible for the FEHB Program, they can continue their TRR coverage for up to 60 days, allowing them time to transfer coverage

7.7.2 Voluntary Disenrollment

- TRS and TRR members and families must take the following actions to end coverage:
  - Log on to the DMDC *Reserve Component Purchased TRICARE Application* at www.dmdc.osd.mil/appj/reservetricare.
  - Complete the *DD Form 2896-1*.
  - Print and mail the completed disenrollment request form to the regional or overseas contractor.

7.7.3 Failure to Make Premium Payments

- Premium payments are due no later than the last day of the month for the next month's coverage (e.g., premium payments for coverage in February would be due by January 31).
- Failure to pay monthly premiums results in termination of coverage.
  - The effective date of termination is the paid-through date.
  - A 12-month purchase lockout will go into effect when coverage is terminated due to premiums not being paid.

7.7.4 Purchase Lockout

- A one-year purchase lockout applies to TRS and TRR members who voluntarily disenroll without submitting a disenrollment form; for example, when a member simply stops making payments.
- Purchase lockout applies for 12 months from the effective date of termination.
- Purchase lockout doesn't apply to Selected Reserve members and their family members if they:
  - Are losing TRS eligibility (See Section 7.7.1 of this module for more information.)
  - Are terminating TRS coverage because they're gaining other TRICARE coverage

7.8 TRS/TRR and Continued Health Care Benefit Program (CHCBP) Eligibility

TRS members and TRR family members may be eligible to purchase CHCBP when their TRS/TRR coverage ends. (See the *Transitional Benefits* module for more information on CHCBP.)

7.9 Distinguishing Between TRS and TRR

It's important to understand the differences between TRS and TRR. The following table lists key features of each plan.

	TRICARE Reserve Select (TRS)	TRICARE Retired Reserve (TRR)
Qualifying	● Must be a member of the Selected Reserve or the Ready Reserve throughout entire period of coverage ● Must not be eligible for or obtain coverage under FEHB	● Must be a retired member of the Retired Reserve of a Reserve Component who has not reached age 60 ● Isn't eligible for or enrolled in FEHB program
Cost-Shares	● ADFM rate	● Retiree rate
Premium Rates (Valid January 1, 2012–December 31, 2012)	● Monthly premium rate: ○ $54.35 for member-only ○ $192.98 for member-and-family ● Minimum 2 month initial premium payment required ● Premiums are adjusted every calendar year, effective January 1 ○ Visit www.tricare.mil/costs for the most recent premium rates	● Monthly premium rate: ○ $419.72 for member-only ○ $1,024.43 for member-and-family ● Minimum 2 months initial premium payment required ● Premiums are adjusted every calendar year, effective January 1 ○ Visit www.tricare.mil/costs for the most recent premium rates
Survivor Coverage	● Surviving family member(s) may purchase or continue TRS coverage for up to six months beyond the date of the sponsor's death (only if TRS coverage [member-and-family or member-only] is in effect when the sponsor passes away)	● Surviving family member(s) may purchase or continue TRR coverage until the date the deceased member would have turned 60 (only if TRR coverage [member-and-family or member-only] is in effect when the sponsor passes away)

7.10 TRS/TRR Application Exercises

1. Captain Brown, a member in the Selected Reserve, is employed full-time at an auto parts store. His spouse works and has an active family plan under the FEHB program. Does Captain Brown qualify to purchase TRS coverage?

2. A retired member of the Guard just celebrated her 60th birthday. True or False: She is now eligible for TRR.

3. True or False: A retired member who has FEHB is also eligible for TRR.

7.11 TRS/TRR Resources

Stateside		
North	**South**	**West**
TRS/TRR Enrollment Address: Health Net Federal Services, LLC. TRS/TRR Enrollment P.O. Box 105402 Atlanta, GA 30348-5402 **Phone:** 1-877-TRICARE (1-877-874-2273) **Fax:** 1-888-299-4114 **Website:** www.hnfs.com	**TRS/TRR Enrollment Address:** Humana Military Healthcare Services, Inc. ATTN: PNC Bank P.O. Box 105389 Atlanta, GA 30348-5389 **Phone:** 1-800-444-5445 **Fax:** 1-866-836-9535 **Website:** www.humana-military.com	**TRS/TRR Enrollment Address:** TriWest Healthcare Alliance P.O. Box 42048 Phoenix, AZ 85080-2048 **Phone:** 1-888-TRIWEST (1-888-874-9378) **Fax:** 1-866-441-8843 **Website:** www.triwest.com/ngr

Overseas (All Areas)
TRS/TRR Enrollment Address: International SOS Assistance, Inc. TOP TRS/TRR Enrollments P.O. Box 11689 Philadelphia, PA 19916 **Phone:** 1-877-451-8659 **Fax:** +1-215-354-5015 **Website:** www.tricare-overseas.com

8.0 Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA provides employment/reemployment protection to uniformed service members who perform military service. The law seeks to ensure that they can keep their civilian employment and benefits. Under USERRA, when a member is on active duty, their family members may continue their health care coverage under their employer-sponsored health plan for up to 24 months.

8.1 Eligibility for USERRA

- Guard/Reserve members activated under federal orders for more than 30 consecutive days
- Guard/Reserve members who receive delayed-effective-date active duty orders to serve for more than 30 consecutive days in support of a contingency operation
    - If a Guard/Reserve member terminates their employer-sponsored health plan during "early TRICARE eligibility," and the orders are cancelled before the member reports for active duty, the member is entitled to reinstatement in their employer-sponsored health plan when they return to civilian employment.

8.2 USERRA Costs and Conditions

- Prior to being ordered to active duty, Guard/Reserve members should investigate their employer's policies regarding continuing health care coverage while on active duty status.
- If continuing coverage, Guard/Reserve members must inform their employer about their desire to continue coverage so their family members aren't dropped from their plan.
- While serving on active duty, they may have to pay:
    - A percentage of the employer-sponsored health plan's premium;
    - The full amount of the premium; or
    - The full cost of the premium plus a two percent administrative fee.
- Upon return from military service, civilian health insurance coverage must be reinstated without any waiting period or exclusions for preexisting conditions.
- If military members delay reinstatement in their employer-sponsored health plan upon return from military service, they may place their USERRA reinstatement protections at risk.
- In particular, members with premium-free TRICARE coverage under the Transitional Assistance Management Program (TAMP) might risk having to wait until the next open season to obtain their employer's sponsored health coverage and shouldn't delay reinstatement to save paying premiums for the employer's health coverage for a few months.

For comprehensive information about USERRA, visit the U.S. Department of Labor website (www.dol.gov/elaws/userra.htm) or DoD's Employer Support of the Guard/Reserve website (www.esgr.org). See *Appendix A* of this module for another example of USERRA's role in supporting Guard/Reserve members.

8.3 Application Exercise

Private Berry is a Guard member who recently received delayed-effective-date active duty orders. He discontinues his employer-sponsored health coverage for himself and his family and enrolls them in TRICARE Prime. After the termination of his employer-sponsored health coverage, but before his actual active duty service began, his orders are cancelled.

Now Private Berry and his family have no medical coverage. He has returned to his civilian employment and wants his family to be reinstated in their previous employer-sponsored health plan.

Based on the scenario above and what you know about USERRA, are Private Berry and his family members entitled to reinstatement in their previous employer-sponsored health plan?

Module Objectives

Summary:

- **Define line of duty determinations and their use**
- **Explain TRICARE coverage for Guard/Reserve members on active duty for more than 30 consecutive days**
- **Describe how delayed-effective-date active duty orders are used**
- **Describe TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR)**
- **Define USERRA and how it impacts Guard/Reserve members**

Appendix A: Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is intended to minimize the disadvantages to an individual that occur when that person must be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides employees with Department of Labor assistance in processing claims.

USERRA covers virtually every individual in the country who serves in, or has served in, the uniformed services (including Guard/Reserve members) and applies to all employers in the public and private sectors, including federal employers.

It's administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service-connected problems with their civilian employment and provides information about the Act to employers.

Continuation of Employer-Sponsored Health Coverage

USERRA requires that service members provide advance written or verbal notice to their employers for all military duty unless giving notice is impossible, unreasonable, or precluded by military necessity. An employee should provide notice as far in advance as is reasonable under the circumstances.

Under USERRA, when a member is on active duty, their family members may continue their health care coverage under their employer-sponsored health plan for up to 24 months.

Under USERRA, when a member is on active duty, their family members may continue their health care coverage under their employer-sponsored health plan. The person may elect to continue that coverage for up to 24 months after the absence begins, or for period of absence, whichever is shorter. During this time, the person may be required to pay the full insurance premium, plus 2% of the premium amount for administrative costs. The person cannot be required to pay more than 102% of the full premium for the coverage. When the uniformed service was for 30 or fewer days, the person cannot be required to pay more than the normal employee share of any premium.

If a person terminates their employer-sponsored health plan coverage because of an absence due to uniformed service, upon their return from military service, health insurance coverage must be reinstated without any waiting period or exclusions for preexisting conditions, other than waiting periods or exclusions that would have applied even if there had been no absence for uniformed service. This rule does not apply to the coverage of any illness or injury determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during, performance of service in the uniformed service. (See 20 CFR, Part 1002.168 for more information.)

TRICARE Fundamentals Course

Other Benefits

10

Participant Guide

References

10 USC § 1079 (d)–(f)
32 CFR §§ 199.5, 6, 8
2002 TRICARE Operations Manual, Chapter 6 and Chapter 18, Section 9
2008 TRICARE Operations Manual, Chapter 6 and Chapter 18, Section 8
2002 TRICARE Policy Manual, Chapter 9
2008 TRICARE Policy Manual, Chapter 9
www.militaryhomefront.dod.mil
www.usfhp.com
www.cap.mil/wsm
www.tricare.mil/tmaprivacy

Brainteaser

What do you see in the picture below?

Module Objectives

- **Identify who may be eligible for coverage under the TRICARE Young Adult program (TYA)**
- **State the purpose of TRICARE Plus**
- **Explain how the US Family Health Plan mirrors TRICARE Prime**
- **Describe the Extended Care Health Option (ECHO)**

1.0 TRICARE Young Adult Program (TYA)

The premium-based TYA program extends TRICARE medical coverage to qualified young adults who lose TRICARE eligibility due to age.

1.1 TYA Eligibility

- Qualified young adults may purchase TYA coverage if they meet all of the following criteria:
  - Are a dependent of a TRICARE-eligible uniformed service sponsor
  - Aren't married
  - Are at least age 21 but under age 26
  - Aren't a member of the uniformed services
  - Aren't eligible to enroll in an employer-sponsored health plan based on the young adult's own employment
  - Aren't eligible for other TRICARE coverage
- TYA coverage depends on the sponsor's program eligibility status (e.g., active duty, retiree, Selected or Retired Reserve) and where the young adult dependent lives.
  - The young adult must meet all TRICARE Overseas and service approval requirements (i.e., command sponsorship) to purchase TRICARE Overseas Program (TOP) Prime/Remote coverage under TYA.
- Young adult dependents of TRICARE for Life sponsors are qualified to purchase a TYA Prime option (stateside, overseas, US Family Health Plan [USFHP]). They must meet all of the TYA and TRICARE Prime rules.
- TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) eligible sponsors must be enrolled in TRS or TRR for the young adult dependent to purchase coverage under TYA Standard/Extra (Prime option coverage isn't available).
  - The young adult dependent can continue TYA coverage when the TRR sponsor becomes a regular retiree or until age 26, whichever comes first.
  - This also applies if the sponsor dies. The young adult dependent's sponsor must have been enrolled in either TRS or TRR for the young adult to continue or purchase TYA coverage.
    - TYA coverage ends six months after a TRS sponsor's death, or when the TYA-enrolled young adult turns 26, whichever comes first.
    - TYA coverage, under a TRR sponsor who dies, continues until the date the sponsor would have become a regular retiree or when the young adult reaches age 26, whichever comes first.
- TYA coverage ends when:
  - The young adult submits a *TRICARE Young Adult Application* (DD Form 2947) asking for coverage to end because he or she no longer qualifies for coverage (e.g., he or she gains health care under an employer)
  - The young adult's sponsor loses TRICARE eligibility
  - The young adult ages out at 26

1.2 TYA Enrollment

- Qualified young adult dependents may purchase TYA coverage on a month-to-month basis as long as they're listed in the Defense Enrollment Eligibility Reporting System (DEERS). (See the *Other Benefits* module for information on USFHP.)
  - TOP Prime and TOP Prime Remote program enrollment requirements still apply (i.e., the young adult must be command-sponsored at the time he/she loses TRICARE eligibility and show as TYA eligible in DEERS). See the *TRICARE Options* and *Prime Remote Options* modules for more information.
- To purchase coverage, qualified young adults must submit a *DD Form 2947* to their regional or overseas contractor, along with an initial two-month premium payment.
  - *DD Form 2947* is available online at www.tricare.mil/forms or www.tricare.mil/tya.

- Coverage effective dates are as follows:
  - TRICARE Standard: the first day of the next month after the *DD Form 2947* is received or up to 90 days in the future
  - TRICARE Prime options: the "20th-of-the-month rule" applies
- Young adult dependents losing TRICARE program coverage (e.g., age out of TRICARE at age 21) may avoid a break in coverage and purchase TYA coverage as long as the *DD Form 2947* is postmarked within 30 days of the previous loss.
- Continuous enrollment requires an electronic debit from a checking or savings account or an automatic recurring credit card charge.
- Once covered, the young adult receives an enrollment card and welcome letter. The young adult and sponsor should then either visit the nearest uniformed service ID card issuing facility or have the young adult present a sponsor-notarized DEERS enrollment form so the young adult dependent can receive a new ID card to present when seeking health care services.
- Qualified young adults may purchase TYA coverage anytime unless locked out due to failure to pay TYA premiums or the sponsor fails to pay their own TRS or TRR premiums.
  - If locked out, the young adult dependent may submit a new *DD Form 2947* up to 45 days before the lockout period ends for new coverage to begin as soon as the lockout ends.
  - Young adults may request reinstatement if there was an enrollment processing error or if there are extraordinary circumstances that justify continued TYA coverage.
    - Requests should be submitted to the regional, overseas, or USFHP contractor within 90 days of when the last full premium was paid.
    - Lockout waiver approval authority rests with the TRICARE Regional Office, TRICARE Area Office (TAO), or USFHP.

1.3 TYA Portability

To switch coverage from one region to another, or from TRICARE to USFHP or vice versa, the young adult must submit a new *DD Form 2947*.

1.4 TYA Coverage

- TYA benefits mirror the option purchased (i.e., TRICARE Standard/Extra, TRICARE Prime, TOP Standard, TOP Prime, USFHP).
- TYA includes pharmacy benefits. (See the *Pharmacy* module for more information.)
- TYA doesn't include dental coverage.

1.5 TYA Costs

1.5.1 Monthly Premiums

- Premiums are based on what the government needs to cover the full cost of health care for qualified young adults.
- Premiums may change each January.
- Coverage and premium costs may change or end as the sponsor's status changes (e.g., if a retiree moves overseas, TYA coverage shifts from TRICARE Prime to TOP Standard) or the young adult moves.
- For the current TYA premiums, visit www.tricare.mil/costs.

1.5.2 Out-of-Pocket Expenses

- TRICARE Standard deductibles, and cost-shares apply, if enrolled in TYA Standard.
- TRICARE Prime copays and cost-shares apply if enrolled in TYA Prime.

- Deductibles, cost-shares, and copays for TRICARE-covered services apply to the individual/family's catastrophic cap.
- TYA premiums aren't credited to the catastrophic cap; they offset health care costs.
- Pharmacy copays and cost-shares apply. (See the *Pharmacy* module for more information.)

2.0 TRICARE Plus

- TRICARE Plus is a primary care enrollment program offered at select military treatment facilities (MTFs) stateside and overseas.
  - Although TRICARE Plus isn't a TRICARE option, it offers primary care at the MTF with an assigned primary care manager (PCM) to Plus enrollees.
  - MTF commanders may limit enrollment based on capability and capacity. Continued enrollment is determined by the MTF commander on a case-by-case basis.

2.1 TRICARE Plus Eligibility

Eligible	Not Eligible
● TRICARE Standard beneficiaries ● TRICARE for Life beneficiaries ● Dependent parents and parents-in-law	● Beneficiaries enrolled in a: ○ Prime option (stateside or overseas) ○ Civilian health maintenance organization (HMO) ○ Medicare HMO

2.2 TRICARE Plus Enrollment

- There are no enrollment fees or cards associated with TRICARE Plus. Eligible beneficiaries must complete a *TRICARE Plus Enrollment Application* (DD Form 2853).
- The MTF validates eligibility in the Defense Enrollment Eligibility Reporting System (DEERS).
- Once approved, the *DD Form 2853* is forwarded to the regional contractor.
- The regional contractor enters the TRICARE Plus enrollment into the Defense Online Enrollment System (DOES). The TRICARE Plus enrollment is then reflected in DEERS.
- A TRICARE Plus enrollment indicator appears in the MTF's medical appointment system allowing MTF staff to schedule appointments for enrollees.

2.3 TRICARE Plus Disenrollment

- TRICARE Plus enrollees may disenroll at any time by submitting a *TRICARE Plus Disenrollment Request* (DD Form 2854).
- The MTF sends the completed disenrollment request to the regional contractor for processing and recording in DEERS.

2.4 TRICARE Plus—Not Portable

Unlike TRICARE Prime, TRICARE Plus isn't a portable option. Those who disenroll from TRICARE Plus at one MTF aren't guaranteed enrollment in TRICARE Plus at another MTF.

2.5 Specialty Care

- TRICARE Plus enrollees may be seen for specialty care at MTFs on a "space-available basis." Otherwise, TRICARE Plus enrollees must seek specialty care from a civilian TRICARE-authorized provider, if TRICARE eligible (i.e., Standard/Extra, TRICARE for Life) or use Medicare or other health insurance.

- The MTF isn't responsible for any costs associated with care outside the MTF and the MTF cannot authorize care with civilian providers.
- TRICARE Standard/Extra, Medicare, or other health insurance (OHI) rules apply, as do applicable cost-shares and deductibles.

3.0 US Family Health Plan (USFHP)

USFHP is a TRICARE Prime-like option available at community-based, not-for-profit health care systems in six areas of the United States.

3.1 USFHP Designated Providers

There are six systems that sponsor the USFHP:

Johns Hopkins Medicine Serving Maryland, Washington DC, and parts of Pennsylvania, Delaware, Virginia, and West Virginia 1-800-808-7347 (toll free) www.hopkinsmedicine.org/usfhp	**Martin's Point Health Care** Serving Maine, New Hampshire, Vermont, upstate and western New York, and the northern tier of Pennsylvania 1-888-241-4556 (USFHP line) www.usfhp.com/martinspoint	**Brighton Marine Health Center** Serving Massachusetts (including Cape Cod), Rhode Island and northern Connecticut 1-800-818-8589 1-888-815-5510 www.usfamilyhealth.org
CHRISTUS Health Serving southeast Texas and southwest Louisiana 1-800-67USFHP (1-800-678-7347) http://christus.usfhp.com	**Pacific Medical Centers (PacMed Clinics)** Serving the Puget Sound area of Washington State 1-888-958-7347 www.pacificmedicalcenters.org	**Saint Vincent Catholic Medical Centers of New York** Serving New York City, Long Island, Southern Connecticut, New Jersey, and Philadelphia and area suburbs 1-800-241-4848 www.usfhp.net

3.2 USFHP Eligibility

To enroll, eligible beneficiaries must be registered in DEERS and live within one of the designated USFHP service areas, as determined by zip code.

Eligible	Not Eligible
● ADFMs and unmarried dependent children until they lose eligibility (See the *DEERS* module for more information.) ● Retired service members, their spouses, and unmarried dependent children (until they lose eligibility) ● Medicare-TRICARE eligible beneficiaries under 65 (and those over 65 who were enrolled before September 30, 2012) ○ Medicare-TRICARE eligible beneficiaries under age 65 who enroll in USFHP after September 30, 2012 lose their eligibility to participate in USFHP upon reaching age 65. They then become Medicare or TRICARE For Life eligible (depending on their Medicare Part B status) and will be required to transition to Medicare. ○ Retirees and their eligible family members who are 65 and older can't enroll in the USFHP after September 30, 2012. ● Eligible unremarried former spouses of active duty or retired service members ● Certain former active duty service members (ADSMs), including Guard/Reserve members and their eligible family members during TAMP	ADSMs

3.3 USFHP Enrollment

- Enrollment is open all year.
- There currently are no enrollment fees for ADFMs or Medicare-eligible beneficiaries who purchase Medicare Part B. All others pay an annual enrollment fee that mirrors the TRICARE Prime enrollment fee. For current USFHP enrollment fees visit www.tricare.mil/costs.
- To enroll, eligible beneficiaries must complete a *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876). They must include an initial 3-month payment, payable by check or electronic funds transfer (ongoing payments may also be made via allotment).
- Re-enrollment is automatic at the beginning of each fiscal year.

3.4 USFHP Coverage

- USFHP is an organized system of health care delivery that relies on primary care managers (PCMs) to arrange for all of an enrollee's health care needs with specific specialty providers and hospitals.
- Covered benefits are available only from USFHP-approved providers, except during a medical emergency.
    - USFHP enrollees must get specialty referrals from their PCM and use USFHP network providers and facilities for specialty services.
    - USFHP offers the point-of-service option where enrollees may self-refer for specialty care. (See the *TRICARE Options* module for more information.)

3.5 Benefit Limitations

Enrollment in USFHP affects the beneficiary's entitlement to use other government-sponsored health care programs. By enrolling, the beneficiary agrees not to use the following health care benefits:

- TRICARE Standard/Extra, TRICARE for Life (TFL), and other TRICARE programs
- TRICARE Pharmacy Program (including TRICARE Pharmacy Home Delivery, TRICARE retail network pharmacies, and MTF pharmacies)
- MTF care, with the following exceptions:
    - When the beneficiary experiences an emergency and the nearest emergency room is an MTF.
    - When the beneficiary receives a prescription from a dentist for dental care not covered by the USFHP, an MTF pharmacy may fill the dental prescription.
    - Enrollees may seek services offered by an MTF that are not covered by the USFHP, such as routine hearing tests, on a space-available basis.
- Medicare Part A or Part B (except for services not routinely covered under USFHP, such as chiropractic care)

3.6 USFHP Costs

- USFHP handles payment for covered services. There are no claim forms when USFHP-approved providers file claims for enrollees. Enrollees are only responsible for the applicable copayment.
- USFHP costs mirror TRICARE Prime.

3.7 USFHP Portability

- When enrollees move within their current USFHP's zip code-defined service area, they should notify their USFHP-designated provider of their new address and select a new PCM (if desired).
    - Their USFHP-designated provider should send a new membership card with the new PCM's name and phone number.
- If enrollees move to another area where the USFHP is available, they may transfer their enrollment.
- If enrollees move to an area where USFHP is not available and they qualify for TRICARE Prime or Prime Remote enrollment, they can transfer their enrollment to the new location; otherwise, they revert to TRICARE Standard or TRICARE for Life, depending on their Medicare status.

3.8 Accessing Medical Care While on Vacation

For medical emergencies, USFHP enrollees should go to the nearest appropriate civilian medical facility or MTF. Enrollees, or an authorized representative, should call the USFHP provider's toll-free number (located on the back of the USFHP enrollment card) or their PCM within 24 hours, to facilitate USFHP coverage, even when traveling overseas. Claims should be sent to the address listed on the enrollee's USFHP enrollment card.

3.9 USFHP Prescription Coverage

- Copayments for prescription medications through the USFHP are:
  - $5 for generic formulary medications for a 30-day supply
  - $12 for brand name formulary medications for a 30-day supply; $9 for mail order up to a 90-day supply
  - $25 for non-formulary medications for a 30-day supply; $25 for mail order up to a 90-day supply
- USFHP also has a home delivery pharmacy option which allows enrollees to receive a 90-day supply for most prescription medications at the same cost as TRICARE Pharmacy Home Delivery. (See the *Pharmacy* module for pharmacy costs.)

3.10 Comparing Plans

Beneficiaries may compare USFHP to other TRICARE plans online at: www.tricare.mil/compareplans.

4.0 Extended Care Health Option (ECHO) Program

- The ECHO program is a supplemental program to the basic TRICARE benefit. It provides qualified active duty family members (ADFMs) with an additional financial resource for services and supplies designed to assist in the reduction of the disabling effects of a family member's qualifying condition.
- Potential ECHO beneficiaries must be ADFMs, have qualifying conditions, and be registered in the Exceptional Family Member Program (EFMP). (Under certain circumstances, this requirement may be waived.)
  - Each service branch has its own EFMP and enrollment process.
  - Members of the U.S. Public Health Service (USPHS) and National Oceanic and Atmospheric Administration (NOAA) are not eligible for the EFMP, but may still qualify for ECHO.

4.1 The Service's Exceptional Family Member Program (EFMP)

- The EFMP identifies active duty family members (ADFMs) with special medical and/or educational needs. The EFMP involves the personnel community, medical commands and the DoD educational system to determine if required services are available to the family at assigned duty stations.
- Enrollment in EFMP helps ensure that services station families in geographical areas where the family members' needs can be met. This is especially important when family members are being screened for approval to accompany the sponsor to an overseas location on permanent change of station order.
  - An exceptional family member is defined as an authorized family member residing with the sponsor who may require special medical or educational services based on a diagnosed physical, intellectual, or emotional condition. An authorized family member may be a spouse, child, stepchild, adopted child, or foster child.
  - Special medical or educational needs may include medical, mental health, developmental or educational requirements, wheelchair accessibility, adaptive equipment, assistive technology devices, and associated services.
- The Services mandate enrollment in EFMP when an ADFM has special needs.
  - To enroll, the sponsor, or an authorized person acting on the sponsor's behalf, must complete a *Family Member Medical Summary* (DD Form 2792) and a *Special Education/Early Intervention Summary* (DD Form 2792-1).
  - This may be waived for National Guard/Reserve members.
- For more information on the EFMP, visit www.militaryhomefront.dod.mil/tf/efmp.

4.2 ECHO and TRICARE Eligibility Status

- If a sponsor or provider believes a family member may qualify for ECHO services, the sponsor should speak with the family member's primary care manager/provider, case manager, regional contractor, overseas TRICARE Area Office (TAO), or USFHP provider to receive an eligibility determination.
- The following family members are eligible for the ECHO program if they have a qualifying condition(s):
  - A spouse, dependent child, or an unmarried person whose sponsor is an active duty member of a uniformed service of the United States, including Guard/Reserve members activated for more than 30 consecutive days
  - A spouse, dependent child, or an unmarried person whose sponsor is a former member of a uniformed service of the United States and the spouse, child, or unmarried person is a victim of physical or emotional abuse (Benefits are limited to the period that the abused dependent is receiving transitional compensation.)
  - A transitional survivor (This is the surviving spouse, for up to three years from the sponsor's death, and surviving dependent children until they lose eligibility. See the *DEERS* module for more information on eligibility.)
  - A family member who is eligible for continued TRICARE medical benefits through the Transitional Assistance Management Program (TAMP).
- Each regional contractor, TAO, or USFHP system determines eligibility for ECHO. If they determine the beneficiary isn't eligible, the decision is regarded as a factual determination and **isn't** appealable.

4.3 ECHO Qualification Determination

- Qualification is based on the evidence of specific mental or physical disabilities and enrollment in EFMP, when applicable.
- The family member may need to see his or her assigned PCM or a TRICARE-authorized/USFHP provider to get the necessary testing, screening, and exams to determine and document the qualifying disability and the need for specialty services.

4.4 ECHO Qualifying Conditions

ECHO qualifying conditions include:

- An extraordinary physical or psychological condition, defined as a complex physical or psychological clinical condition of such severity that it results in the beneficiary being home bound
- Multiple disabilities, which aren't ECHO qualifying conditions on their own, that cause disabilities in separate body systems and can be used to determine a qualifying condition
- Neuromuscular developmental conditions or other conditions that are expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability in infants or toddlers under age three

4.5 ECHO Registration

- The sponsor, or other authorized persons acting on behalf of the family member, must submit the following documents to the regional contractor, TAO, or USFHP responsible for administering the ECHO program in their geographical area:
  - Proof the sponsor is an active duty service member in one of the uniformed services
  - Medical records of qualifying conditions (copies)
  - Proof from the sponsor's branch of service that the family member is enrolled in the EFMP
    - This requirement may be waived when either the sponsor's service doesn't provide the EFMP (i.e., Guard/Reserve, Coast Guard, USPHS, NOAA), the beneficiary is a transitional survivor, or the beneficiary resides with a custodial parent who is not the active duty sponsor.
- To avoid delay of ECHO services due to a delay in the EFMP enrollment process, the regional contractor, TAO, or USFHP may grant provisional ECHO status for a 90-day period.

4.6 ECHO Benefits

4.6.1 Services Covered Under ECHO

- Medical and rehabilitative services
- Durable equipment, including adaptation and maintenance
- Training to use assistive technology devices
- Assistive services, such as those from a qualified interpreter or translator
- Institutional care when a residential environment is required
- Transportation for institutionalized beneficiaries to receive authorized ECHO benefits
- In-home medical services
- ECHO respite care: ECHO family members are eligible for 16 hours of respite care per month in any month the family member receives other authorized ECHO benefits
- Applied behavior analysis (ABA) (which includes the DoD Enhanced Access to Autism Services Demonstration, discussed in Section 5.0 of this module) and other services that are not available through schools or other local community resources

Note: All ECHO benefits must be prior-authorized by the regional contractor, ECHO case manager, TAO, or USFHP before the family member receives any services, supplies, or equipment.

4.6.2 Services Not Available Under ECHO

- Inpatient care for medical or surgical treatment of an acute illness or an acute exacerbation of the qualifying condition
- Structural changes to living space and permanent fixtures, including changes necessary to accommodate installation of equipment or to facilitate entrance or exit
- Dental care and orthodontic treatment (covered under adjunctive dental care or purchase of a dental program option)
- Certain durable medical equipment and maintenance for beneficiary-owned equipment
- Homemaker services that provide assistance with household chores, except those provided by the ECHO Home Health Care benefit

4.6.3 ECHO Benefit Authorization

- ECHO benefits are authorized when:
  - The family member is registered in ECHO
  - The requested service/item is an allowable ECHO benefit
  - The requested service/item meets the public facility use requirement, when applicable
- The prior authorization specifies the requested services by type, scope, frequency, duration, dates, amounts, requirements, limitations, provider name and address, and all other information necessary to provide exact identification of approved benefits.
- Authorizations remain in effect until the regional contractor, TAO, or USFHP determines that:
  - The family member is no longer eligible for ECHO
  - The authorized ECHO service or item is no longer appropriate or required by the family member
  - The authorized ECHO service or item becomes a basic TRICARE benefit as established by law | and/or policy
- All ECHO services, supplies, and equipment must be received from a TRICARE-authorized/USFHP provider.
- If the family member changes providers, they must obtain a new referral and authorization.
- Beneficiaries may appeal the denial of ECHO services and supplies.

4.7 ECHO Costs

- ECHO has no deductibles or enrollment fees.
- Beneficiaries may incur cost-shares for health services which:
  - Establish qualifying conditions
  - Confirm the severity of the disabling effects of a qualifying condition
  - Measure the extent of functional loss
- For example, the sponsor of a beneficiary who uses TRICARE Standard/Extra to receive diagnostic services that result in the diagnosis of an ECHO-qualifying condition is liable for cost-shares and deductibles associated with the diagnostic services. These cost-shares and deductibles are not reimbursable under ECHO.

4.7.1 Cost-Shares

- A monthly cost-share must be paid during the months registered family members receive ECHO benefits. ECHO cost-shares don't count towards the family's catastrophic cap.
- Cost-shares are based on the sponsor's pay grade:

Sponsor Pay Grade	Sponsor Cost-Share	Sponsor Pay Grade	Sponsor Cost-Share
E-1–E-5	$25	CWO-5, O-5	$65
E-6	$30	O-6	$75
E-7, O-1	$35	O-7	$100
E-8, O-2	$40	O-8	$150
E-9, CWO-1, CWO-2, O-3	$45	O-9	$200
CWO-3, CWO-4, O-4	$50	O-10	$250

4.7.2 Government's ECHO Cost-Share Limit

The maximum amount the government pays toward ECHO benefits (excluding the ECHO Home Health Care benefit) is $36,000 per registered family member, per fiscal year (October 1–September 30).

4.8 Claims for Benefits with Prior Authorization

- When family members file claims for ECHO-authorized care, they or their sponsor must submit:
  - A *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request For Medical Payment* (DD Form 2642)
  - A copy of the family member's prior authorization
- Claims should be sent to the TRICARE regional/USFHP claims processing contractor where the family member lives.

4.9 ECHO Resources

For more information about ECHO visit www.tricare.mil/echo.

5.0 DoD Enhanced Access to Autism Services Demonstration

- The DoD Enhanced Access to Autism Services Demonstration allows non-certified educational intervention service providers, or tutors, to provide services to ECHO enrollees in the U.S. diagnosed with an autism spectrum disorder.
- The demonstration is effective for services provided from March 15, 2008 through March 14, 2014.
- Non-certified tutors may provide ABA services under close supervision. Authorized supervisors are required to direct and oversee the tutors who provide the "hands-on" services and verify that tutors are trained and able to perform the services required to treat ECHO-enrollees with autism.
- For more information about the DoD Enhanced Access to Autism Services Demonstration, refer to the 2008 TRICARE Operations Manual, Chapter 18, Section 8 at http://manuals.tricare.osd.mil.

Note: The allowed cost of services provided by the DoD Enhanced Access to Autism Services Demonstration accrue to the ECHO FY government maximum limit. (See Section 4.7.2 of this module for more information.)

Module Objectives

Summary:

- **Identify who may be eligible for coverage under the TRICARE Young Adult program (TYA)**
- **State the purpose of TRICARE Plus**
- **Explain how the US Family Health Plan mirrors TRICARE Prime**
- **Describe the Extended Care Health Option (ECHO)**

Appendix A: Computer/Electronic Accommodations Program

The Computer/Electronic Accommodations Program (CAP) is the federal government's centrally funded reasonable accommodations program for employees with disabilities in the Department of Defense (DoD) and throughout the federal government.

CAP's mission is to provide assistive technologies and accommodations to ensure that people with disabilities and wounded service members (WSMs) have equal access to the information environment and opportunities throughout DoD and the federal government. CAP is helping to make the federal government the model employer for people with disabilities by eliminating the costs of assistive technology and accommodation solutions.

The Defense Authorization Act of 2000 granted CAP the authority to expand its services to agencies outside of DoD. CAP has formal partnership agreements with 66 Federal agencies.

In 2004, CAP launched its Wounded Service Member Initiative to support WSMs in their recovery and rehabilitation by equipping them with the appropriate assistive technologies, thereby empowering them for future employment opportunities.

On October 17, 2006, Public Law 109-364 authorized WSMs to retain assistive technology and services provided by CAP when they separate from active duty service.

CAP Eligibility

- Disabled employees who work for the DoD or one of the 66 federal agencies that have a partnership with CAP.
- ADSMs with limitations resulting from injury or illness sustained while on active duty.

CAP Services

- Assistive technology to increase access to the computer and telecommunications environment
- Individualized needs assessments
- Demonstration and evaluation of assistive technology
- Installation, integration, and training
- Disability education and awareness
- CAP is available to provide support to WSMs during the following phases:
    - **Phase 1**: **Recovery and Rehabilitation:** CAP provides assistive technology to support the recovery and rehabilitation of WSMs at MTFs around the world.
    - **Phase 2**: **Transition:** CAP works closely with therapists, providers, case managers, and military liaisons to provide the appropriate assistive technologies to WSMs during their recovery process.
    - **Phase 3**: **Employment:** Active duty service members may keep assistive technologies provided to them as personal property when they separate from active duty. CAP provides free workplace accommodations to separated service members who are in a federal internship program, or who return to the federal government as civilian employees.

CAP Websites

For more information on CAP, please visit:

- www.cap.mil (support for federal civilian employees with disabilities)
- www.cap.mil/wsm (support for wounded service members)

TRICARE Fundamentals Course

TRICARE and Medicare

11

Participant Guide

References

32 CFR § 199
National Defense Authorization Act, FY 2001, Section 712
2002 TRICARE Operations Manual, Chapter 22
2008 TRICARE Operations Manual, Chapter 20
2002 and 2008 TRICARE Policy Manuals, Chapter 7
2002 and 2008 TRICARE Reimbursement Manuals, Chapter 4
Medicare & You Handbook 2012
Medicare Prescription Drug, Improvement, and Modernization Act of 2003
www.medicare.gov

Brainteaser

Each of the eight items below is a separate puzzle.

How many can you figure out?

1. BRIDGE w t r a e	2. issue issue issue issue issue issue issue issue issue issue	3. p o o r	4. T T T T R R R R R R R R
5. Answer Answer Answer Answer ⟵	6. P----------P L---L A N---N E----------E	7. CITY	8. injury + insult

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

- **State what TRICARE for Life (TFL) is and who is eligible**
- **Identify how active duty status affects Medicare Part B enrollment**
- **Discuss the interaction between TFL and other health insurance (OHI)**

1.0 TRICARE for Life (TFL) Overview

TRICARE for Life (TFL) combines TRICARE Standard coverage with Medicare Part A and Part B to provide wrap-around medical coverage to dual-eligible (TRICARE and Medicare) beneficiaries.

2.0 Eligibility

- TFL is for TRICARE beneficiaries entitled to premium-free Medicare Part A and who purchase Medicare Part B, regardless of their age or place of residence. (Some exceptions apply. See Section 5.1.1 of this module for more information.)
- TFL benefits start on the first day that Medicare Part A and Part B are in effect.
- Dual-eligible beneficiaries under age 65 may enroll in TRICARE Prime if available in their local area; Prime enrollment fees are waived for those who have Medicare Part B.

3.0 Defense Enrollment Eligibility Reporting System (DEERS)

- TRICARE and Medicare exchange files to verify beneficiaries' Medicare Part A entitlement and Part B status. TFL status is shown as pending until verified.
- TFL beneficiaries' must ensure DEERS reflects their current Medicare status.

4.0 Basics of Medicare

Medicare is a health insurance program. Eligibility is based on age, disability or disease, to include:

- Individuals age 65 or older
- Individuals under age 65 with certain disabilities
- Individuals of any age with end-stage renal disease (ESRD)
- Individuals of any age with amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease
- Individuals of Lincoln County, Montana who have an asbestos-related disease

4.1 Medicare Part A and Part B

- Medicare Part A (Hospital insurance), funded through payroll taxes, helps cover inpatient care and costs in hospitals, skilled nursing facilities, hospice care, and home health care. If a beneficiary paid into Medicare for 40 quarters, he or she is entitled to premium-free Medicare Part A at age 65.
    - If eligible for premium-free Medicare Part A, a beneficiary receives a *Notice of Award*, the official letter from the Social Security Administration (SSA) advising the beneficiary of his/her entitlement to premium-free Medicare Part A and enrollment in Medicare Part B (or enrollment in Medicare Part B only).
    - If not eligible for premium-free Medicare Part A based on their own work history, beneficiaries should contact SSA to find out if they may qualify under their spouse's or divorced spouse's social security number. (See *Appendix A* of this module for more information.)
- Medicare Part B (Medical insurance) helps cover medically necessary outpatient services, such as doctor services, outpatient hospital care, home health services, some preventive health services, and other medical services. Medicare Part B premiums are based on an individual's reported income.
    - Beneficiaries should enroll in Medicare Part B when first eligible to avoid paying higher Medicare premium penalties due to delayed enrollment.
- The Defense Manpower Data Center (DMDC) automatically notifies TRICARE beneficiaries approximately three months before their 65th birthday of the requirement to enroll in Medicare B.

5.0 TRICARE for Life

5.1 Medicare Part B Enrollment Is Required

Under Federal law, TRICARE beneficiaries entitled to premium-free Medicare Part A must have Medicare Part B to remain TRICARE eligible. Beneficiaries lose their TRICARE benefits and claims are denied if they do not have Medicare Part B, disenroll from Medicare Part B, or stop paying their Medicare Part B premiums.

5.1.1 Exceptions to Medicare Part B Enrollment Requirement:

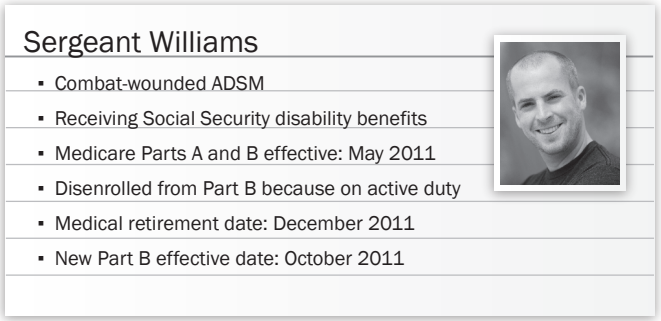
The following beneficiaries do not have to be enrolled in Medicare Part B to remain TRICARE eligible.

- Active duty service members (ADSMs) and active duty family members (ADFMs) who are entitled to premium-free Medicare Part A don't have to enroll in Medicare Part B while the sponsor is on active duty to maintain TRICARE eligibility.
    - Medicare Part B MUST be in effect on or before the sponsor's retirement date, whether medical or regular, to avoid a break in TRICARE coverage.
    - If the beneficiary enrolls in Medicare Part B after the sponsor's retirement date, there may be a break in TRICARE coverage until Medicare Part B takes effect.
- TRICARE Reserve Select and TRICARE Retired Reserve enrollees who are entitled to premium-free Medicare Part A are not required to have Medicare Part B to qualify for these programs.

5.2 Scenarios

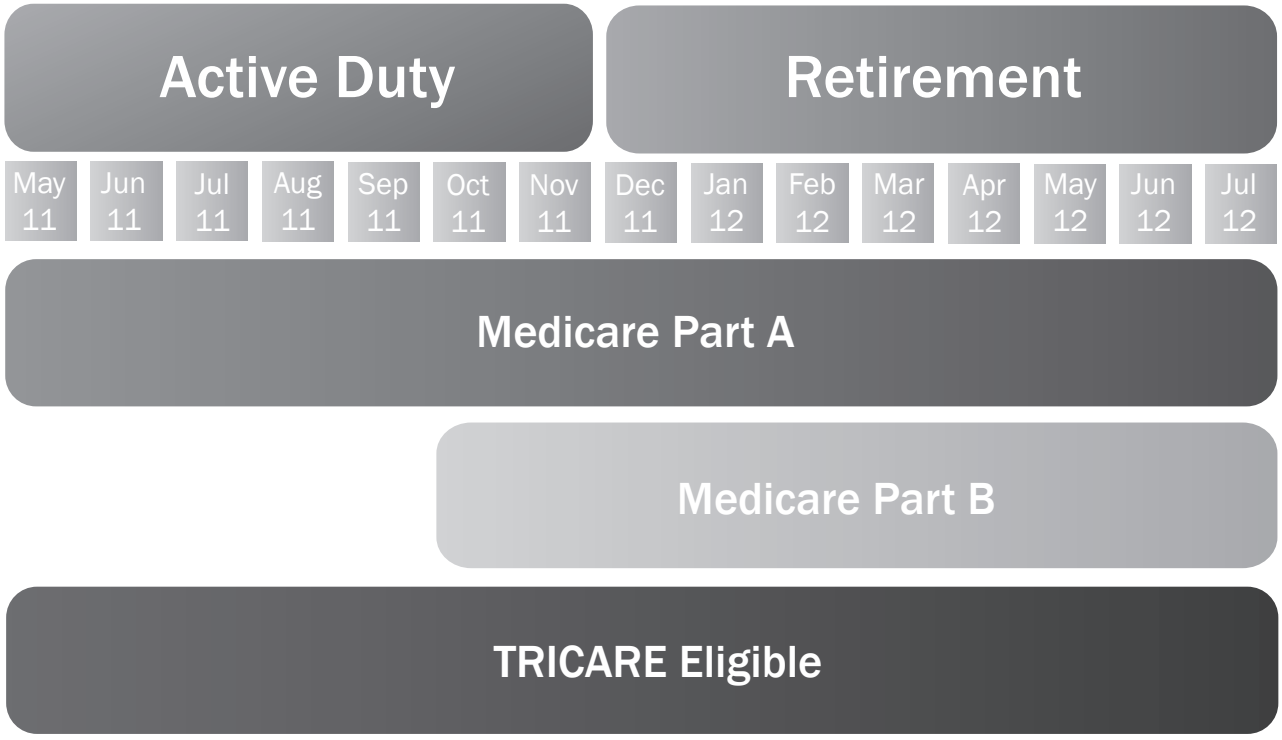
5.2.1 Scenario 1

Sergeant Williams is a combat-wounded ADSM receiving Social Security disability benefits. He receives notice that his Medicare Part A and Part B effective dates are May 2011. He disenrolls from Medicare Part B because he is on active duty. His service notifies him that his medical retirement date is December 1, 2011. He decides to enroll in Medicare Part B, while still on active duty, with his Medicare Part B effective October 1, 2011. Although he declined his Medicare Part B when he was first eligible, he enrolled prior to his retirement, ensuring that his TRICARE eligibility continues without a break in coverage.



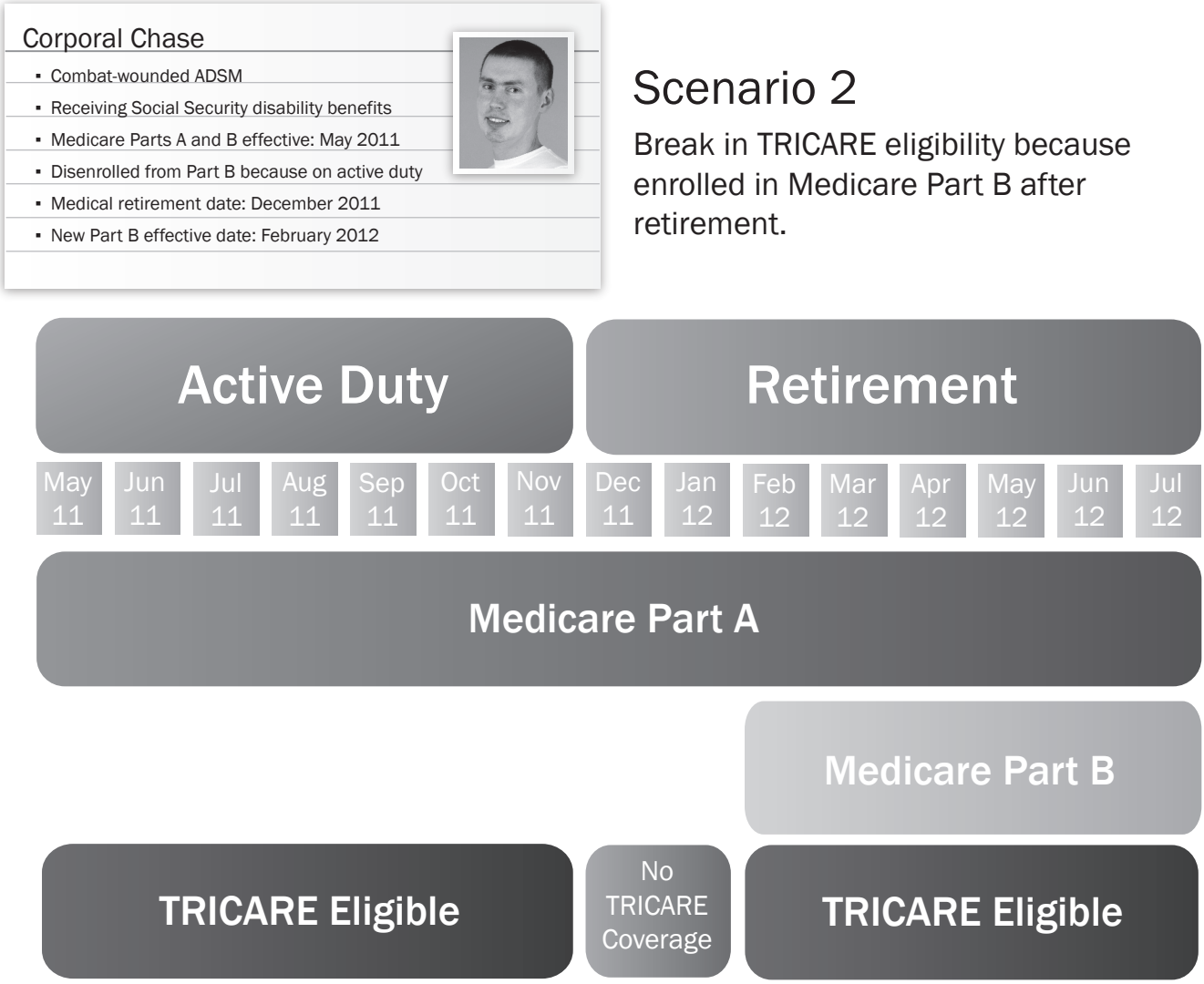
Scenario 1

No break in TRICARE eligibility because enrolled in Medicare Part B prior to retirement.



5.2.2 Scenario 2

Corporal Chase is a combat-wounded ADSM receiving Social Security disability benefits. He receives notice that his Medicare Part A and Part B effective dates are May 2011. He disenrolls from Medicare Part B because he is still on active duty. His service notifies him that his medical retirement date is December 1, 2011. Corporal Chase decides to enroll in Medicare Part B on January 1, 2012. Based on Medicare guidelines, his Medicare Part B becomes effective February 1, 2012. He has a break in TRICARE coverage.



6.0 How TFL Works with Medicare

6.1 Services Covered by Both Medicare and TRICARE:

- Medicare is the primary payer for services covered by both Medicare and TRICARE. TRICARE pays second, typically covering the beneficiary's Medicare deductible and cost-shares.
- Medicare Part B usually pays 80 percent of covered costs and TRICARE usually pays the remaining 20 percent.

6.2 Services Covered by Medicare, But Not by TRICARE:

Medicare pays as usual; TRICARE makes no payment. The beneficiary is responsible for Medicare's deductible and cost-shares. (Example: Limited chiropractic services)

6.3 Services Covered by TRICARE, But Not by Medicare:

Medicare denies payment; TRICARE pays as the primary payer. The beneficiary pays TRICARE's deductible and cost-shares (Standard/Extra rates). (Example: Medicare doesn't cover compression stockings. TRICARE becomes the primary payer. TRICARE deductibles and cost-shares apply.)

6.4 Services Not Covered by TRICARE or Medicare:

The beneficiary is responsible for the entire cost of care. (Examples: Cosmetic surgery, beneficiary not following Medicare rules)

6.5 Payer Table

	✓ Medicare ✓ TRICARE	✓ Medicare ✗ TRICARE	✓ TRICARE ✗ Medicare	✗ TRICARE ✗ Medicare
Medicare	Pays First	Pays First	Does Not Pay	Does Not Pay
TRICARE	Pays Second	Does Not Pay	Pays First	Does Not Pay
Beneficiary	Minimal Out-of-Pocket Expenses	Pays Remaining Medicare Cost Shares and/or Deductibles	Pays TRICARE Cost Shares and/or Deductibles	Pays Total Charges

7.0 TFL and Other Health Insurance (OHI)

When a beneficiary has Medicare, TRICARE, and OHI (including host nation insurance), TRICARE is the last payer for TRICARE-covered services.

- If the beneficiary has employer group health plan coverage based on current employment, the employer group pays first, Medicare pays second, and TRICARE pays last.
- If the beneficiary is currently retired or not working and has OHI, Medicare pays first, OHI pays second, and TRICARE pays last.
    - When the OHI processes the claim after Medicare, the beneficiary must submit a claim to the TFL claims processor for any remaining reimbursement.

8.0 Working Beneficiaries Age 65 and Older

- Medicare allows individuals age 65 and older with group health plan coverage, based on current employment, to delay Part B enrollment and sign up during a special enrollment period, which is available within the eight months following either (1) retirement, or (2) the end of the group health plan coverage, whichever comes first.
- To remain TRICARE eligible, these beneficiaries must purchase Medicare Part B when they first become eligible for Part B (typically at age 65). Until they purchase Part B, they are not eligible for TRICARE for Life.
    - If they don't purchase Part B when they first become eligible, beneficiaries should purchase Part B before they retire or lose group health plan coverage to ensure TRICARE for Life coverage begins immediately, and so they don't have a gap in health care coverage.
    - TFL coverage begins on the same day as the Medicare Part A **and** Medicare Part B effective dates.

9.0 Using TFL While Overseas

TFL is available to dual-eligible beneficiaries living overseas, provided they have Medicare Part A and Part B.

- Medicare provides coverage in U.S. territories (Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and Northern Mariana Islands). In these areas, claims are processed as usual, with the provider billing Medicare first. Medicare processes the claim and forwards it to the TFL claims processor.
- For beneficiaries living overseas in areas not covered by Medicare, TRICARE is the primary payer (as long as there is no other health insurance) and no Medicare Summary Notice (MSN) is required. (See Section 10.0 of this module for more information.)
    - Overseas TFL beneficiaries should be prepared to pay the total billed charges up front and file their own claims for reimbursement. TFL beneficiaries receiving care in these areas submit the claim form *TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment* form (DD Form 2642) and a copy of the provider's itemized bill to the overseas claims processor.

10.0 TFL Claims Processing

When a beneficiary has Medicare and TRICARE:

- The TFL claims processor handles all claims for TFL beneficiaries, except those living or receiving services overseas, including those enrolled in TRICARE Prime who have Medicare Part A.
- Medicare process the claim. It issues an MSN to the provider and beneficiary.
    - An MSN the services and/or supplies that providers and suppliers billed to Medicare during a three month period, what Medicare paid, and what the beneficiary may owe the provider. It's not a bill.
- Medicare then electronically forwards the claim to TRICARE for processing according to TRICARE policy as long as the beneficiary identified him/herself as TRICARE eligible and there is no other OHI).
- Beneficiaries then receive a monthly TFL explanation of benefits (EOB) detailing claims processed that month.
    - TFL beneficiaries may choose to receive their EOBs electronically by registering to receive e-mail alerts at www.TRICARE4u.com. The e-mail alert provides a link to a secure website where registered users can view and/or print their TFL EOBs.
- It's important to note that Medicare, as the primary payer, is responsible for determining medical necessity. If Medicare does not pay because it determines the care is not medically necessary, TFL also does not pay.
    - The beneficiary may appeal Medicare's decision, and if Medicare reconsiders and provides coverage, TFL also reconsiders coverage. (See the *Claims and Appeals* module for more information).

11.0 Pharmacy and TFL

The TRICARE pharmacy benefit does not change under TFL. TFL Beneficiaries do not need to enroll in a Medicare prescription drug plan (Medicare Part D) to keep the TRICARE pharmacy benefit. (See the *Pharmacy* module for more information.)

If a beneficiary later chooses to enroll in Medicare Part D, he/she does not incur a penalty for late enrollment, as the TRICARE Pharmacy Program is considered creditable drug coverage.

Overseas TFL beneficiaries pay for covered prescription medications up front and file a claim for reimbursement with the overseas claims processor; TRICARE deductible and cost-shares apply.

12.0 Application Exercises

Scenario 1
Mrs. White, a uniformed service retiree, has Medicare Part A and Part B, OHI, and TFL. TFL will be primary payer. True or False? Why?

Scenario 2
Mr. Smythe is a uniformed service retiree, who is still employed full time at age 69. Mr. Smythe has Medicare Part A but doesn't have Medicare Part B. He is eligible for TFL. True or False? Why?

Scenario 3
Sergeant Jones was an ADSM receiving social security disability benefits. She is now retired. Prior to her retirement, she enrolled in Medicare Part B. She is eligible for TFL. True or False? Why?

Scenario 4
Mr. Green is a retired uniformed service member who lives outside of the United States. He is entitled to Medicare Part A and enrolled in Medicare Part B. He is eligible for TFL. True or False? Why?

Module Objectives

Summary:

- **State what TRICARE for Life (TFL) is and who is eligible**
- **Identify how active duty status affects Medicare Part B enrollment**
- **Discuss the interaction between TFL and other health insurance (OHI)**

Appendix A: What If I Am Not Eligible for Premium-Free Medicare Part A?

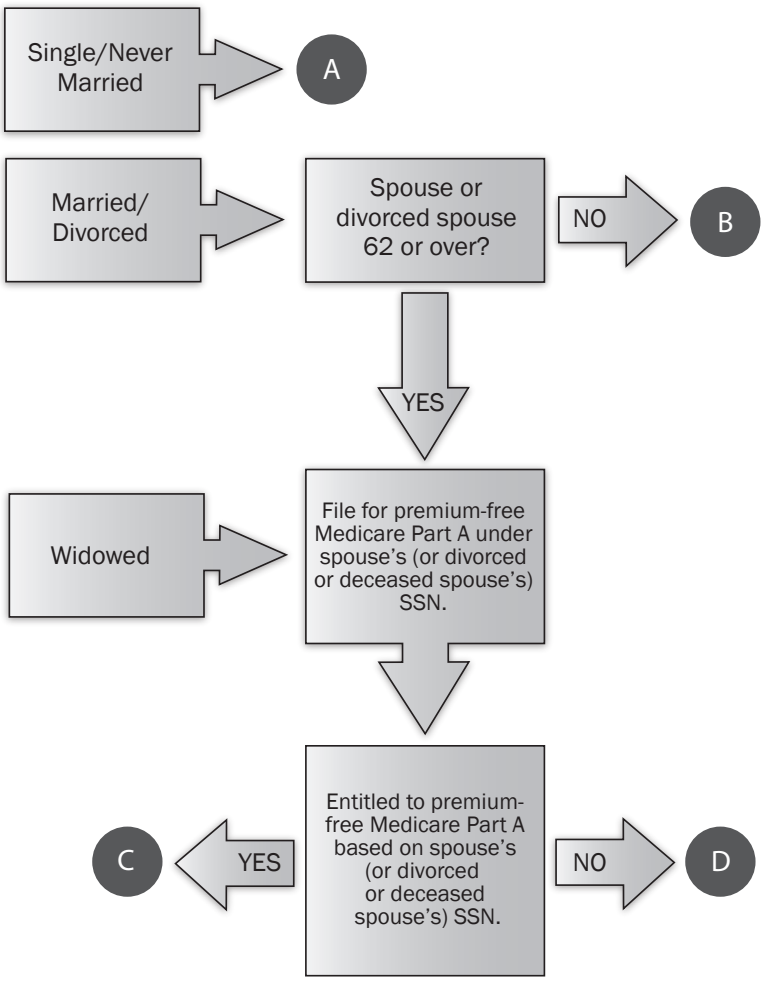
"What if I apply for Medicare benefits on my own SSN and I'm not eligible for premium-free Medicare Part A at age 65?"

If you're not eligible for premium-free Medicare Part A based on *your* Social Security Number (SSN) and work history, you receive a *Notice of Award* or a *Notice of Disapproved Claim* from your regional Social Security Administration office.

- A *Notice of Award* is an official letter that advises you of your entitlement to premium-free Medicare Part A and/or Part B enrollment, *or* enrollment in Part B only.
- A *Notice of Disapproved Claim* is an official letter that advises you of your non-entitlement to premium-free Medicare Part A.

If you sign up for Medicare Part B when first eligible, you avoid paying a Medicare premium surcharge if later you decide, or are required to, have Part B.

Use the diagram below to find the scenario that fits you best and follow the necessary steps to remain TRICARE-eligible. Even if you're not eligible for premium-free Medicare Part A at age 65, you're still eligible for Part B.



To Remain TRICARE Eligible

A. Take your *Notice of Award* and/or *Disapproved Claim* based on your SSN to your local ID card issuing facility to update your DEERS record and receive a new ID card. Then you can remain eligible for TRICARE Prime and Standard/Extra past your 65th birthday

B. Follow instructions for A. Then, three to four months before your spouse (or divorced spouse) turns 62, file for premium-free Medicare Part A under his or her SSN. If you didn't enroll in Part B when first eligible, you must wait until the Medicare General Enrollment Period (GEP) to enroll. If you wait to enroll during the GEP you may have a break in TRICARE coverage.

C. You receive a *Notice of Award* based on your spouse's (or divorced or deceased spouse's) SSN. Enroll in Part B. To avoid a break in TRICARE coverage, be sure to enroll three to four months before your 65th birthday. Take your Medicare card showing Parts A and B to your local ID card issuing facility to update your DEERS record. Your TRICARE benefits begin on the earliest date that you have both Parts A and B.

D. You receive a *Notice of Award* and/or *Disapproved Claim* based on your spouse's (or divorced or deceased spouse's) SSN. Take this notice and the original notice based on your SSN to your local ID card issuing facility to update your DEERS record and receive a new ID card. Then you can remain eligible for TRICARE Prime and Standard/Extra past your 65th birthday.

Appendix B: Medicare Overview

- Medicare Part A (Hospital insurance)
  - Funded through payroll taxes, helps cover inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care
  - The Social Security Administration (SSA) determines entitlement to premium-free Medicare Part A based on an individual's/spouse's work history
- Medicare Part B (Medical insurance)
  - Helps cover medically-necessary outpatient services like doctor services, home health services, some preventive services, and other outpatient medical services
  - Individuals enroll in Medicare Part B and pay a monthly premium; premiums may change on an annual basis
    - Most people will pay the standard premium amount, while others may have to pay more depending on their income
- Medicare Part C (Medicare Advantage Plans)—includes Medicare HMOs, Medicare PPOs, Medicare special needs plans and Medicare private fee-for-service plans
  - Provides all of Medicare Part A and Part B coverage, and may offer vision, hearing, dental and/or health and wellness coverage
  - Includes a prescription benefit
  - Details about Medicare Advantage plans are available online at www.medicare.gov/choices/advantage.asp
- Medicare Part D (Medicare Prescription Drug Coverage) helps cover the cost of prescription drugs run by Medicare approved private insurance companies.

Medicare Eligibility

Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of any age with end-stage renal disease (ESRD)
- People of any age with amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease
- People of Lincoln County, Montana who have an asbestos-related disease

Medicare Part B Enrollment Periods

Initial Enrollment Period

- The seven-month period that begins three months before the month the beneficiary is first eligible for Medicare Part B.
  - Individuals with a birthday on the first of the month are eligible for Medicare the month before their 65th birthday.
  - Individuals with a birthday that is other than the first of the month are eligible for Medicare the first of the month in which they turn 65.
- Beneficiaries receiving Social Security or Railroad Retirement Board (RRB) retirement benefits before age 65 automatically get Medicare Part A and Medicare Part B beginning on the first day of the month they turn age 65, or the month prior if their birthday falls on the first of the month.

- Disabled beneficiaries under age 65 automatically get Medicare Part A and Part B starting the 25th month of receiving disability benefits (Social Security Disability Insurance) or disability from the RRB.
- Beneficiaries should receive their Medicare card in the mail about three months before their 65th birthday or three months before their 25th month of disability benefit entitlement (only if they're getting SSA or RRB benefits).

General Enrollment Period

The General Enrollment Period runs from January 1 through March 31 of every year. Medicare Part B coverage begins July 1 of that year. Individuals may have to pay a higher premium for late enrollment.

Special Enrollment Period

The Special Enrollment Period (SEP) is for individuals who didn't sign up for Medicare Part B when they were first eligible because either they or their spouses were working and they had group health plan coverage. This includes beneficiaries whose sponsor was on active duty.

During the SEP, individuals may enroll in Medicare:

- Any time they're covered by employee group health plan coverage based on current employment
- During the eight month period that begins the month following the month that employment ends or the employee group health plan coverage ends, whichever comes first
    - Beneficiaries who enroll in Medicare Part B during the SEP do not pay a Medicare Part B premium surcharge for late enrollment.
    - Medicare Part B coverage begins the month following enrollment.

Medicare Part B Premium Penalty

Most people do not pay for Medicare Part A because they (or their spouse) paid Medicare taxes while they were working. Medicare Part B, however, is premium-based and requires enrollment. If an individual does not enroll in Medicare Part B when first eligible, he or she may have to pay a Medicare premium penalty to get it later. For each 12-month period that the individual could have enrolled in Part B, but chose not to, he or she will have to pay an extra 10 percent for the Part B premium.

Example

MSgt Miller's (Ret) initial enrollment period ended June 30, 2009. He did not enroll in Medicare Part B during his initial enrollment period. He waited until January 2012 to enroll in Medicare Part B. His Part B effective date will be July 1, 2012. His Part B premium penalty is 20 percent. He will have to pay a higher Medicare Part B premium because his Part B is effective 24 months after he was first eligible.

Medicare Prescription Drug Benefit — Medicare Part D

- Medicare prescription drug coverage is available to Medicare beneficiaries for a monthly premium.
- This benefit covers both brand name and generic drugs at participating pharmacies.

Medicare Part D Enrollment

- Enrollment window: Beneficiaries can join or switch Medicare drug plans every year during the open enrollment period.
- Medicare drug coverage generally begins on January 1 of the following year.
- Penalty: Individuals who do not join a Medicare drug plan when first eligible for Medicare Part A and/or B and go without creditable prescription drug coverage for 63 continuous days or more may have to pay a late enrollment penalty to join a Part D plan later.
- TRICARE beneficiaries may disenroll from Part D at anytime because the TRICARE pharmacy program benefit is considered creditable coverage.

TRICARE Fundamentals Course

Claims and Appeals

12

Participant Guide

References

32 CFR § 199.7, 199.10
2002 TRICARE Operations Manual, Chapter 8–11 and 13–14
2008 TRICARE Operations Manual, Chapter 8–10 and 12–13
2002 TRICARE Reimbursement Manual, Chapter 1
2008 TRICARE Reimbursement Manual, Chapter 1

Brainteasers

Each of the eight items below is a separate puzzle.

How many can you figure out?

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Module Objectives

- **Explain who can file claims and where claims should be submitted**
- **Describe how to resolve claims issues**
- **Identify three reasons why an Explanation of Benefits (EOB) may be delayed**
- **Distinguish between what can and cannot be appealed**

Disclaimer: *The content in this module applies primarily to claims for health care services, and not to pharmacy or dental claims. See the Pharmacy and Dental modules for claims and appeals information for those services. Fraud information is provided for all contractors.*

1.0 Claims

- Claims are filed to issue payment for services or supplies provided by civilian sources of medical care.
- Professional providers include physicians, whether independent providers or group practice, physical therapists, and other TRICARE-authorized providers.
- Institutional providers include:
  - Hospitals
  - Pharmacies
  - Ambulance companies
  - Physical therapy
  - Skilled nursing facilities
  - Medical suppliers
  - Laboratories
  - Veterans Affairs (VA) treatment facilities

2.0 Claims Filing

- TRICARE-eligible beneficiaries and all TRICARE-authorized providers of services or supplies may file claims. However, **the beneficiary is ultimately responsible for making sure claims are filed** no matter what type of provider he/she uses.
- The spouse, parent, or legal guardian of a minor (under age 18) or incompetent beneficiary may submit a claim on behalf of the beneficiary, unless otherwise specified.

2.1 Filing Deadlines

- Beneficiaries should file claims as soon as possible after receiving service.
- If claims are not filed by the deadlines below, they will be denied.

United States and Puerto Rico	Overseas and All Other U.S. Territories
Within one year of the date of service or date of discharge for inpatient care	Within three years of the date of service or date of discharge for inpatient care

3.0 Submitting Claims

- Claims are submitted to the claims processor based on the beneficiary's residential address or Prime enrollment region, except overseas. All claims for care received overseas are submitted to and processed by the overseas claims processor.
- There are two major TRICARE claims processors:

North and South Regions	West/Overseas Regions and TRICARE for Life
Palmetto Government Benefits Administration (PGBA)	Wisconsin Physicians Service (WPS)

- If a beneficiary sees a network provider, the provider files the claim.
- If a beneficiary sees a non-network provider, the provider is not required to file the claim, but may do so voluntarily.
  - The beneficiary is responsible for making sure the claim is filed.
  - The beneficiary can be held liable for the charges if the provider fails to timely file.
- If sent to the regional contractor instead of the claims processor, the contractor forwards it to the claims processor.

- If a claim is sent to the wrong claims processor, the claim is either forwarded to the appropriate claims processor, returned to the sender, or may be denied as "patient not eligible."
- TRICARE-eligible beneficiaries are responsible for keeping their personal contact information up to date with their providers and in the Defense Enrollment Eligibility Reporting System (DEERS) so claims go to the correct claims processor and related payment or other information can be sent to the beneficiary.

4.0 Claim Forms

4.1 Beneficiaries

Beneficiaries use *DD Form 2642* to submit claims for services or supplies provided by civilian providers and for prescription drugs. A *DD Form 2642* submitted by a provider will be returned to the provider.

- *DD Form 2642* is available online for download at:
  - TRICARE website: www.tricare.mil/forms
  - PGBA website: www.myTRICARE.com
  - WPS website: www.TRICARE4u.com
- Beneficiaries may request *DD Form 2642* by calling the regional contractor's toll-free number or visiting a TRICARE Service Center (TSC).
- Beneficiaries must submit a separate claim and claim form for each:
  - Episode of care
  - Service provided by different providers
  - Family member, even if several family members visit the same provider on the same day
- For prescription drug claims, one claim form per family member is required; the claim may reflect more than one prescription medication.

Note: Box 13 on the *DD 2642* asks beneficiaries if they would like payment issued in local currency. The term "local" refers to the country where services were provided. If marked "yes," the payment is issued in that country's currency. If the box is marked "no" or neither "yes" or "no" box is checked, the payment is issued in U.S. dollars.

4.2 Providers

- Stateside:
  - Professional providers submit claims using the CMS 1500 08/2005, *Health Insurance Claim Form*.
  - Institutional providers submit a claim using the CMS 1450 UB-04, *Health Insurance Claim Form*.
- Overseas providers are asked to submit a *CMS 1500* (08/2005).

4.3 Items That Accompany a Claim

Beneficiaries need to include the following documents when filing a claim:

- An itemized list of charges for each service or supply, with the accompanying diagnosis. This list must be written on the provider's letterhead or on a standard form along with the provider's tax ID number
- An itemized list of charges from the pharmacy. This list must also be written on the pharmacy's letterhead or billing form.
- Proof of purchase for care received overseas
- OHI claim forms: The health plan's payment determination, denial statement, or Explanation of Benefits (EOB)
- *Statement of Personal Injury—Possible Third-Party Liability* (DD Form 2527)
  - Required with *DD Form 2642* in instances where a beneficiary's condition is potentially accident related, work related, or both, and when certain procedure or diagnostic codes indicate there may be third-party liability involved.

- Beneficiaries may submit *DD Form 2527* after the initial claim is submitted or when requested by the regional claims processor.
- Failure to submit form *DD Form 2527* within the time frame specified on the form may result in the claim being pended or denied.

5.0 Claims Processing Procedures

TRICARE processes claims using specific procedures to make sure claims are processed in a timely manner and government-furnished funds are spent only for services or supplies authorized by law and regulation.

5.1 Processing Criteria

Claims processors verify the following criteria in this order:

1. The beneficiary is eligible.
2. The beneficiary/provider filed the claim in a timely manner.
3. The provider of services or supplies is TRICARE-authorized.
4. The service or supply provided is a TRICARE benefit.
5. The service or supply provided is medically necessary and appropriate or is an approved TRICARE clinical preventive service.
6. The beneficiary is legally obligated to pay for the service or supply (when appropriate).
7. The claim contains sufficient information to determine the TRICARE allowable charge for each service or supply.

5.2 Processing Criteria for Newborn Claims

- Claims for newborns not registered in DEERS can be processed as long as:
  - The newborn's date of birth is within 365 days of the contractor's eligibility query; ***and***
  - The sponsor is/was eligible for TRICARE for the date(s) of care on the newborn's claim
- Exception: If the sponsor (and family) are enrolled in TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR), a *Reserve Component Health Coverage Request* form (DD Form 2896-1) must be received or postmarked no later than 60 days after the newborn's birth date for the newborn's claims to be paid as an eligible and covered dependent. If the required forms are not received within 60 days, the newborn's claims are denied as "not eligible."
- See the *DEERS* module for more information on eligibility.

6.0 TRICARE Overseas Program (TOP) Prime Remote Claims

There are a number of processes that are unique to TOP Prime Remote claims. The following tables give details on submitting and processing these claims.

Overseas (TOP Prime Remote)
● When a purchased care/host nation provider accepts an authorization for services, the provider submits the claim to the overseas claims processor for payment and it's processed as "cashless-claimless." ● When receiving care from a purchased care/host nation provider that does not accept TRICARE, enrollees pay up front and file their own claims for reimbursement. ○ Please note that box 13 on the *DD Form 2642* asks beneficiaries if they would like payment issued in local currency. The term "local" refers to country where services were provided. If marked "yes," the payment is issued in that country's currency. If the box is marked "no" or neither "yes" or "no" box is checked, the payment is issued in US dollars.

Overseas Point of Contact (POC) Program
● Embassy providers who act as primary care managers (PCMs) may refer enrollees to host nation providers. ● TOP procedures for host nation provider claims: ○ The POC help the enrollee complete and submit claims. ▪ The overseas contractor provides a dedicated P.O. Box, fax number, and e-mail address for POC-submitted claims and correspondence. ○ The overseas contractor returns payment (foreign currency/U.S. dollars) and EOBs to the POC for distribution to providers and beneficiaries (when requested). **Note 1:** POCs may not sign as a claimant for any beneficiary's claim. **Note 2:** Professional services rendered by U.S. Embassy health clinics are not covered by TRICARE/TOP.

Overseas Claims Payments for Service Specific Fund Sites
● When ADSMs seek care from a purchased care/host nation provider in a TOP Prime Remote location without an authorization for service from the TOP contractor, the claims will be denied. In these cases, reimbursement should be sought through the ADSM's service-specific fund.

7.0 TRICARE and Other Health Insurance (OHI)

By law, TRICARE is second payer to all other medical/hospital insurance, medical service, or health plans. (Exceptions: Medicaid, Indian Health Service, and certain other programs identified by the Director, TRICARE Management Activity (TMA) [e.g., State Assistance Plans]).

- If a beneficiary has OHI, the beneficiary or the provider must file a claim with that health insurance plan/service before filing with TRICARE.
- After the OHI processes the claim, the beneficiary can fill a claim with TRICARE, attaching a copy of the OHI plan's EOB and the itemized bill.
- Beneficiaries must notify their regional contractor or the claims processor about OHI and any associated changes in carriers or coverage. Claims processing may be delayed or a recoupment action may occur later if beneficiaries don't tell TRICARE about their OHI.
- When the OHI does not cover a procedure or benefit that is a TRICARE-covered benefit, the beneficiary may submit a claim to TRICARE along with the OHI's EOB stating the reason for non-payment.
    - TRICARE then considers the claim for payment. If approved, applicable TRICARE deductibles, cost-shares, and copays apply.

7.1 Host Nation Insurance

- Family members who are native to the host country may have host nation insurance.
- Host nation insurance including, but not limited to, German Statutory Health Insurance, Japanese National Insurance, and Australian Medicare, is considered OHI and cannot be waived.
    - Host nation insurance is the primary payer and TRICARE pays last.
    - Claims are submitted to the overseas contractor, with a copy of the document showing what the host nation insurance paid.

8.0 Resolving Claims Issues

- To resolve claims issues, beneficiaries should first call their regional contractor's toll-free number and select the option for claims assistance, or visit a local TRICARE Service Center (TSC) if near a military treatment facility (MTF).
- If the claim issue remains unresolved, the beneficiary may contact an MTF or a TRICARE Regional Office (TRO)/TRICARE Area Office (TAO) Beneficiary Counseling and Assistance Coordinator (BCAC).

- If an unresolved debt results in a collection action, the beneficiary should first contact the regional contractor, and then an MTF, or TRO/TAO Debt Collection Assistance Officer (DCAO), if additional assistance is needed.
- Beneficiaries and BCACs/DCAOs must register for access to the regional claims processor's online system (www.myTRICARE.com or www.TRICARE4u.com) to review claim status information for their respective region.

8.1 Assisting the Beneficiary with Claims Issues

When working with a beneficiary on a claims issue, consider the following questions:

- When was the date of service? What was the beneficiary's eligibility status or category at the time of service?
- What type of service did the beneficiary receive (e.g., medical appointment, hospitalization, medications administered in a provider's office, supplies)?
- Was this an inpatient or outpatient service?
- Did the beneficiary contact the claims processor for that benefit (regional, dental, pharmacy)? If yes, what was the result?
- Did the beneficiary bring his/her EOB, summary payment voucher, or bill?
- If the EOB is available, study the notes to determine how and why the claim processed as it did. For example:
    - Point of service (POS)
    - No authorization on file
    - Beneficiary was not eligible
    - Not a TRICARE benefit

If beneficiaries state they never received an EOB, look up claims information online if access is available or call the claims processor to find out if the provider submitted a claim. If not, advise the beneficiary to contact the provider to request that the office file a claim or determine if and when the provider submitted the claim and to resubmit if it was not received by the claims processor

- BCACs and DCAOs should try to work consistently with one key claims processor staff member to build rapport and maintain consistency in the communication process when researching/resolving beneficiary claim issues.

9.0 Explanation of Benefits (EOB)

- After submitting claims, the beneficiary and provider each receive a TRICARE EOB from the claims processor showing how the claim processed.
- The claims processor mails or posts the EOB online at either www.TRICARE4u.com or www.myTRICARE.com, depending on the region.

9.1 When to Expect an EOB

- For the majority of claims, the beneficiary and the provider should each receive an EOB within six weeks of submitting a claim.
    - Some complex claims may take 60 days or more to complete.
- If the beneficiary does not receive an EOB or cannot find the claim on the claim processor's website within six weeks of the date of service, tell the beneficiary that he/she should contact the provider or facility to verify that a claim was submitted. This also ensures the claim does not miss the timely filing deadline. If it appears the provider submitted the claim, the beneficiary should follow-up with the regional claims processor or contractor.
- Remind beneficiaries to follow up with ambulance companies separately, as insurance information isn't typically shared between hospitals, physicians and ambulance companies.

9.2 Reasons for Delays in Processing a Claim or Receiving an EOB

- Wrong address
- Medical necessity is not documented
- A Third-Party Liability form wasn't received
- Provider delayed submitting a claim
- Diagnosis is missing or inconsistent with services provided
- There is a government-directed delay (possibly because the provider is being investigated or because of fraud)
- Claim is incomplete
- OHI forms are missing
- Claim is complex and requires an extensive review
- Service is non-authorized
- Provider's unique Provider Identification Number or National Provider Identification is missing
- Eligibility is being questioned or DEERS information is inaccurate

9.3 Importance of Reviewing EOBs

- Beneficiaries should carefully compare each EOB against services they received and their bills, checking that the right provider(s) and right service(s) are billed.
    - Beneficiaries should contact the claims processor about charges for a service they did not receive. Incorrect charges may be due to a simple error in the provider's billing or entry in the claims system, or an indication of fraud.
- Beneficiaries may contact the regional contractor or claims processor by phone, internet, or at the nearest TSC with questions about their EOB.
- Beneficiaries may also seek assistance from the nearest MTF or regional BCAC/DCAO if the regional contractor fails to resolve the claims issue.

9.4 Components of an EOB

- **Claims Processor:** The claims processor that processed the claim and issued the EOB. This can be important. Example: A claim could be denied if it was submitted to the wrong processor. Verify it was processed and denied by the correct region/claims processor for which the beneficiary is/was enrolled in for that date of service.
- **Date of Notice:** The date the claims processor prepared the TRICARE EOB.
- **Mail to Name and Address:** The TRICARE EOB is mailed to the beneficiary's (or beneficiary's parent's or guardian's) address as submitted on the claim.
- **Claim Number:** Each claim is assigned a unique tracking number as it's processed; this number should be used for reference if there are questions or concerns.
- **Sponsor SSN/Sponsor Name:** Claims are processed using the sponsor's SSN (active duty, retired, or deceased) or the individual's DoD health benefits number. The sponsor is the active duty service member (ADSM) or retiree through whom family members are eligible for TRICARE. Only the last four digits of the SSN appear on the EOB.
- **Beneficiary Name:** The individual who received the service/procedure and for whom the claim is filed.
- **Service Provided By:** This section lists who provided the care/services.
- **Services Provided:** This section describes the medical services provided on the claim by listing the specific procedure code and description of the service billed by the provider.
- **Date of Services:** This section lists the date the beneficiary received the care.
- **Amount Billed:** The amount the provider charged for a particular service(s).
- **TRICARE Allowed:** This is the contracted amount allowed by TRICARE based on the date of service and the geographic location of the provider.
- **See Remarks:** There may be a code or a number here specific to a claims processing action; look at the "Remarks" section for the code description and explanation of how the claim processed.

- **Claim Summary/Beneficiary's Name:** A summary of totals on the entire claim/EOB. Includes the following: Total amount billed, total allowed amount by TRICARE, non-covered amount (if any), total amount OHI/ Medicare paid (if applicable), total amount paid by TRICARE, total cost-share/copay (if any), total amount applied to the deductible (if any), patient responsibility (e.g., total of deductible, cost-share/copay, and possible non-covered services combined).
- **Out-of-Pocket Expense:** This section shows the beneficiary's/family's out-of-pocket costs and what was applied to the annual deductible and catastrophic cap (maximum out-of-pocket expense) as of the date on the EOB. Claims processors calculate annual deductibles and catastrophic cap expenses by fiscal year.
- **Remarks:** Explanations of the codes or numbers listed in "See Remarks" appear here.
- **Paid To:** This field indicates who the check was issued to if payment was made. This can be the provider, sponsor, or beneficiary depending on the provider's status and how the claim was billed. If the provider is a network provider, payment is issued to the provider. If a provider agrees to participate (by accepting assignment on a claim), the payment is issued to the provider unless he/she indicated on the claim that the patient paid the charges.
- **Amount Paid:** The amount that TRICARE pays on the claim.
- **Check Number:** A check number appears if payment is issued on the claim. This number identifies the check that the payment is issued against. (This can be helpful when one check is issued to a beneficiary or provider as payment for multiple claims.)

9.5 Application Exercises

9.5.1 Group Activity: Reading an Explanation of Benefits (EOB)

Answer the questions below based on the fictitious sample EOB provided.

1. What is the date of notice on this EOB?
2. Who is the sponsor?
3. Who is the beneficiary that received services?
4. Who provided the care and what type of care was received?
5. How much was billed?
6. How much did TRICARE cover, and what is the term for this approved amount?
7. What do the remark codes indicate?
8. What amount was paid by TRICARE?
9. How much (if any) was applied to the deductible?
10. How much was the cost-share/copay?
11. How much was the beneficiary's responsibility?
12. Was payment made to the provider or the beneficiary?
13. What type of provider was this?
14. Which TRICARE option was the beneficiary using? How do you know?
15. By law, how much can the provider bill Jane Smith?

TRICARE®

TRICARE EXPLANATION OF BENEFITS

Administered by: TRICARE University

This is a statement of the action taken on your TRICARE claim. Keep this notice for your record.

Jane Smith
123 S. Christmas Lane
Nice, SC 20315

Date of Notice	January 15, 2012
Sponsor SSN	XXX-XXX-XXXX
Sponsor Name	John Smith
Beneficiary Name	Jane Smith
Claim Number	345678901
Provider Number	XX-XX648
Check Number	512340

If you have any questions about this notice, please call 1-800-123-4569 or visit us online at www.tricare.mil/tricareu

Explanation of Benefits **THIS IS NOT A BILL** Explanation of Benefits

SERVICES PROVIDED BY	DATE OF SERVICE	SERVICES PROVIDED	AMOUNT BILLED	TRICARE ALLOWED	SEE REMARKS
Pierce, Hunnicutt, & Winchester, P.C.	11/29/2011	Outpatient Visit (99214)	$200.00	$80.00	01, 02, 03
Totals:			$200.00	$80.00	

CLAIMS SUMMARY		BENEFICIARY SHARE	
TRICARE Amount Billed	$200.00	Copay	$0.00
TRICARE Allowed	$80.00	Cost-Share	$20.00
TRICARE Paid	$60.00	Deductible	$0.00
Other Ins. Allowed	$0.00	Patient Responsibility	$20.00
Other Ins. Paid			
Other Ins. Patient Resp.			

OUT OF POCKET EXPENSES

Beginning October 1, 2011			Beginning October 1, 2011		
	Met To Date	Limit		Met To Date	Limit
Deductible	$150.00	$300.00	Catastrophic Cap	$170.00	$3,000.00

REMARKS

01—Billed amount exceeds allowance.

02—You receive maximum benefits when you use a network provider. By law, a non-network non-participating provider may balance bill an additional 15% above the TRICARE-allowable charge.

03—$20.00 has been applied toward the catastrophic cap of $3,000.00.

PAID TO	AMOUNT PAID	CHECK NUMBER
Jane Smith	$60.00	512340

9.5.2 Practice Scenario

Mrs. Jane Smith just walked into your office, irate and irrational. She recently had a visit at Pierce, Hunnicutt, & Winchester, P.C. She paid the doctor's office $200 at the time of service and was told that she could file with TRICARE for reimbursement of her payment. Mrs. Smith filed her reimbursement claim with the appropriate claims processor. She received her EOB, along with a check for $60. She is upset because she was not reimbursed the full $200 that she paid to the doctor's office. Mrs. Smith wants a resolution to this matter as soon as possible.

Based on her EOB and your knowledge of TRICARE claims, please assist Mrs. Smith with understanding why she was not reimbursed the full $200 by TRICARE.

10.0 Appeals

- To appeal means to request that the contractor or TMA review coverage, authorization, or claims denial decision.
- The appeals process varies, depending on whether the denial involves:
  - Provider sanction
  - Medical necessity
  - Factual determination
  - Dual-eligible beneficiary (Medicare-TRICARE eligible beneficiaries)
- All initial denials and appeal determinations explain how, where, and by when to file the next level of review.

10.0.1 Provider Sanction

A sanctioned provider is a provider who is denied approval as a TRICARE-authorized provider or who was terminated, excluded, suspended, or otherwise sanctioned.

- Providers may be sanctioned by TRICARE because of the following:
  - Failure to maintain credentials
  - Provider fraud
  - Abuse
  - Conflict of interest
  - Other reasons
- Only the provider or his/her representative can appeal the sanction.
- If the provider appeals the sanction, an independent hearing officer conducts a hearing administered by the TMA Appeals, Hearings, and Claims Collection Division in Aurora, Colorado.

10.1 Who Can Appeal?

- An appealing party must be able to prove that he/she is eligible for TRICARE benefits including:
  - Any TRICARE beneficiary, or a parent or guardian of a beneficiary who is under 18 years of age
  - The guardian of a beneficiary who is not competent to act on his/her own behalf
- A health care provider who was:
  - Denied approval
  - Suspended, excluded, or terminated as a TRICARE-authorized provider
- Providers who participate in TRICARE
- A representative, appointed in writing by a beneficiary or provider
  - While a provider may not directly file an appeal on behalf of a beneficiary, a beneficiary can choose to appoint a provider as a representative by completing an *Appointment of Representative and Authorization to Disclose Information* form.

  - Certain individuals may not serve as beneficiary representatives due to a conflict of interest, including:
    - A legal officer (member of a uniformed service legal office)
    - BCAC/DCAO/Health Benefits Advisor (HBA)
    - Employee of the federal government, such as a uniformed service member, MTF provider, or an employee of a uniformed service, unless the representative is an immediate family member
- Non-participating providers and network providers **cannot** file appeals.

10.2 What Can Be Appealed?

- The facts of a beneficiary's case that can be appealed:
  - The diagnosis
  - The necessity to be an inpatient
  - The denial of pre-authorization for services, including mental health
  - The termination of treatments or services that were previously authorized
  - The denial of TRICARE payment for services or supplies received
  - The denial of TRICARE payment for continuation of services or supplies that were previously authorized
  - The denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE

10.3 What Can't Be Appealed?

The following are examples of what can't be appealed:

- The TRICARE allowable amount for a particular service (The beneficiary may ask the regional contractor for an allowable charge review, but cannot file an appeal.)
- The decision by the regional contractor or TRICARE Management Activity (TMA) to ask the beneficiary for more information before taking action on the beneficiary's claim or appeal request
- Whether a provider is a network or authorized provider
- A decision relating to TRICARE eligibility
  - The services determine eligibility and DEERS reports it
  - Beneficiaries must appeal decisions regarding their eligibility through their branch of service

11.0 Appeals of Medical Necessity Determinations

- "Medical necessity" is based on whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition, including decisions on custodial and mental health care services.
- It may be necessary to prove medical necessity for inpatient, outpatient, and specialty care.
- If appealing the denial, the beneficiary must send a package to the regional contractor, including a cover letter with relevant case information, a copy of the denial letter, and any associated EOBs, claims, bills, and/or documents that the beneficiary feels support overturning the denial decision.
  - Failure to include a copy of the denial letter may delay the review process or cause the appeal to be routed incorrectly.
  - If beneficiaries can't get all of the supporting documents in on time, they should send the appeal anyway and state in the cover letter their intention to submit additional information when it becomes available.
  - The beneficiary should keep originals of all paperwork related to the appeal.
- There are two kinds of medical necessity determination appeals, expedited and non-expedited (most appeals are non-expedited).

11.1 Expedited Appeal

- An expedited appeal should only be submitted for reconsideration of inpatient stays or prior authorization of services.
- A beneficiary must file a request for an expedited reconsideration of a pre-admission/pre-procedure denial within three calendar days after the date of the receipt of the initial denial determination.
- Beneficiaries are notified of a decision within three working days after the regional contractor receives the request.

11.1.1 Second Level Expedited Appeal

- If the contractor's reconsideration determination is less than fully favorable and $50 or more remains in dispute, the contractor shall include a statement explaining the right of the beneficiary to request an appeal to the TRICARE Quality Monitoring Contractor (TQMC) for a second reconsideration.
- The beneficiary shall file the expedited appeal request with the TQMC within three calendar days after the date of receipt of the initial reconsideration determination.
- The TQMC will issue a second reconsideration determination within three working days of receipt of the reconsideration request.

11.2 Non-Expedited Appeal

- To file a non-expedited appeal, the beneficiary sends the information package (see Section 11.0 of this module for more information on information packages) to the regional contractor at the address specified in the determination notice, included on their EOB or denial letter.
- The package must be postmarked or received within 90 days of the date on the EOB or initial denial determination notice (usually a letter).
- The regional contractor reviews the case and issues a reconsideration review determination within 30 days of receipt of the reconsideration request, either supporting or overturning the denial.
- If the amount is less than $50, the decision is final.

11.2.1 Second Level Non-Expedited Appeal

- If the contractor again upholds the denial determination and the amount in dispute is greater than $50, the beneficiary can appeal to the TQMC per instructions provided in the reconsideration review determination letter.
- The beneficiary sends an appeal to the TQMC.
    - The package must be postmarked or received within 90 days of the date on the regional contractor's reconsideration decision determination notice.
    - A copy of the reconsideration decision and any supporting documents not previously submitted must be included with the letter. If beneficiaries cannot get all of the supporting documents in on time, they should state in the cover letter their intention to submit additional information in the near future.
    - The beneficiary should keep the originals or copies of all paperwork submitted.
- The TQMC reviews the case and issues a second reconsideration decision within 30 calendar days of receipt of reconsideration request.

12.0 Appeals of Factual Determinations

Factual determinations involve issues other than medical necessity, such as coverage issues, provider authorization (status) requests, hospice care, foreign claims, and denial of a provider's request for approval as a TRICARE-authorized provider. Medical or peer review may be necessary to reach a factual determination.

12.1 Factual Determination Appeal Process

- To file a factual determination appeal, the beneficiary submits the same kind of packet they would submit for a medical necessity appeal. (See Section 11.0 of this module for more information.)
- This reconsideration letter must be postmarked or received within 90 days of the date on the EOB or initial denial determination notice.
- The regional contractor issues a reconsideration determination of a factual appeal within 60 days of the beneficiary's request.
  - If the beneficiary appeals an amount less than $50, the regional contractor's reconsideration (second) determination is final.
  - If the beneficiary appeals an amount greater than $50, the regional contractor issues a determination, and if the denial is upheld, instructs the beneficiary to file a formal review request with TMA.
- To request a formal review, beneficiaries must send a letter to TMA within 60 days (postmarked or received) of the date on the factual reconsideration decision notice and include copies of the decision along with additional supporting documents.
- TMA typically issues a formal review decision within 90 days.
  - If the disputed amount is less than $300, TMA's decision is final.
  - If the disputed amount is more than $300, the beneficiary can request an independent hearing.
- To request an independent hearing, the beneficiary must send a request to TMA-Aurora within 60 days (postmarked or received) from the date of TMA's formal review determination.
- The beneficiary should include a copy of the formal review determination and any supporting documents not previously submitted.
- An independent hearing officer then conducts the hearing at a location convenient to both the requesting party and the government.
- The hearing officer makes a decision recommendation and the Assistant Secretary of Defense, Health Affairs issues the final decision.
- Factual appeals and appeal correspondence for the TMA should be addressed to:

TRICARE Management Activity
Appeals, Hearings and Claims Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

13.0 TRICARE Prime Remote (TPR) Appeals

- If an active duty service member (ADSM) in a designated remote location (stateside or overseas) does not receive prior authorization for specialty care his or her claim may be denied:
  - The ADSM may appeal by first contacting the appropriate authorization authority:
    - The Military Medical Support Office (MMSO) Service Point of Contact (SPOC) if care was received in the United States or the U.S. Virgin Islands
    - MTF staff, if care was based on an MTF referral or the ADSM shows as enrolled in TRICARE Prime at an MTF on the date of service
    - The overseas regional contractor if care was received in an overseas location (other than the U.S. Virgin Islands)
  - ADSMs, their primary care manager (PCM), or network or TRICARE-authorized provider may send additional written information or documentation to the SPOC to support the ADSM's appeal request.
- If the request is denied on appeal, the ADSM may then appeal to their service Surgeon General or the senior medical officer of their respective service. The address for this second appeal is provided to the ADSM upon denial of the first appeal.

13.1 Service Points of Contact (SPOCs) at the Military Medical Support Office (MMSO)

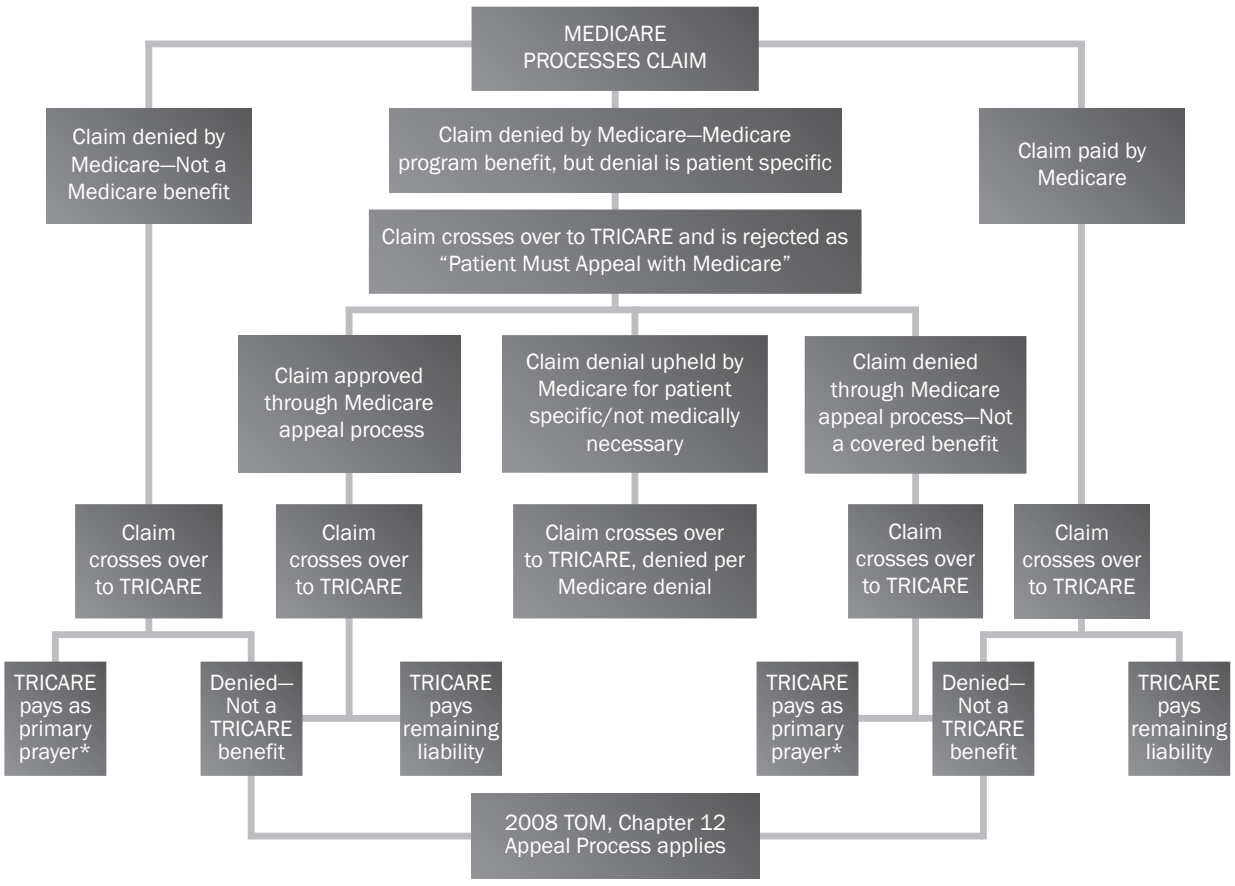
- ADSMs from the Army, Marine Corps, Navy, and Air Force may contact their SPOC at 1-888-MHS-MMSO/1-888-647-6676. Send written inquires to:

  [Insert branch of service] Point of Contact
  Military Medical Support Office (MMSO)
  P.O. Box 886999
  Great Lakes, IL 60088-6999

- ADSMs from the Coast Guard may contact their SPOC at 1-800-647-6676.
- U.S. Public Health Service (USPHS) and members may contact their Beneficiary Medical Program SPOC at 1-800-368-2777, option 2.
- National Oceanic and Atmospheric Administration (NOAA) members may contact their Beneficiary Medical Program SPOC at 1-800-224-6622

14.0 Appeals for Dual Eligibility Determinations—Medicare-TRICARE Eligibles

- Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process.
  - If a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE.
  - Services and supplies denied payment by Medicare will be considered for coverage by TRICARE if the Medicare denial of payment is not appealable under Medicare.
- See the chart below for additional information on claims for Medicare-TRICARE eligibles.



*If a TRICARE-covered benefit

15.0 Program Integrity

- The TMA Office of Program Integrity:
  - Is the investigative arm of TMA
  - Provides management of the TMA anti-fraud program
  - Is responsible for national coordination and control of cases through their work with contractors, the Department of Justice, and investigative agencies
  - Provides oversight to all contractor program integrity units to ensure compliance in the area of anti-fraud activities
- Program Integrity is responsible for deterring fraud, waste, and abuse through prevention, detection, coordination, and enforcement

15.1 What is Fraud?

- Fraud is any intentional deception or misrepresentation that an individual or entity does which could result in an unauthorized TRICARE benefit or payment.
- TRICARE considers the following fraudulent acts under the program:
  - Submitting claims for services not rendered or used
  - Falsified claims or medical records
  - Misrepresentation of dates, frequency, duration, or description of services rendered
  - Billing for services at a higher level than provided or necessary
  - Over-utilization of services
  - Breach of provider participation agreement
- Fraud could result in criminal conviction, civil settlement, administrative action by the contractor, termination action or exclusion action (i.e., removal from the TRICARE program)

15.2 Who Commits Fraud?

- Dishonest health care providers and other health care professionals commit the majority of fraud (e.g., physicians, dentists, labs, hospitals, psychiatrists, ambulance companies, and clinics)
- Contractors and contract employees
- A lesser percent is beneficiary fraud

15.3 Fraud Indicators

- Excessive charges by provider
- Reluctance of provider to submit records
- Correspondence for rapid adjudication
- Conflicting dates of service
- Diagnosis or treatment inconsistent with patient's age or sex
- Excessive billing by provider for low cost items or services
- Providers routinely billing the same procedures to every patient, regardless of diagnosis
- Provider who uses post office boxes for the remit to address
- Claims with excessive or vague documentation
- Overlapping services on the same date
- Illogical places of service
- Too many providers for same date of service
- High volume of treatment for a particular condition or diagnosis
- Claims handwritten in the same ink for both the beneficiary and provider portion of claim
- Provider is not in the same geographic area as the beneficiary, particularly when patterns occur
- Claims with misused or misspelled medical terms

15.4 Where to Report Potential Fraud Cases

TRICARE North Region: **Health Net Federal Services** Fraud Hotline: 1-800-977-6761 E-mail: program.integrity@healthnet.com	**TRICARE Region South:** **Humana Military Healthcare Services** Fraud Hotline: 1-800-333-1620 Online: http://infocenter.humana-military.com/south/bene/progintegreferral.asp
TRICARE West Region: **TriWest Healthcare Alliance** Fraud Hotline: 1-888-584-9378 E-mail: pi@triwest.com	**TRICARE Overseas:** **International SOS** Fraud Hotline: 1-877-342-2503 E-mail: TOPProgramIntegrity@internationalsos.com
TRICARE Management Activity **Program Integrity Office** Phone: 1-303-676-3824 Fax: 1-303-676-3981 E-mail: fraudline@tma.osd.mil	**TRICARE for Life (TFL):** **Wisconsin Physician Services** Phone: 1-866-773-0404 E-mail: reportit@wpsic.com
TRICARE Dental Program: **MetLife** Fraud Hotline: 1-800-462-6565	**TRICARE Retiree Dental Program:** **Delta Dental** Phone: 1-888-838-8737
Active Duty Dental Program: **United Concordia** Fraud Hotline: 1-877-968-7455 Online: https://secure.addp-ucci.com/ddpddw/privacy/privacyAct-06.xhtml	**TRICARE Pharmacy Program:** **Express Scripts, Inc.** Phone: 1-800-332-5455 E-mail: fraudtip@express-scripts.com

16.0 Summary

16.1 Where to Get Additional Claims and Appeals Information for Beneficiaries

Direct beneficiaries to their:

- Regional contractor or claims processor
- TRICARE Service Center (TSC)
- Nearest MTF
- Military Medical Support Office (stateside and Virgin Island TPR ADSMs only)
- BCACs/DCAOs at the TRO/TAO

16.2 Beneficiary Appeals Checklist

When helping beneficiaries with an appeal, please check that they:

- Meet all the required deadlines
- Send appeals in writing with signatures
- Include copies of all supporting documents with the appeal (If all paperwork is not available, send the letter within the deadline and note that more information will be sent; then send it in a timely manner.)
- Keep originals or copies of everything (e.g., EOB, Denied Authorization Letter)
- Include a copy of the most recent denial providing appeal rights, without this the next level reviewer (i.e., TMA or TQMC) has no way of knowing the appeal was already reviewed at the 1st level.

Module Objectives

Summary:

- **Explain who can file claims and where claims should be submitted**
- **Describe how to resolve claims issues**
- **Identify three reasons why an Explanation of Benefits (EOB) may be delayed**
- **Distinguish between what can and cannot be appealed**

Appendix A: Claims Resources

North Region Claims Processor

North Region Locations
Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (Rock Island Arsenal area), Kentucky (except Fort Campbell), Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, and Wisconsin
Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P. O. Box 870140 Surfside Beach, SC 29587-9740 1-877-874-2273 www.myTRICARE.com

South Region Claims Processor

South Region Locations
Alabama, Arkansas, Florida, Georgia, Kentucky (Fort Campbell area), Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, Texas (excluding the El Paso area)
TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 www.myTRICARE.com

West Region Claims Processor

West Region Locations
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner, including El Paso), Utah, Washington, and Wyoming
West Region Claims P.O. Box 77028 Madison, WI 53707-7028 1-888-915-4001 www.TRICARE4u.com

TRICARE Eurasia-Africa Claims Processor

TRICARE Eurasia-Africa Locations	
Africa, Europe, and the Middle East	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976
1-877-678-1207 (Stateside) +44-20-8762-8384 (Overseas) www.TRICARE4u.com	

TRICARE Latin America and Canada Claims Processor

TRICARE TLAC Locations	
Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
1-877-451-8659 (Stateside) +1-215-942-8393 (Overseas) www.tricare4u.com	

TRICARE Pacific Claims Processor

TRICARE Pacific Locations	
Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
Singapore: 1-877-678-1208 (Stateside) +65-6339-2676 (Overseas) Sydney: 1-877-678-1209 (Stateside) +61-2-9273-2710 (Overseas) www.tricare4u.com	

TRICARE for Life Claims

United States and U.S. Territories	Overseas
WPS TRICARE For Life (TFL) P.O. Box 7890 Madison, WI 53707-7890 1-866-773-0404 www.tricare4u.com	Use the appropriate overseas region address listed above

Appendix B: Sample Explanation of Benefits Statements

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

North Region—Sample Explanation of Benefits

How to Read Your TRICARE EOB for the North Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the region where you live.
2. **Regional Contractor:** The name "Health Net Federal Services" and the Health Net Federal Services, LLC logo appear here.
3. **Date of Notice:** PGBA prepared your TRICARE EOB on this date.
4. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) or Department of Defense Benefits Number of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor.
5. **Beneficiary Name:** This is the name of the patient who received medical care and who this claim was filed for.
6. **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.
7. **Partial Benefits Were Payable To:** This field appears only if your doctor accepts assignment. This means the doctor accepts the TRICARE maximum-allowable charge as payment in full for the services you received.
8. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it's processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Services Provided By/Date of Services:** This section lists who provided your medical care, the number of services, procedure codes, and the date(s) you received care.
10. **Services Provided:** This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved:** This is the amount TRICARE approves for the services you received.
13. **See Remarks:** If you see a code or a number here, look at the "Remarks" section (18) for more information about your claim.
14. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved 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. A check number will appear here only if a check accompanies your EOB.
15. **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 cost-share or copayment you must pay.
16. **Patient Responsibility:** This is the total amount you owe for this claim.
17. **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. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the "Fiscal Year Beginning" date in this section for the first date of the fiscal year.
18. **Remarks:** Explanations of the codes or numbers listed in "See Remarks" section (13) appears here.
19. **Toll-Free Telephone Number:** If you have questions about your TRICARE EOB, please call PGBA toll-free at 1-877-TRICARE (1-877-874-2273). Our professional customer service representatives will gladly assist you.

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

(2) Health Net®
Federal Services
WWW.HNFS.COM

TRICARE EXPLANATION OF BENEFITS

This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

(3) **Date of Notice:** October 22, 2011
(4) **Sponsor SSN:** ***-**-9898
Sponsor Name: TRICARE SPONSOR
(5) **Beneficiary Name:** TRICARE BENE

(6) **TRICARE BENE**
5362 ANY STREET
ANYCITY XX 88888-9999

(7) **Partial benefits were payable to:**
PATHOLOGY LABDOE
STE 999
9999 N JERGENS ST
TOLEDO OH 99999

(8) **Claim Number: 999999999-00-00**

Services Provided By/ Date of Services (9)	Services Provided (10)	Amount Billed (11)	TRICARE Approved (12)	APC#	See Remarks (13)
PATHOLOGY LABDOE					
09/02/2011	001 Emergency dept visit (99282)	32.84		11111	1, 2. 3
09/02/2011	001 Repair superficial wound(s) (12002)	161.84	161.84	11111	1, 2
Totals:		194.68	161.84		

Claim Summary (14)

Amount Billed:	194.68
TRICARE Approved:	161.84
Non-covered:	32.84
Paid by Beneficiary:	0.00
Other Insurance:	0.00
Paid to Provider:	161.84
Paid to Beneficiary:	0.00
Check Number:	6990666666

Beneficiary Liability Summary (15)

Deductible:	0.00
Copayment:	0.00
Cost Share:	0.00
Patient Responsibility:	0.00

(16)

Benefit Period Summary (17)

Fiscal Year Beginning:
October 01, 2011

	Individual	Family
Deductible:	0.00	0.00
Catastrophic Cap:		0.00

Remarks: (18)

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

2 - YOUR CLAIM HAS BEEN PROCESSED UNDER THE SUPPLEMENTAL HEALTH CARE PROGRAM. IF YOU HAVE QUESTIONS ABOUT THE PROCESSING OF YOUR CLAIM PLEASE CALL PGBA AT 1-877-874-2273. IF YOU WISH TO APPEAL YOUR CLAIM YOU MUST SUBMIT YOUR REQUEST IN WRITING TO YOUR SERVICE POINT OF CONTACT.

3 - GREAT NEWS! PGBA IS MAKING TRICARE EASIER. YOU CAN NOW VIEW THE STATUS OF YOUR CLAIMS AT WWW.MYTRICARE.COM. FOR MORE INFORMATION VISIT OUR WEB SITE TODAY.

(19) **1-877-TRICARE (1-877-874-2273)**

THIS IS NOT A BILL

If you have questions regarding this notice, please call or write us at telephone number/address listed above.

TRICARE North

South Region—Sample Explanation of Benefits

How to Read Your TRICARE EOB for the South Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the region where you live.
2. **Regional Contractor:** The name "Humana Military Healthcare Services" and the Humana Military Healthcare Services, Inc. logo appear here.
3. **Date of Notice:** PGBA prepared your TRICARE EOB on this date.
4. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) or Department of Defense Benefits Number of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor. For security reasons, only the last four digits of your sponsor's SSN appear on the EOB.
5. **Beneficiary Name:** This is the name of the patient who received medical care and who this claim was filed for.
6. **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.
7. **Partial Benefits Were Payable To:** This field appears only if your doctor accepts assignment. This means the doctor accepts the TRICARE maximum allowable charge as payment in full for the services you received.
8. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it's processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Services Provided By/Date of Services:** This section lists who provided your medical care, the number of services, procedure codes, and the date(s) you received care.
10. **Services Provided:** This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved:** This is the amount TRICARE approves for the services you received.
13. **See Remarks:** If you see a code or a number here, look at the "Remarks" section (17) for more information about your claim.
14. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved 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. A check number will appear here only if a check accompanies your EOB.
15. **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 cost-share or copayment you must pay.
16. **Patient Responsibility:** This is the total amount you owe for this claim.
17. **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. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the "Fiscal Year Beginning" date in this section for the first date of the fiscal year.
18. **Remarks:** Explanations of the codes or numbers listed in the "See Remarks" section (13) appear here.
19 . **Toll-Free Telephone Number:** If you have questions about your TRICARE EOB, please call PGBA at this toll-free number. Our professional customer service representatives will gladly assist you.

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

(2) HUMANA MILITARY
HEALTHCARE SERVICES
★ ★ ★ ★ ★
www.humana-military.com

TRICARE EXPLANATION OF BENEFITS

This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

(3) Date of Notice: October 1, 2011
(4) Sponsor SSN: ***-**-6789
Sponsor Name: **NAME OF SPONSOR**
(5) Beneficiary Name: **NAME OF BENEFICIARY**

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

(7) Benefits were payable to:
PROVIDER OF MEDICAL CARE
ADDRESS
CITY STATE ZIP CODE

(8)

Claim Number: 9279X0000-00-00

Services Provided By/ Date of Services (9)		Services Provided (10)	Amount Billed (11)	TRICARE Approved (12)	See Remarks (13)
PROVIDER OF MEDICAL CARE					
10/01/2011	001	Initial comprehensivc preve (99381)	97.00	85.10	1, 2
10/01/2011	001	Diptheria, tetanus toxoids, (90698)	101.00	78.84	1
10/01/2011	001	Pnuemococcal conjugate vacci (90669)	110.00	95.48	1
Totals:			308.00	259.42	

Claim Summary (14)

Amount Billed:	308.00
TRICARE Approved:	259.42
Non-covered:	259.42
Paid by Beneficiary:	259.42
Other Insurance:	259.42
Paid to Provider:	259.42
Paid to Beneficiary:	0.00
Check Number:	

Beneficiary Liability Summary (15)

Deductible:	0.00
Copayment:	0.00
Cost Share:	0.00
Patient Responsibility: (16)	0.00

Benefit Period Summary (17)

Fiscal Year Beginning:
October 01, 2011

	Individual	Family
Deductible:	0.00	0.00
Catastrophic Caps:		9.00

Remarks: (18)

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

2 - VISIT WWW.HUMANA-MILITARY.COM AND WWW.MYTRICARE.COM TO MANAGE YOUR HEALTH CARE ONLINE. FIND A PROVIDER, READ YOUR BENEFITS INFORMATION, CHECK INDIVIDUAL CLAIM AND REFERRAL STATUS, ELIGIBILITY, AND MUCH MORE.

(19) **1-800-403-3950**

THIS IS NOT A BILL
If you have questions regarding this notice, please call or write us at telephone number/address listed above.

TRICARE

Page 1 of 1

West Region—Sample Explanation of Benefits

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 of the military 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's 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 only 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 approved 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. See the "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.

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®

TRICARE Fundamentals Course

Resources and Tools

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Participant Guide

Air Force: www.af.mil

Air Force Reserve Command: www.afrc.af.mil

Air National Guard: www.ang.af.mil

Appeals and Grievances:

North Region	South Region	West Region
Claims Appeals Health Net Federal Services, LLC TRICARE Claim Appeals P.O. Box 105266 Atlanta, GA 30348-5266 **Authorization Appeals** Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 105087 Atlanta, GA 30348-5087	**Claims Appeals** TRICARE South Region Appeals P.O. Box 202002 Florence, SC 29502-2002 **Authorization Appeals** Humana Military Healthcare Services, Inc. Attn: Clinical Appeals P.O. Box 740044 Louisville, KY 40201-9973	**Claims Appeals** TriWest Healthcare Alliance Claims Appeals P.O. Box 86508 Phoenix, AZ 85080 **Authorization Appeals** TriWest Healthcare Alliance Reconsideration Appeals P.O. Box 86508 Phoenix, AZ 85080
TRICARE Overseas Program (TOP)—All Regions		
Claims Appeals TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992 USA		
Authorization Appeals		
TRICARE Management Activity Appeals, Hearings, and Claims Collection Division 16401 E. Centretech Parkway Aurora, CO 80011-9066		
www.tricare.mil/appeals		

Army One Source: www.myarmyonesource.com

BCAC/DCAO Directory: www.tricare.mil/bcacdcao (also known as the Customer Service Community Directory)

Beneficiary Web Enrollment (BWE): www.dmdc.osd.mil/appj/bwe

Becoming a TRICARE Provider: www.tricare.mil/tma/prospectiveproviders.aspx

Certificates of Credible Coverage:

Phone: 1-800-538-9552, say “proof of insurance” when prompted

Fax: 1-831-655-8317, TYY/TDD: 1-866-363-2883
(please note: only use the fax option when in urgent need of a Certificate of Credible Coverage)

E-mail: hipaamail@tma.osd.mil

Written Requests:

Defense Manpower Data Center Support Office (DSO)
ATTN: Certificate of Credible Coverage
400 Gigling Rd
Seaside, CA 93955-6771

Coast Guard Employee Office of Work Life:

www.uscg.mil/worklife

1-800-872-4957

Coast Guard Health Benefits Assistance Line: 1-800-9-HBA-HBA/1-800-942-2422

Continued Health Care Benefits Program (CHCBP):

www.humana-military.com (click CHCBP located at the bottom right corner of the page)

Continued Health Care Benefit Program Application	Send CHCBP Claims To:
www.tricare.mil/mybenefit/download/forms/chcbp_enrollment_form.pdf **Mail to:** Humana Military Healthcare Services, Inc. Attn: CHCBP P.O. Box 740072 Louisville, KY 40201	PGBA, LLC P.O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 (Monday to Friday 8am - 6pm) www.myTRICARE.com

Customer Service Community Directory: www.tricare.mil/bcacdcao (also known as the BCAC/DCAO Directory)

Defense Manpower Data Center (DMDC)/DEERS Support Office (DSO):

DMDC Website: www.dmdc.osd.mil

MilConnect website: http://milconnect.dmdc.mil

Toll-free: 1-800-538-9552, TTY/TDD: 1-866-363-2883

Fax address changes to: 1-831-655-8317

Mail address changes to:

Defense Manpower Data Center Support Office (DSO)
ATTN: COA
400 Gigling Rd
Seaside, CA 93955-6771

DSO Research and Analysis (BCACs/DCAOs only): 1-831-583-2500; DSN 1-878-3522/3523

DSO Help Desk (for technical support): 1-800-372-7437

Defense Medical Information System (DMIS) ID Resource Page: www.dmisid.com

DoD Hotline/Force Health Protection & Readiness (FHP&R) Policy & Program Office: 1-703-681-3279

Express Scripts, Inc.: (See Pharmacy)

Family Support and Hotline Information:

Navy	1-800-372-5463
Marine Corps	1-800-336-4663
Coast Guard	1-800-872-4957, ext. 932
Army	1-800-833-6622
Air Force	1-800-435-9941
National Guard Bureau	1-888-777-7731
Deployment Health Support Hotline	1-800-497-6261
Defense Logistics Agency (DLA)	1-800-222-0364

Formulary Search Tool: www.pec.ha.osd.mil/formulary_search.php

Health Insurance Portability and Accountability Act (HIPAA):

E-mail: hipaatcsimail@tma.osd.mil

Website: www.tricare.mil/hipaa

Health Net Federal Services, LLC:

www.hnfs.com

1-877-TRICARE/1-877-874-2273

Humana Military Healthcare Services, Inc:

www.humana-military.com

1-800-444-5445

Marine Corps: www.usmc.mil

Marine Forces Reserve: www.marines.mil/unit/marforres

Medicare Services/Centers for Medicare and Medicaid:

www.medicare.gov

1-800-MEDICARE/1-800-633-4227

Military One Source: www.militaryonesource.mil

1-800-342-9647, TTY/TDD 1-866-607-6794

Refer to the "Contact Us" page for international dialing instructions

MMSO (Military Medical Support Office):

1-888-MHS-MMSO/1-888-647-6676

www.tricare.mil/mmso

Military Medical Support Office (MMSO)
P.O. Box 886999
Great Lakes, IL 60088-6999

MMSO Medical Eligibility Verification Reserve Component Form:

www.tricare.mil/tma/mmso/pdf/mmsoformmedicaleligibility.pdf

National Guard and Reserve:

<table>
<tr><th colspan="2">National Guard and Reserve Contact Information</th></tr>
<tr><td>North Region
Health Net Federal Services, LLC
1-877-TRICARE/1-877-874-2273
www.hnfs.com

TRICARE Reserve Select
1-800-555-2605</td><td>West Region
TriWest Healthcare Alliance Corp.
1-888-TRIWEST/1-888-874-9378
www.triwest.com

National Guard and Reserve Resource Center
www.triwest.com/ngr</td></tr>
<tr><td>South Region
Humana Military Healthcare Services, Inc.
1-800-444-5445
www.humana-military.com

National Guard and Reserve
1-877-298-3408</td><td>Overseas
(Includes All Areas)
International SOS Assistance, Inc.
1-877-451-8659 (stateside toll-free)

www.tricare-overseas.com</td></tr>
<tr><td>TRICARE Reserve Select
www.tricare.mil/trs</td><td>TRICARE Retired Reserve
www.tricare.mil/trr</td></tr>
<tr><td colspan="2">National Guard Family Program: www.jointservicessupport.org</td></tr>
</table>

PGBA:

www.mytricare.com

1-877-TRICARE/1-877-874-2273

Mail North Region claims to: PGBA, LLC
P.O. Box 870140
Surfside Beach, SC 29587-9740

Mail South Region claims to: PGBA, LLC
P.O. Box 7031
Camden, SC 29020-7031

Pharmacoeconomic Center: www.pec.ha.osd.mil

Pharmacy:

TRICARE Pharmacy Program	
Stateside Contacts	
Phone: 1-877-363-1303 www.express-scripts.com/tricare	
Overseas Contacts*	
Germany	00+800-3631-3030
Italy	00+800-3631-3030
Japan-IDC	0061+800-3631-3030
Japan-Japan Telecom	0041+800-3631-3030
Japan-KDD	010+800-3631-3030
Japan-Other	0033+800-3631-3030
South Korea	002+800-3631-3030
Turkey	0811-288-0001 (once prompted, input 877-363-1303)
United Kingdom	00+800-3631-3030
All other areas outside of the US	1-866-ASK-4PEC/1-866-275-4732
TDD Toll-Free	1-877-540-6261
E-mail	DOD.customer.relations@express-scripts.com
Pharmacy Claims Contacts	
Mail Stateside Pharmacy Claims To: Express Scripts, Inc. ATTN: Claims Department P.O. Box 66773 St. Louis, MO 63166-6773	**Mail Overseas Prescription Claims To:** TRICARE Overseas Program ATTN: Claims Department TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
Stateside Pharmacy Appeals: Express Scripts, Inc. P.O. Box 60903 Phoenix, AZ 85082-0903	**Pharmacy Home Delivery:** www.tricare.mil/homedelivery 1-877-363-1303 (toll-free if in the U.S.) Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954
Member Choice Center (MCC) - Pharmacy Home Delivery: 1-877-363-1433 (toll-free)	
Pharmacy Locator: www.express-scripts.com/TRICARE/pharmacy	

Note: Beneficiaries residing overseas who are located in areas outside the countries in the overseas list in the chart above should call their point of contact number, which will provide access to the Express Scripts Contact Center.

Overseas Pharmacy Claims (other than U.S. Territories)	
Stateside	TRICARE Management Activity (TMA) Military Medical Support Office (MMSO) ATTN: RC Retail Pharmacy Reimbursement P.O. Box 886999 Great Lakes, IL 60088-6999 Fax: 1-847-688-6460
Overseas **(All Active Duty Claims)**	TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 1-608-301-2311, opt. 2
Eurasia-Africa **(All Non-Active Duty Claims)**	TRICARE Overseas Program P.O. Box 8976 Madison, WI 53707-8976 1-608-301-2310, opt. 2
Latin America and Canada **(All Non-Active Duty Claims)**	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-608-301-2311, opt. 2
Pacific **(All Non-Active Duty Claims)**	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-608-301-2311, opt. 2

Rapids Site Locator: www.dmdc.osd.mil/rsl

Reserve Affairs:

http://ra.defense.gov
Family Readiness: http://ra.defense.gov/programs/fepp/family.html

Service Points of Contact (MMSO):

Service Points of Contact (SPOC)	
Active Duty Service Members	1-888-MHS-MMSO/1-888-647-6676
United States Public Health Service (USPHS)	1-800-368-2777, opt. 2
Other General Inquiries	[Insert branch of Service] Point of Contact Military Medical Support Office (MMSO) P.O. Box 886999 Great Lakes, IL 60088-6999 **DoD (Army, Air Force, Navy, Marine Corps) and Coast Guard** 1-888-MHS-MMSO/1-888-647-6676

Social Security Administration:

1-800-772-1213

TTY/TDD 1-800-325-0778

www.ssa.gov

TMA Privacy and Civil Liberties Office:

www.tricare.mil/tma/privacy

1-703-681-7500

TPR and Remote Reserve Component LOD Care Questions:

MMSO: 1-888-MHS-MMSO/1-888-647-6676, opt. 4

www.tricare.mil/tma/mmso

TRICARE Authorized Providers: www.tricare.mil/findaprovider

TRICARE Contracts Toolkit: www.tricare.mil/contractstoolkit

TRICARE Dental Program (TDP)/TRICARE Dental Program Overseas:

MetLife Contact Information		
By Phone	Stateside 1-855-MET-TDP1/1-855-638-8371	Overseas 1-855-MET-TDP2/1-855-638-8372
	TDD/TYY: 1-855-MET-TDP3/ 1-855-638-8373	
Online	https://mybenefits.metlife.com	
Enrollment	Online Forms & Enrollment: www.dmdc.osd.mil/appj/bwe Costs & Premiums: www.tricare.mil/costs	By Mail MetLife TRICARE Dental Program (TDP) P.O. Box 14185 Lexington, KY 40512
Claims	Stateside MetLife TRICARE Dental Program (TDP) P.O. Box 14181 Lexington, KY 40512 Fax: 1-855-763-1333	Overseas MetLife TRICARE Dental Program (TDP) P.O. Box 14182 Lexington, KY 40512 Fax: 1-855-763-1334 E-mail: OCONUSdentalclaims@metlife.com

TRICARE For Life: www.tricare.mil/tfl (for program description); www.tricare4u.com (for TFL contractor)

1-866-773-0404, TDD 1-866-773-0405

See website for additional overseas contact information

Send claims to:	**Written correspondence:**
WPS/TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890	WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889

TRICARE Forms: www.tricare.mil/forms

TRICARE Media Center: www.tricare.mil/mediacenter

TRICARE Online: www.tricareonline.com

TRICARE Overseas:

<table>
<tr><td rowspan="2">TRICARE
Eurasia-Africa

(Africa, Europe and the Middle East)</td><td colspan="2">www.tricare.mil/eurasiaafrica
Toll-Free: 1-888-777-8343, opt.1
Commercial: +49-6302-67-6314
Commercial Fax: +49-6302-67-6378
DSN: 1-314-496-6314
DSN Fax: 1-314-496-6378
teoweb@europe.tricare.osd.mil</td></tr>
<tr><td>TOP Regional Call Center
1-877-678-1207
+44-20-8762-8384
tricarelon@internationalsos.com</td><td>Medical Assistance
+44-20-8762-8133</td></tr>
<tr><td rowspan="2">TRICARE
Latin America and Canada

(Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)</td><td colspan="2">www.tricare.mil/tlac
Toll-Free: 1-888-777-8343, opt. 3
DSN: 554-8582
Commercial: +1-210-292-8520
Commercial Fax: +1-210-292-3224
taolac@tma.osd.mil</td></tr>
<tr><td>TOP Regional Call Center
+1-215-942-8393 (overseas)
1-877-451-8659 (U.S.)
tricarephl@internationalsos.com</td><td>Medical Assistance
+1-215-942-8320</td></tr>
<tr><td rowspan="2">TRICARE
Pacific

(Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries)</td><td colspan="2">www.tricare.mil/pacific
Singapore: 1-877-678-1208, opt. 4
Sydney: 1-877-678-1209, opt. 4
(toll-free if calling from the U.S.)
Commercial: +81-6117-43-2036
Commercial Fax: +81-6117-43-2037
DSN: 315-643-2036
DSN Fax: 315-643-2037
tpao.csc@med.navy.mil</td></tr>
<tr><td>TOP Regional Call Center
Singapore: +65-6339-2676
sin.tricare@internationalsos.com
Sydney: +61-2-9273-2710
sydtricare@internationalsos.com</td><td>Medical Assistance
Singapore: +65-6338-9277
Sydney: +61-2-9273-2760</td></tr>
<tr><td>International SOS</td><td>www.tricare-overseas.com
1-703-588-1848</td><td>Customer Service
TRICAREPHL@internationalsos.com</td></tr>
</table>

TRICARE Products/Educational Materials: www.tricare.mil/smart

TRICARE Providers: www.tricare.mil/providers

TRICARE Regional Contractors:

Regional Contractor North	**Health Net Federal Services** Customer service: 1-877-874-2273
Regional Contractor South	**Humana Military Healthcare Services** Customer service: 1-800-444-5445
Regional Contractor West	**TriWest Healthcare Alliance** Customer service: 1-800-558-1746

TRICARE Regional Offices (TRO):

TRO South	www.tricare.mil/trosouth trosouthcs@tros.tma.osd.mil
TRO North	www.tricare.mil/tronorth tronorth@tma.osd.mil
TRO West	www.tricare.mil/trowest trow-southwest@trow.tma.osd.mil

TRICARE Retired Reserve: www.tricare.mil/trr

TRICARE Retiree Dental Program:

Delta Dental Plan of California

1-888-838-8737

www.trdp.org

TRICARE Reserve Select: www.tricare.mil/trs

TRICARE Service Centers: www.tricare.mil/contactus

TRICARE Website: www.tricare.mil

TRICARE Young Adult (TYA): www.tricare.mil/tya

TriWest Healthcare Alliance:

www.triwest.com

1-888-TRIWEST/1-888-874-9378

U.S. Army Wounded Warrior Program:

1-877-393-9058

www.wtc.army.mil/aw2

Uniformed Services Employment and Reemployment Rights Act (USERRA): www.dol.gov/vets

U.S. Public Health Service Beneficiary Medical Program:

1-800-368-2777, opt. 2

www.usphs.gov

US Family Health Plan (USFHP):

1-800-748-7347

www.usfhp.com

US Family Health Plan (USFHP) Designated Providers	
Johns Hopkins Medical Services Corporation (Serving central Maryland, Washington DC, and parts of Pennsylvania, Virginia and West Virginia)	USFHP Customer Service Department 6704 Curtis Court Glen Burnie, MD 21060 Toll-free: 1-800-808-7347 www.hopkinsmedicine.org/usfhp
Brighton Marine Health Center (Serving Massachusetts [including Cape Cod], Rhode Island and northern Connecticut)	US Family Health Plan 77 Warren Street Brighton, MA 02139 1-800-818-8589 www.usfamilyhealth.org
Martin's Point Health Care (Serving Maine, New Hampshire, Vermont, upstate and western New York and the northern tier of Pennsylvania)	US Family Health Plan at Martin's Point P.O. Box 9746 Portland, ME 04104-5040 1-888-241-4556 www.usfhp.com/martinspoint
Pacific Medical Centers (PacMed Clinics) (Serving the Puget Sound area of Washington State)	Pacific Medical Center (Beacon Hill) 1200 12th Avenue South Seattle, WA 98144 1-888-4-PACMED/1-888-472-2633 www.pacmed.org
CHRISTUS Health (Serving southeast Texas and Southwest Louisiana)	US Family Health Plan P.O. Box 924708 Houston, TX 77292 1-800-678-7347 www.christus.usfhp.com

U.S. State Department: www.usembassy.state.gov

Wisconsin Physicians Service (WPS): www.TRICARE4u.com

1-866-773-0404, TDD: 1-866-773-0405

WPS/TRICARE For Life
P.O. Box 7889
Madison, WI 53707-7889

Women, Infants, and Children (WIC) Overseas: www.tricare.mil/wic

Brainteaser Answer Key

Module 2: Electronic Resources

Picture: My treat
Riddle: The letter M

Module 4: TRICARE Options

1. Go long
2. Sailing over the seven seas
3. Apartment
4. Neon light
5. Split second timing
6. Man overboard
7. Tennessee
8. Free for all

Module 5: Prime Remote Options

Picture: In your dreams
Riddle: The letter E

Module 6: Transitional Benefits

Picture: Water under the bridge
Riddle: A stop light

Module 7: Pharmacy

1. Toolbox
2. Topless bathing suit
3. Let bygones be bygones
4. 7-Up Cans
5. Ice Cube
6. Son of a gun
7. GI overseas
8. Blood is thicker than water

Module 8: Dental

Picture: Reverse Psychology
Riddle: A nose

Module 9: National Guard and Reserve

1. Paradox
2. Five pounds overweight
3. Mother-in-law
4. Quarterback, halfback, fullback
5. One step forward, two steps back
6. Stuck up
7. West Indies
8. Crossbow

Module 10: Other Benefits

Picture: A man playing a saxophone/A woman's face.

Module 11: TRICARE and Medicare

1. Bridge over troubled waters
2. Tennis shoes
3. Downpour
4. 49ers
5. Final answer
6. Explain
7. Capital City
8. Adding insult to injury

Module 12: Claims and Appeals

1. Reading between the lines
2. Go stand in the corner
3. Foreign language
4. Captain Hook
5. Paradise
6. Double Dribble
7. Six feet underground
8. A little misunderstanding between two friends

TRICARE Fundamentals Course

Acronyms

14

Participant Guide

References

TRICARE Operation Manual 2008
TRICARE Policy Manual 2008
TRICARE Reimbursement Manual 2008
TRICARE Systems Manual 2008

The following list includes some of the acronyms that you may encounter when interacting with beneficiaries, working beneficiary cases, interacting with coworkers, or researching the TRICARE manuals.

Note: This list is not all inclusive.

ACN	Appointment Control Number
ADA	American Dental Association
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AMA	American Medical Association
APN	Assigned Provider Number
APO	Aerial Post Office
ASC	Ambulatory Surgical Center
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AWP	Average Wholesale Price
BCAC	Beneficiary Counseling Assistance Coordinator
BE&S	Beneficiary Education & Support
BLS	Basic Life Support
BMI	Body Mass Index
BRAC	Base Realignment and Closure
BWE	Beneficiary Web Enrollment
CAC	Common Access Card
CATCAP	Catastrophic Cap
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CDCF	Central Deductible and Catastrophic Cap File
CDT	Current Dental Terminology
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program for the Uniformed Service
CHCBP	Continued Health Care Benefits Program
CMAC	CHAMPUS Maximum Allowable Charge
CMS	Center for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Credible Coverage
CONUS	Continental United States
COR	Contracting Officer's Representative
CRSC	Combat-Related Special Compensation
CPT	Current Procedural Terminology
CRI	CHAMPUS Reform Initiative
CSS	Customer Service and Support
CY	Calendar Year
DAA	Defense Appropriations Act
DC	Direct Care

DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DEOB	Dental Explanation of Benefits
DFAS	Defense Financial and Accounting Service
DHHQ	Defense Health Headquarters
DMDC	Defense Manpower Data Center
DMIS	Defense Medical Information System
DOB	Date of Birth
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DBN	Department of Defense Benefit Number
DoD ID Number	Department of Defense Identification Number
DOES	Defense Online Enrollment System
DOS	Date of Service
DPO	Dental Provider Organization
DPP	Deployment Prescription Program
DRG	Diagnostic Related Group
DS (Logon)	DoD Self-Service (Logon)
DSO	DMDC Support Office
DTF	Dental Treatment Facility
DTS	Defense Travel System
DX	Diagnosis
DXCD	Diagnosis Code
ECHO	Extended Care Health Option
EFMP	Exceptional Family Member Program
EFT	Electronic Funds and Transfers
EHHC	ECHO Home Health Care
EOB	Explanation of Benefits
EOC	Episode of Care
ER	Emergency Room
ESI	Express Scripts Inc.
ESRD	End Stage Renal Disease
FAQ	Frequently Asked Question
FDA	Food and Drug Administration
FEHB	Federal Employee Health Benefit
FFM	Foreign Force Member
FFS	Fee For Service
FPO	Fleet Post Office
FRC	Federal Records Center
FY	Fiscal Year
GIQD	General Inquiry of DEERS

HA	Health Affairs
HA/TMA	Health Affairs/TRICARE Management Activity
HBA	Health Benefits Advisor
HCF	Health Care Finder
HCPC	Healthcare Common Procedure Code
HEDIS	Health Plan Employer Data and Information Set
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HIPAA	Health Insurance Portability and Accountability Act
HMHS	Humana Military Health Services
HMO	Health Maintenance Organization
HNFS	Health Net Federal Services
HNP	Host Nation Provider
IA	Information Assurance
ICN	Internal Control Number
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ID	Identification
IP	Inpatient
IPPS	Inpatient Prospective Payment System
IRR	Individual Ready Reserve
JFTR	Joint Federal Travel Regulation
LOD/LOD-D	Line of Duty/Line of Duty Determination
LOS	Length of Stay
MCC	Member Choice Center (Pharmacy benefit-related)
MCSC	Managed Care Support Contractor
MHS	Military Health System
MMSO	Military Medical Support Office
MOH	Medal of Honor
MSN	Medicare Summary Notice
MTF	Military Treatment Facility
NARF	Non-Availability Referral Form
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NDAA	National Defense Authorization Act
NEO	Non-Combatant Evacuation Operations
NOAA	National Oceanic and Atmospheric Administration
NOE	Notice of Eligibility
OASD/HA	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	Outside the Continental United States
ODTF	Overseas Dental Treatment Facility
OGC	Office of the General Counsel

OHI	Other Health Insurance
OP	Outpatient
OPPS	Outpatient Prospective Payment System
OSD	Office of the Secretary of Defense
OTC	Over-the-Counter
P&R	Personnel and Readiness
P&T	Pharmacy & Therapeutics
PacMed	Pacific Medical Centers/Clinics
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCP	Primary Care Physician/Provider
PDTS	Pharmacy Data Transaction Service
PEC	PharmacoEconomic Center
PEPR	Patient Encounter Processing Reporting
PGBA	Palmetto Government Benefits Administrators
POC	Point of Contact or Pharmacy Operations Center
POS	Point of Service
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSA	Prime Service Area
PTSD	Post Traumatic Stress Disorder
QLE	Qualifying Life Event
R-ADDP	Remote Active Duty Dental Program
RAPIDS	Real-Time Automated Processing Identification System
RC	Reserve Component
RCPTA	Reserve Component Purchased TRICARE Application
RD	Regional Director
RVU	Relative Value Unit
SELRES	Selected Reserve
SF	Standard Form
SPOC	Service Point of Contact
SSA	Social Security Administration
SSAN	Social Security Administration Number
SSN	Social Security Number
TAD	Temporary Additional Duty
TAMP	Transitional Assistance Management Program
TAO	TRICARE Area Office
TCSRC	Transitional Care for Service-Related Condition
TDD	Telecommunications Device for the Deaf
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program
TDY	Temporary Duty

TED	TRICARE Encounter Data
TFC	TRICARE Fundamentals Course
TFL	TRICARE for Life
TIN	Taxpayer Identification Number (provider claims) or Temporary Identification Number (for DMDC purposes)
TLAC	TRICARE Latin America and Canada
TMA	TRICARE Management Activity
TMAC	TRICARE Maximum Allowable Charge
TOL	TRICARE Online
TOM	TRICARE Operations Manual
TOP	TRICARE Overseas Program
TOPD	TRICARE OCONUS Preferred Dentists
TOP POC	TRICARE Overseas Program Point of Contact
TPL	Third Party Liability
TPM	TRICARE Policy Manual
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TQMC	TRICARE Quality Monitoring Contract
TRDP	TRICARE Retiree Dental Program
TRM	TRICARE Reimbursement Manual
TRO	TRICARE Regional Office
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy Benefit
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TSM	TRICARE Systems Manual
TTY	Teletypewriter
TYA	TRICARE Young Adult
UCCI	United Concordia Companies, Inc.
URFS	Unremarried Former Spouse
USERRA	Uniformed Services Employment and Reemployment Rights Act
USFHP	US Family Health Plan
USMTF	Uniformed Services Military Treatment Facility
USPHS	United States Public Health Service
VA	Veterans Affairs/Administration
VHA	Veterans Health Administration
WIC	Women, Infants, and Children Overseas Program
WPS	Wisconsin Physicians Service
WSM	Wounded Service Member
WTU	Warrior Transition Unit
WWR	Wounded Warrior Regiment

TRICARE Fundamentals Course

Glossary of Terms

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Participant Guide

References

www.tricare.mil/mybenefit/Glossary
2002 TRICARE Operations Manual, Appendices
2008 TRICARE Operations Manual, Appendix B

The following glossary lists and defines common terms seen when working with TRICARE beneficiaries. This list is not all inclusive. For additional terms, please go to www.tricare.mil/mybenefit/Glossary.do or consult the TRICARE manuals at http://manuals.tricare.osd.mil.

20th-of-the-Month Rule
The effective date of certain TRICARE programs as determined by the date the contractor receives the enrollment form. If received by the 20th of the month, coverage begins on the first day of the next month. If received after the 20th of the month, coverage begins on the first day of the second month following receipt of the application. Note that the application must be received and in processing by the 20th of the month, not merely postmarked by the 20th of the month.

Access Standards
Established standards for access to care in a timely manner and within a reasonable distance for TRICARE Prime enrollees. Drive times and distances may vary slightly depending on which Prime option the enrollee uses. In general, Prime access standards are:

- The wait time for an urgent care appointment should not exceed 24 hours (one day).
- The wait time for a routine appointment should not exceed one week (seven days).
- The wait time for a specialty care appointment or wellness visit should not exceed four weeks (28 days).

Additionally, Prime enrollees should have access to a primary care manager whose office is within 30 minutes of their home (under normal driving circumstances); specialty care should be available within one hour from their home.

Active Duty Service Member (ADSM)
An individual currently serving in one of the seven uniformed services of the United States under a call or order that does not specify a period of 30 days or less.

Adjunctive Dental Care
Dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition; or, is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

Appeal
A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative to resolve a disputed question of coverage, payment, or status.

Authorization for Care
The determination made by a licensed health care professional that a beneficiary's requested treatment, service, procedure or admission is medically necessary, delivered in the appropriate setting, and is a TRICARE benefit.

Authorized Providers
An authorized provider is any individual, institution/organization, or supplier that is licensed by a state, accredited by a national organization, or meets other standards of the medical community and is certified to provide benefits under TRICARE. It's the beneficiary's responsibility to determine whether a provider is TRICARE-authorized. Regional contractors must verify a provider's authorized status before they pay any portion of a claim.

Balance Billing
When a provider bills a beneficiary for the difference between billed charges and the TRICARE allowable charge after TRICARE (and any other health insurance) and the beneficiary have paid their required amounts. Network and participating providers are prohibited from balance billing. By law, non-participating providers can only be paid up to 15 percent above the TRICARE allowable charge.

Benefit
The TRICARE benefit consists of those services, (payment amounts, cost-shares, and copayments) authorized by Title X and implemented via the TRICARE manuals. The TRICARE benefit is an entitlement under the law (Title 10 and Code of Federal Regulation) and addresses payment for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

Beneficiary
A person who, by law, is eligible for TRICARE benefits. Beneficiaries include: active duty service members (ADSMs) and their families, retired service members and their families, certain National Guard and Reserve members and their families, survivors and widows, certain unremarried former spouses, and Medal of Honor recipients and their families and others identified as being eligible by the respective uniformed services. Family members include spouses and children (biological, adopted, or step) up to age 21, 23, or 26 (depending on the child's eligibility).

Beneficiary Counseling and Assistance Coordinator (BCAC)
Individuals assigned to military treatment facilities (MTFs) and TRICARE Regional and Area Offices, who serve as beneficiary advocates and are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining health care under TRICARE.

Billed Charge
The total cost of care from a provider, without discounts or reduced fees.

Beneficiary Liability
The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of health care or treatment received. Specifically, for the purposes of services and supplies covered by TRICARE, beneficiary liability includes any annual deductible amount, cost-sharing amounts, or amounts above the TRICARE-determined allowable cost or charge when using a non-participating provider. Beneficiary liability also includes expenses for health care or related services and supplies not covered by TRICARE.

Cashless-Claimless
TRICARE Overseas Program (TOP) Prime/TOP Prime Remote experience when seeking prior-authorized care from a specific, certified host nation provider. The provider files the claim and the TOP contractor pays the provider. The enrollee is not required to pay up front for services.

Catastrophic Cap
The maximum out-of-pocket expenses that a TRICARE beneficiary is responsible for in a given fiscal year (October 1–September 30). The following expenses are not creditable to the catastrophic cap:

- Point-of-service (POS) cost-shares and deductibles
- The additional 15 percent above the TRICARE-allowable charge that beneficiaries pay to non-participating providers
- TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and TRICARE Young Adult (TYA) premiums
- Costs for services that are not covered by TRICARE

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)
A program of medical care for spouses and dependent children of disabled or deceased disabled veterans who meet the eligibility requirements of the Department of Veterans Affairs.

Claim
A document that reflects a request for payment from a beneficiary, a beneficiary's representative, or a network or non-network provider for health care services rendered. This includes requests for reimbursement of dispensed pharmaceutical agents and equipment and supply items.

Clinical Preventive Services
Services such as health screenings and examinations, often conducted at regular intervals, that are meant to keep individuals healthy or detect health problems in a timely manner. Preventive services include procedures like pap smears, mammograms, colorectal cancer exams, prostate cancer exams, cholesterol tests, and vaccinations

Confidentiality Requirements
The procedures and controls that assure the confidentiality of medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, the Privacy Act, and the Health Insurance Portability and Accountability Act (HIPAA).

Contingency Operation
A military operation that results in the call or order to, or retention of, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

Continued Health Care Benefit Program (CHCBP)
A premium-based health care program that offers temporary transitional health coverage for 18 to 36 months after TRICARE eligibility or premium-based program coverage ends for certain former beneficiaries.

Contractor
An organization with which TMA enters into a contractual agreement for delivery of and/or processing of payment for services, performance of related administrative support activities, such as enrollment/application processing, claims processing, quality monitoring or customer service.

Coordination of Benefits
The process by which TRICARE delays coverage determinations and claims processing on a claim until all other coverage plans (other health insurance, Medicare) complete their claims' process, except for Medicaid, the Indian Health Service and other programs identified by the Director, TMA (e.g., States Victim Assistance Programs).

Copayment
The fixed amount a TRICARE Prime enrollee pays for care in the civilian sector.

Cost-Share
The amount/percentage a beneficiary pays for covered inpatient and outpatient services as set forth in 32 CFR 199.4, 199.5, and 199.17.

Date of Determination
The date of completion appearing on a reconsideration determination, formal review determination, or hearing final decision.

Debt Collection Assistance Officer (DCAO)
Persons located at military treatment facilities (MTFs) and TRICARE Regional Offices (TROs/TAOs) who assist in resolving TRICARE-related collection actions. DCAOs work with beneficiaries that have a negative credit rating or were sent to a collection agency for a TRICARE-related debt.

Deductible
The amount beneficiaries have to pay in any one fiscal year before TRICARE begins cost-sharing.

Defense Enrollment Eligibility Reporting System (DEERS)
A system operated by the Defense Management Data Center used to reflect personal, eligibility, enrollment, and catastrophic cap information. Beneficiaries are responsible for maintaining the accuracy of their DEERS records.

Defense Manpower Data Center (DMDC)
The office responsible for the DEERS data repository and providing customer service to beneficiaries trying to establish, maintain, or determine their eligibility for TRICARE. DMDC also sends beneficiaries certificates of creditable coverage upon loss of eligibility.

Demonstration
A study or test project with respect to alternative methods of delivery and payment for health services, cost-sharing by eligible beneficiaries, methods of encouraging efficient and economical delivery of care, innovative approaches to delivery and financing services and prepayment for services provided to a defined population. Following completion and evaluation of the test project, it may or may not become part of the benefit.

Dental Treatment Facility (DTF)
Military facilities that provide dental care, primarily to active duty service members. DTFs may see other beneficiaries based on capacity and capability.

DoD Benefit Number (DBN)
A unique 11-digit family member identifier that ties a family member to a sponsor and identifies the cardholder as one who has DoD benefits, such as health care and base exchanges services.

DoD Identification Number (DoD ID)
A 10-digit electronic DoD identification number that replaces the sponsor's Social Security number on the uniformed services ID and the Common Access Card (CAC) as a means to identify specific individual's eligibility for services.

Double Coverage
Coverage of a TRICARE beneficiary in another insurance, medical service, or health plan that may duplicate all or part of a beneficiary's TRICARE benefits.

Emergency Services
Medical services provided for a sudden or unexpected medical, dental, or psychiatric condition, or the sudden worsening of a chronic (ongoing) condition that is threatening to life, limb, or sight and needs immediate medical treatment, or which has painful symptoms that need immediate relief to stop a beneficiary's suffering.

Enrollee
A TRICARE beneficiary who elects coverage under a TRICARE Prime option (including USFHP).

Enrollment Fees
The amount paid by some categories of beneficiaries to enroll in and receive the benefits of a TRICARE Prime option (including USFHP).

Enrollment Transfer (Portability)
A transfer of TRICARE Prime enrollment from one location to another. There are two types of enrollment transfers:

- Between regions—Usually involves a change of contractor and primary care manager (Note: The term "contractors" includes the US Family Health Plan.)
- Within a region—Usually involves a change of address and possibly primary care managers

Exceptional Family Member Program (EFMP)
A mandatory Department of Defense enrollment program that works with military and civilian government agencies to provide comprehensive and coordinated community support, housing, education, health care, and personnel services worldwide to U.S. military families with special needs. EFMP registration is especially important when family members are being screened for approval to accompany their sponsor to an overseas location on permanent change of station orders.

Explanation of Benefits (EOB)
A statement, prepared by insurance carriers, health care organizations, and TRICARE, informing beneficiaries and providers of actions taken on a claim.

Exclusion
Exclusion means that items, services, and/or supplies furnished can't be reimbursed under TRICARE.

Extended Care Health Option (ECHO)
ECHO is a supplemental program to the TRICARE basic program. ECHO provides qualified active duty family members (ADFMs) with an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the family member's qualifying condition, such as moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is home bound.

Fee for Service (FFS)
TRICARE Standard is a fee-for-service option.

Fiscal Year (FY)
The federal government's 12-month accounting period, which runs from October 1–September 30.

Fit for Duty
Medical and/or dental status of an active duty service member (ADSM), as determined by the member's service.

Freedom of Information Act (FOIA)
A law enacted in 1967, as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing provisions making information available to the public. TMA and contractors are subject to these provisions.

Grievance
A written complaint by a beneficiary on a non-appealable issue which primarily deals with a perceived failure of a network provider, contractor, subcontractor, or contracted providers to furnish the level or quality of care and or service expected by a beneficiary.

Good Faith Payments
Payments made to civilian providers for care to persons presenting as TRICARE eligible but who are determined later to be ineligible for benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must use reasonable precautions to identify a person as eligible (e.g., copy of ID card, online inquiry) and billed the beneficiary for services provided.

Health Benefits Advisors (HBAs)
Individuals located at military treatment facilities (on occasion at other locations) that are responsible for providing general information concerning availability and access to care in the uniformed services, direct medical care system, and information on TRICARE benefits.

Health Insurance Portability and Accountability Act (HIPAA)
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

Health Maintenance Organization (HMO)
A health plan in which a fixed member pays a premium for an assortment of medical services, usually including primary and preventive care. The primary purpose of an HMO is to coordinate care to eliminate unnecessary care and costs. HMOs typically have copayments rather than cost-shares. The TRICARE Prime options are similar to HMOs.

Host Nation Provider
A hospital, clinic, laboratory, individual doctor or provider certified to practice or deliver health care in a foreign country.

Initial Determination
A formal written decision on a TRICARE claim, a request for benefit authorization, a request by a provider for approval as a TRICARE-authorized provider, or a decision sanctioning a TRICARE provider. EOBs are considered initial determination documents.

Inpatient Care
Care provided to a patient admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, with the registration and assignment of an inpatient number or designation.

Inquiry
Requests for information or assistance made by or on behalf of a beneficiary, provider, the public or the government. Written inquiries may be made in any format (e.g., letter, memorandum, note attached to a claim). Allowable charge complaints, grievances, and appeals are not included in this definition.

Managed Care Support Contractor (MCSC)
Regional contractors providing managed care support to the Military Health System (MHS). The MCSCs are responsible for assisting the TMA Regional Directors, TROs, TAOs, and MTF Commanders in operating an integrated health care delivery system, combining resources of the military's direct medical care system and the contractor's managed care support to provide health, medical and administrative support services to eligible beneficiaries.

Medicaid
Medical benefits program authorized under Title XIX of the Social Security Act that is provided to qualified recipients as administered by various state agencies.

Medically Necessary
A collective term for determinations based on medical necessity, appropriate level of care, custodial care or other reason relative solely to reasonableness, necessity or appropriateness. By law, TRICARE may only pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury. Benefits are restricted to drugs, devices, treatments, or procedures for which the safety and efficacy are proven to be comparable or superior to conventional therapies.

TRICARE uses a hierarchy of reliable evidence to determine whether a drug, device, medical treatment or procedure moves from the status of unproven to the position of nationally accepted medical practice, as evidence includes:

- Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature
- Published formal technology assessments
- Published reports of national professional medical associations
- Published national medical policy organization positions
- Published reports of national expert opinion organizations

Medical Necessity
A determination as to the reasonableness, necessity, and appropriateness of care.

Medical Necessity Determination—Pharmacy
A review by the pharmacy contractor of non-formulary drugs and whether or not a beneficiary will pay the full non-formulary copayment for a drug. If medical necessity is justified, a beneficiary pays the formulary copayment for all prescriptions for the non-formulary drug. Generally, for medical necessity to be established, one or more of the following criteria must be met for **all** of the available **formulary** alternatives:

- The use of the formulary alternative is contraindicated
- The beneficiary experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the beneficiary is reasonably expected to tolerate the non-formulary medication
- The formulary alternative results in therapeutic failure, and the beneficiary is reasonably expected to respond to the non-formulary medication
- The beneficiary previously responded to a non-formulary medication and changing to a formulary alternative would incur unacceptable clinical risk
- There is no formulary alternative

Medicare
Medical benefits authorized under Title XVIII of the Social Security Act that are provided to persons 65 or older, certain disabled persons, persons with end stage renal disease or amyotrophic lateral sclerosis, and individuals of Lincoln County, Montana who have an asbestos-related disease. Medicare is divided into four parts:

- Medicare Part A: Covers inpatient stays, to include hospice and skilled nursing facility care.
- Medicare Part B: Covers outpatient services and products, such as doctor's services, outpatient hospital care and other medical services that Part A does not cover (e.g., physical and occupational therapy, x-rays)
- Medicare Part C (Medicare Advantage Plan): Provides all of Medicare Part A and Part B coverage, and may offer vision, hearing, dental and/or health and wellness coverage—a type of Medicare HMO.
- Medicare Part D: A prescription drug program available through Medicare-approved private insurance carriers.

Medical Summary Notice (MSN)
After receiving a Medicare-covered service, Medicare sends Medicare eligible beneficiaries a Medicare Summary Notice (MSN) by mail every three months. The notice shows what services and/or supplies providers and suppliers billed to Medicare during that three month period, what Medicare paid, and what the beneficiary may owe the provider. This notice is not a bill.

Military Medical Support Office (MMSO)
The joint services organization responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty for service members in remote locations. MMSO is also responsible for authorizing care related to a line of duty injury, illness, or condition for inactive Guard/Reserve. Service Points of Contact (SPOCs) for Army, Marine Corps, Navy, and Air Force active duty service members are assigned to the MMSO.

Military Treatment Facility (MTF)
A hospital or clinic run by the military, usually located on a military installation.

Military Treatment Facility (MTF)-Referred Care
When MTF Prime enrollees require medical care that is not available at the MTF, the MTF refers the person to another MTF or to the civilian sector. The regional contractor then issues an authorization determination.

National Defense Authorization Act (NDAA)
The NDAA is under the jurisdiction of the Senate and House Armed Services Committees and provides statutory direction across all DoD programs by establishing, changing, or eliminating programs and activities, to include uniformed services health care services. Established TRICARE in public law.

Negotiated Rate
The negotiated or discounted rate that contracted network providers agree to accept for covered services.

Network
The network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the contractor as part of the total contracted delivery system. The agreements for health care delivery made by the contractor with the MTFs are also included in this definition.

Network Pharmacies
Retail pharmacies that serve TRICARE beneficiaries through a contractual agreement with the pharmacy contractor.

Network Provider
A professional or institutional provider who has a contractual relationship with a TRICARE regional contractor to provide care services at a negotiated rate. A network provider agrees to follow TRICARE program requirements, file claims and handle other paperwork for TRICARE beneficiaries and typically administers care to TRICARE Prime beneficiaries and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option). A network provider accepts the negotiated rate as payment in full for services rendered.

Non-Network Provider
Non-network providers do not sign agreements with regional contractors. They still have to be TRICARE authorized for TRICARE to pay on the claim. May be a participating or non-participating provider.

Non-Participating Provider
A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnishes medical services or supplies to a TRICARE beneficiary, but does not agree to participate or to accept the TRICARE-determined allowable cost or charge as the total charge for the services. A non-participating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider. The beneficiary is responsible for paying the non-participating provider.

Other Health Insurance (OHI)
Health care insurance, medical plan or other entity that offers health care benefits. OHI is acquired through an employer, entitlement program, or other source.

Out-of-Pocket Costs
The amount of money a beneficiary pays for services. This includes enrollment fees, cost-shares, deductibles, copayments, and personal expenses for the point of service option and for non-covered services.

Participating Provider
An authorized provider who agrees to accept the TRICARE-allowable charge (government + beneficiary cost shares) as payment in full. TRICARE-allowable charge plus applicable cost-shares is paid by the beneficiary as payment in full for services. Non-network providers may choose to participate on a claim-by-claim basis.

Pending Claim, Correspondence, or Appeal
The claim/correspondence/appeal case has been received but a final determination hasn't yet been made.

Point of Service (POS)
The POS option allows Prime option enrollees to self-refer for nonemergency care to any TRICARE-authorized provider. The enrollee pays a 50% cost share when using the POS option.

Preferred Provider Organization (PPO)
An organization of providers who, through contractual agreements with a contractor, agree to provide services to beneficiaries at agreed upon rates and to file claims on behalf of the beneficiary. TRICARE Extra is a PPO-like option for Standard beneficiaries who use network providers.

Primary Care
The standard, usual, and customary services provided as routine care. Services include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services include care for routine illness and injury; periodic physical examinations of newborns, infants, children, and adults; immunizations, injections, allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services also include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

Primary Care Manager (PCM)
An MTF provider, team of providers or a civilian network provider to whom a Prime-option enrollee is assigned for primary care services. Enrollees agree to initially seek all nonemergency, non-mental health care services from their PCMs.

Prime Service Area (PSA)
A geographic area where TRICARE Prime benefits are offered. Regional contractors are required to establish a Prime Service Area at MTF and Base Realignment and Closure locations.

Prior Authorization
A process of reviewing requests for medical, surgical, and behavioral health services to ensure medical necessity, appropriateness of care, and TRICARE coverage prior to services being rendered (or within 24 hours of an emergency admission). Services requiring prior authorization may vary from region to region.

Privacy Act, 5 USC 552a
A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. At the same time, it requires Government activities which collect, maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

Professional Fees
Charges for medical professional services that hospitals or third-party payers require to be separately identified on an inpatient billing form.

Provider
A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies in accordance with 32 CFR 199.

Provider Termination
When a provider's status as a TRICARE-authorized provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications to be a TRICARE-authorized provider.

Reconsideration
An appeal to a contractor of an initial determination issued by the contractor.

Referral
The process of sending a beneficiary to another professional provider for consultation or a health care service that the referring provider believes is necessary but is not prepared or qualified to provide.

Region
A geographic area determined by the U.S. Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Regional Contractor
A TRICARE civilian health care partner who provides health care services and support in each TRICARE region. The regional contractors help combine the services available at military treatment facilities (MTFs) and those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of beneficiaries within the region.

Regional Director
The individual responsible for supporting TRICARE contract administration in a specific region and directing the activities of the TRICARE Regional Office (TRO).

Residence
For TRICARE purposes, "residence" is a beneficiary's dwelling place for day-to-day living. A temporary living place during periods of temporary duty or during a period of confinement, such as a residential treatment center, does not constitute a residence. Minor children's residence is the same as the residence of the custodial parent(s) or the legal guardian. Incompetent adult beneficiaries' residence is the same as the residence of the legal guardian. Under split enrollment, when an eligible family member resides away from home while attending school, their residence is where they currently live.

Respite Care
Short-term care for a patient in order to provide rest and change for primary caregivers who have been caring for the patient at home. Respite care consists of providing skilled and non-skilled services to a beneficiary such that in the absence of the primary caregiver, management of the beneficiary's qualifying condition and safety are provided.

Retiree
A member or former member of a uniformed service who is entitled to retired, retainer, or equivalent pay based on duty in a uniformed service.

Routine Care
Includes general office visits for the treatment of symptoms, chronic or acute illnesses, diseases and follow-up care for an ongoing medical condition including preventive care. Also known as primary care.

Secondary Payer
The plan or program whose medical benefits are payable in double coverage situations only after the primary payer adjudicates the claim.

Service Point of Contact (SPOC)
The uniformed services office or individual responsible for coordinating civilian health care for active duty service members (ADSMs) in stateside remote locations and the Virgin Islands and line-of-duty care for Guard/Reserve members. The service point of contact (SPOC) reviews requests for specialty and inpatient care to determine the impact on the ADSM's fitness for duty; determines whether the ADSM receives care related to fitness for duty at a medical military treatment facility (MTF) or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for the remote ADSMs. The SPOC is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. SPOCs are assigned to the Military Medical Support Office (MMSO).

Specialty Care
Specialized medical diagnosis, treatment, or services that a primary care physician cannot provide.

Split Enrollment
Refers to multiple family members enrolled in a TRICARE Prime option under different regional contractors, including stateside and overseas and U.S. Family Health Plan (USFHP) designated providers.

Sponsor
The active duty service member, Guard/Reserve member, or retiree through whom family members are eligible for TRICARE.

Student Status
A dependent of a member or former member of a uniformed service who has not passed age 23, is enrolled as a full-time student in an accredited institution of higher learning, and is dependent on the sponsor for over 50 percent of his/her financial support.

Supplemental Health Care Program (SHCP)
The SHCP is a program for eligible uniformed service members and other designated patients who require medical care that is not available at a military treatment facility (MTF) and that upon the approval of the MTF Commander or the Director, TMA may be purchased from civilian providers under TRICARE payment rules.

Survivor
The status of a spouse three years after their active duty sponsor's death, as determined by the service. Survivors have the same enrollment fees, cost-shares, and copayments as a retiree family member.

Third Party Liability (TPL) Claims
TPL claims are claims in favor of the Government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The Government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (FMCRA).

Third Party Payer
An insurance, medical service, or health plan that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies (e.g., automobile liability insurance, no fault insurance carrier, worker's compensation program or plan).

Timely Filing
The filing of TRICARE claims within prescribed time limits.

Transitional Assistance Management Program (TAMP)
Transitional health care for certain uniformed service members and their eligible family members who separate from active duty.

Transitional Care for Service Related Conditions (TCSRC)
The TCSRC benefit provides extended transitional health care coverage to former active duty service members with certain service-related conditions. The TCSRC coverage period is 180 days from the date the diagnosed condition is validated by a Department of Defense (DoD) physician. Family members are not eligible for this benefit.

Transitional Survivor
A TRICARE-eligible family member whose sponsor, at the time of death, was on active duty for 30 consecutive days or more. Transitional survivors are eligible to receive the same health care benefits as active duty family members to include coverage under Prime options, for as long as they maintain TRICARE eligibility. Spouses of the deceased sponsor are considered transitional survivors for three years from the date of the sponsor's death. Eligible dependent children (including qualifying students over 18) of the deceased sponsor remain transitional survivors as long as they remain eligible for TRICARE.

TRICARE
The DoD's managed health care program for active duty service members (ADSMs), service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard plan, TRICARE Extra plan, and TRICARE Prime plan.

TRICARE-Allowable Charge
The maximum amount TRICARE pays for a particular covered service. By law, the TRICARE allowable charge matches Medicare rates whenever practical.

TRICARE Area Office (TAO)
The office responsible for the development and execution of an integrated plan for the delivery of health care, within designated areas in the overseas region, including Eurasia-Africa, Latin America/Canada, and the Pacific.

TRICARE-Authorized Provider
A provider who meets TRICARE's licensing and certification requirements and is certified to provide care to TRICARE beneficiaries. There are two types of TRICARE-authorized providers: network and non-network.

TRICARE Dental Program (TDP)
A voluntary premium-based dental insurance program available to eligible active duty family members (ADFMs), members of the National Guard and Reserve and their families, and other select members.

TRICARE Extra
An option similar to a preferred provider organization (PPO) where Standard beneficiaries choose to receive care from civilian network providers (with reduced cost-sharing).

TRICARE for Life (TFL)
TRICARE for Life combines TRICARE Standard coverage with Medicare Part A and Medicare Part B to provide wrap-around medical coverage to beneficiaries worldwide who are eligible for Medicare and TRICARE. These are also known as dual-eligible beneficiaries. TRICARE beneficiaries entitled to premium-free Medicare Part A are required by federal law to have Medicare Part B to remain TRICARE eligible (with some exceptions).

TRICARE Management Activity (TMA)
The Department of Defense organization responsible for managing the TRICARE contracts and day-to-day operations of the TRICARE benefit.

TRICARE Overseas Program (TOP)
The Department of Defense's health care program in all geographic areas and territorial waters outside of the 50 United States and the District of Columbia.

TRICARE Overseas Program-Prime (TOP Prime)
TOP Prime offers the benefits of TRICARE Prime in overseas military treatment facility (MTF) locations. TOP Prime enrollees are assigned a primary care manager (PCM) who delivers and/or manages routine and urgent medical care and coordinates care with the overseas contractor as needed. TOP Prime enrollees pay no copayments, cost-shares or deductibles for care rendered by the PCM or for authorized services rendered by a purchased care/host nation provider. TOP Prime is only available to active duty service members (ADSMs) and command-sponsored family members.

TRICARE Overseas Program Prime Remote (TOP Prime Remote)
Offers the benefits of TRICARE Prime to active duty service members (ADSMs) permanently assigned to designated remote overseas locations, and to their eligible family members. The TOP contractor has networks of licensed, purchased care/host nation providers in these remote overseas locations to deliver health care to TOP Prime Remote enrollees. The TOP contractor acts as enrollee's PCMs and authorizes all other care provided by host-nation providers.

TRICARE Plus
A primary care enrollment program offered at select military treatment facilities (MTFs). All beneficiaries eligible for care at MTFs (except those enrolled in TRICARE Prime or a health maintenance organization (HMO)) may seek enrollment for primary care at select MTFs where enrollment capacity exists.

TRICARE Prime
A health management organization (HMO)-like option where beneficiaries voluntarily enroll in a program which provides TRICARE Standard benefits and enhanced primary and preventive benefits with nominal beneficiary cost-sharing. TRICARE Prime requires beneficiaries to use a primary care manager (PCM) located at either the MTF or from the contractor's network and follow Prime rules for accessing specialty care services, except when beneficiaries are exercising their freedom of choice under the point-of-service (POS) option.

TRICARE Prime Remote (TPR)
A TRICARE Prime option that provides health care coverage through civilian network or TRICARE-authorized providers for uniformed service members who are assigned to duty stations and reside in remote areas, typically 50 or more miles from a military treatment facility (MTF). TPR requires enrollment.

TRICARE Prime Remote for Active Duty Family Members (TPRADFM)
A TRICARE Prime option that provides health care coverage through civilian network or TRICARE-authorized providers for family members of uniformed service members who are assigned to duty stations and reside in certain designated remote areas, typically 50 or more miles from a military treatment facility. TPRADFM requires enrollment; family members must reside with the sponsor (with some exceptions).

TRICARE Prime Service Area (PSA)
A geographic area where TRICARE Prime benefits are offered. At a minimum, this includes areas around MTFs and Base Realignment and Closure (BRAC) sites.

TRICARE Regional Office (TRO)
A division of the TRICARE Management Activity (TMA) which oversees the integrated health care delivery system in the three United States-based TRICARE regions: North, South, and West.

TRICARE Reserve Select (TRS)
A premium-based health care plan that qualified Selected Reserve members may purchase for themselves and eligible family members. Offers TRICARE Standard benefits.

TRICARE Retired Reserve (TRR)
A premium-based, worldwide health plan that qualified Retired Reserve members may purchase for themselves and eligible family members. Offers TRICARE Standard benefits.

TRICARE Retiree Dental Program (TRDP)
A voluntary dental insurance program available for purchase by retired service members and their family members.

TRICARE Service Center (TSC)
A customer service center operated by the regional contractors and TRICARE Area Offices (TAOs) in each TRICARE region or overseas area. The TSC can help with enrollment, specialty care authorizations, and provides general TRICARE information and claim-processing assistance.

TRICARE Standard
A fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized provider. Beneficiaries are responsible for payment of an annual deductible and cost-shares, and may be responsible for other costs.

TRICARE Young Adult (TYA)
Voluntary premium-based program that extends TRICARE coverage to certain family members under the age of 26 who have lost or will lose TRICARE eligibility due to age (typically 21 or 23).

Uniform Formulary
A list of TRICARE-covered prescription medications and supplies.

Uniformed Services
The seven uniformed services of the United States are: U.S. Army, U.S. Marine Corps, U.S. Navy, U.S. Air Force, U.S. Coast Guard, Commissioned Corps of the United States Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). The services determine TRICARE eligibility.

Uniformed Services Employment and Reemployment Rights Act (USERRA)
USERRA provides employment/reemployment protection to uniformed service members who perform military service.

United States Public Health Service (USPHS)
An agency within the U.S. Department of Human Health Services (HHS) that has a Commissioned Corps that are classified as members of the “uniformed services.”

Unproven Drugs, Devices, and Medical Treatments or Procedures
Drugs, devices, medical treatments or procedures are considered unproven if:

- FDA approval is required and has not been given
- If the device is a FDA Category A Investigational Device Exemption (IDE)
- If there is no reliable evidence that documents that the treatment or procedure has been the subject of well-controlled studies of clinically meaningful endpoints that have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis
- If the reliable evidence shows that the consensus among experts regarding the treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis.

Urgent Care
Medically necessary services required for illnesses or injuries that will not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

US Family Health Plan (USFHP)
A TRICARE Prime-like option available in six geographic locations across the United States that offers benefits to active duty family members (ADFMs), retirees and their eligible family members, survivors, certain former spouses and other eligible beneficiaries (active duty service members cannot enroll in USFHP).

Veteran
A person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable. Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," (which refers to payments of a continuing nature and are payable at fixed intervals from the Government for military service) neither the veteran nor his or her family members are eligible for benefits under TRICARE.