TRICARE® Stateside Guide

Your guide to TRICARE stateside benefits

Welcome to the TRICARE Stateside Guide

We are committed to providing you and your family access to the best possible health care around the globe. TRICARE brings together military hospitals and clinics with a network of civilian health care providers to offer you medical program options, dental programs and a pharmacy benefit.

This page highlights a few handy features you'll find throughout this guide to help you get the information you need about your TRICARE benefit.

We look forward to serving your health care needs.

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A Note About TRICARE Program Information

At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. Military hospital and clinic guidelines and policies may be different than those outlined in this publication. For the most recent information, contact your TRICARE regional contractor or your local military hospital or clinic. More information about TRICARE, including the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, can be found online at www.tricare.mil.

TRICARE Meets the Minimum Essential Coverage Requirement under the Affordable Care Act

The Affordable Care Act (ACA) requires most Americans to maintain basic health care coverage, called minimum essential coverage. The TRICARE program meets the minimum essential coverage requirement under the ACA. The Internal Revenue Service will collect penalties from most individuals who do not maintain minimum essential coverage. Visit www.tricare.mil/aca for more information about your minimum essential coverage requirement. You can also find other health care coverage options at www.healthcare.gov.

TRICARE Beneficiary Rights and Responsibilities

As a TRICARE beneficiary, you have rights regarding your health care and responsibilities for participating in your health care decisions.

Patient Rights

As a patient in the Military Health System (MHS), you have the right to:

- Easy-to-understand information about TRICARE.
- A choice of health care providers that is sufficient to ensure access to appropriate high-quality health care. Some restrictions apply to active duty service members.
- Necessary emergency health care services.
- Review information about the diagnosis, treatment and progress of your condition.
- Fully participate in all decisions related to your health care or to be represented by family members, conservators or other duly appointed representatives if you are unable to fully participate in treatment decisions.
- Considerate, respectful care from all members of the health care system without discrimination based on race, ethnicity, national origin, religion, sex, age, intellectual or physical disability, sexual orientation, genetic information or source of payment.
- Communicate with health care providers in confidence and to have the confidentiality of your health care information protected.
- Review, copy and request amendments to your medical records.
- A fair and efficient process for resolving differences with your health plan, health care providers and the institutions that serve you.

Patient Responsibilities

As a patient in the MHS, you have the responsibility to:

- Maximize healthy habits, such as exercising, not using tobacco and maintaining a healthy diet.
- Be involved in health care decisions, which means working with providers in developing and carrying out agreed-upon treatment plans, disclosing relevant information and clearly communicating your wants and needs.
- Be knowledgeable about TRICARE coverage and program options, including covered benefits; limitations; exclusions; rules regarding use of network providers; coverage and referral rules; appropriate processes to secure additional information; and appeals, claims and grievance processes.
- Be respectful of other patients and health care workers.
- Make a good-faith effort to meet financial obligations.
- Follow the claims process and to use the disputed claims process when you have a disagreement concerning your claims.
- Consider reporting any wrongdoing or fraud to the appropriate resources or legal authorities.

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INTRODUCTION

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TRICARE Stateside Regions

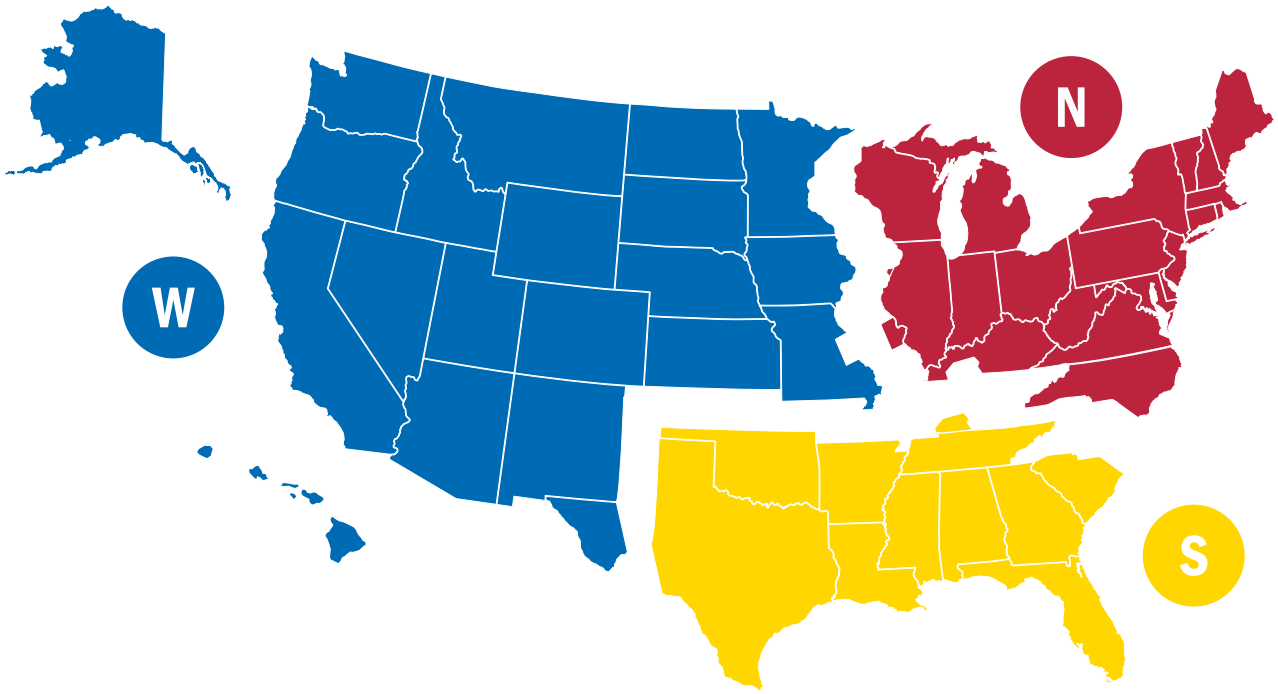
TRICARE is available worldwide and managed regionally. There are three TRICARE regions in the U.S.:

- TRICARE North
- TRICARE South
- TRICARE West

Your TRICARE benefit is the same regardless of where you are, but there are different customer service contacts for each region. Each region is managed by a contractor who partners with the Military Health System to provide you with health, medical and administrative support including customer service, claims processing and prior authorizations for certain health care services. Your regional contractor is your main resource for TRICARE benefit information and assistance.

You may also contact Beneficiary Counseling and Assistance Coordinators (BCACs), who are located at military hospitals and clinics and at the TRICARE Regional Offices. Go to the Customer Service Community Directory at www.tricare.mil/bcacdcao to find a BCAC near you.

Your Regional Contractor Is Your First Stop



N TRICARE North

Health Net Federal Services, LLC
1-877-874-2273
www.hnfs.com

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

S TRICARE South

Humana Military
1-800-444-5445
HumanaMilitary.com

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

W TRICARE West

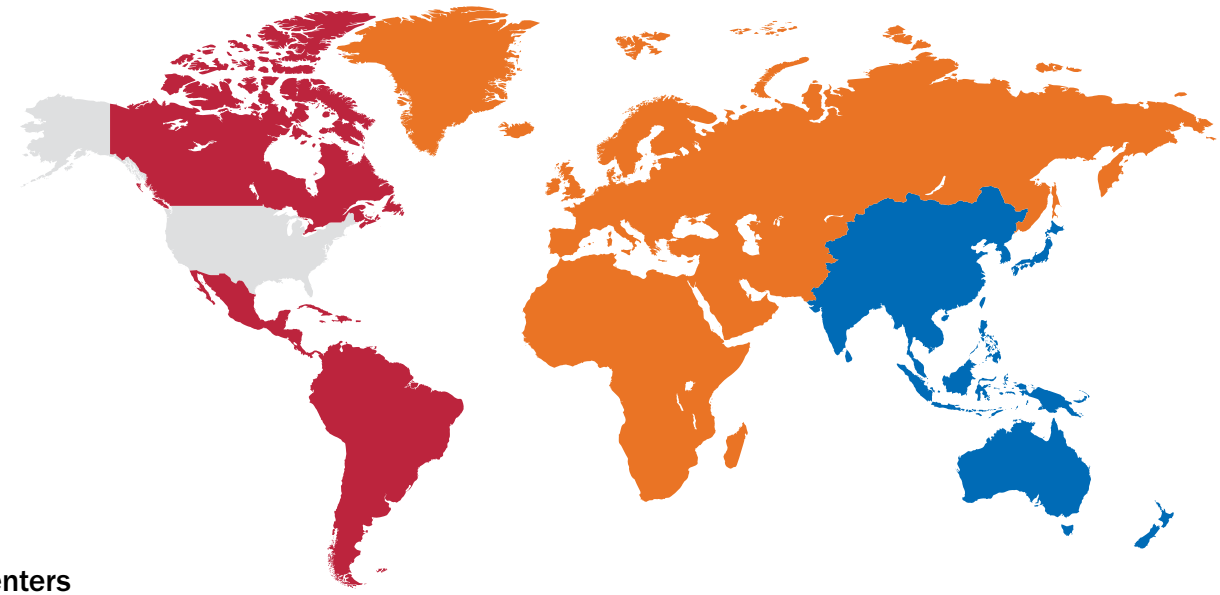
UnitedHealthcare Military & Veterans
1-877-988-9378
www.uhcmilitarywest.com

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

TRICARE Overseas Program

In addition to the three stateside regions, TRICARE also has one overseas region with three areas—TRICARE Eurasia-Africa, TRICARE Latin America and Canada and TRICARE Pacific. The contractor for this region is International SOS Government Services, Inc.

There are four regional call centers that support the overseas areas. The following table lists the phone numbers and email addresses for each call center. Go to www.tricare-overseas.com for information about the overseas benefit.



TRICARE Overseas Program (TOP) Regional Call Centers

TOP AREA	TOP REGIONAL CALL CENTER	MEDICAL ASSISTANCE
TRICARE Eurasia–Africa	1-877-678-1207 (stateside) +44-20-8762-8384 (overseas) tricarelon@internationalsos.com	+44-20-8762-8133
TRICARE Latin America and Canada	1-877-451-8659 (stateside) +1-215-942-8393 (overseas) tricarephl@internationalsos.com	+1-215-942-8320
TRICARE Pacific–Singapore	1-877-678-1208 (stateside) +65-6339-2676 (overseas) sin.tricare@internationalsos.com	+65-6338-9277
TRICARE Pacific–Sydney	1-877-678-1209 (stateside) +61-2-9273-2710 (overseas) sydtricare@internationalsos.com	+61-2-9273-2760

Managing Your TRICARE Benefit

www.tricare.mil

The official site of the TRICARE program, it is your one-stop shop for information on your TRICARE benefit. Find information on enrolling, getting care under your health plan, covered services, special programs and more.

www.health.mil

The official site of the Military Health System (MHS) and the Defense Health Agency. Find the latest news on how the MHS is addressing your health care needs around the globe.

TRICARE Self-Service Options

There are many options for managing your benefit at home or on the go at www.tricare.mil. Just click "Secure Login."

For full access to secure self-service options, you will need to log in with one of the following:

- Common Access Card (CAC): www.cac.mil or **1-800-477-8227**
- Defense Finance and Accounting Service (DFAS) myPay PIN: https://mypay.dfas.mil or **1-888-DFAS411** (**1-888-332-7411**)
- DoD Self-Service Logon (DS Logon): https://myaccess.dmdc.osd.mil, in person at a Veterans Affairs Regional Office or uniformed services ID card office, or your sponsor can set up a logon for you using his or her CAC

TRICARE Contacts

Go to www.tricare.mil/contactus for a detailed list of contacts and customer service options that can help you get the information and care you need.

milConnect

Go to http://milconnect.dmdc.osd.mil to get benefit updates online, update your contact information, check your current health coverage, transfer education benefits and more.

Beneficiary Web Enrollment Website

The Beneficiary Web Enrollment website, available at www.dmdc.osd.mil/appj/bwe, is a secure portal that lets you:

- Update your contact information and add your email address in the Defense Enrollment Eligibility System (DEERS)
- Enroll in or disenroll from TRICARE Prime options, TRICARE Young Adult, the TRICARE Dental Program and the TRICARE Retiree Dental Program
- Transfer your TRICARE Prime enrollment
- Select or change a primary care manager
- View enrollment information and check enrollment status
- Request a new enrollment card
- Add or update your other health insurance

Sign in using your valid CAC, DFAS myPay PIN or DS Logon.

TRICARE Publications Webpage

Go to www.tricare.mil/publications to view, print or download copies of TRICARE educational materials.

TRICARE Programs and Resources

Continued Health Care Benefit Program Humana Military	www.tricare.mil/chcbp HumanaMilitary.com 1-800-444-5445
Nurse Advice Line	1-800-TRICARE (1-800-874-2273) choose option 1
TRICARE Active Duty Dental Program United Concordia Companies, Inc.	www.tricare.mil/addp www.addp-ucci.com 1-866-984-2337
TRICARE Dental Program MetLife	www.tricare.mil/tdp www.metlife.com/tricare 1-855-MET-TDP1 (1-855-638-8371) 1-855-MET-TDP3 (1-855-638-8373) (TDD/TTY)
TRICARE For Life Wisconsin Physicians Service—Military and Veterans Health	www.tricare.mil/tfl www.TRICARE4u.com 1-866-773-0404
TRICARE Pharmacy Program Express Scripts, Inc.	www.tricare.mil/pharmacy www.express-scripts.com/TRICARE 1-877-363-1303
TRICARE Retiree Dental Program Delta Dental of California	www.tricare.mil/trdp www.trdp.org 1-888-838-8737 (current beneficiaries) 1-855-827-6436 (prospective beneficiaries)
US Family Health Plan	www.tricare.mil/usfhp www.usfhp.com 1-800-748-7347

Beneficiary Counseling and Assistance Coordinators	www.tricare.mil/bcacdcao
Claims	www.tricare.mil/claims
Customer Service Community Directory	www.tricare.mil/bcacdcao
Debt Collection Assistance Officers (DCAOs)	www.tricare.mil/bcacdcao
Enrollment	www.tricare.mil/enroll
Find a Provider	www.tricare.mil/findaprovider
Forms (including enrollment, claims and more)	www.tricare.mil/forms
Frequently Asked Questions	www.tricare.mil/faqs
Health Insurance Marketplace	www.healthcare.gov
Mental Health Care	www.tricare.mil/mentalhealth
Military OneSource	www.militaryonesource.mil
Sign Up for TRICARE Program Updates by Topic	www.tricare.mil/subscriptions
U.S. Department of Veterans Affairs	www.va.gov

Service Points of Contact

Commissioned Corps of the U.S. Public Health Service and National Oceanic and Atmospheric Administration	Medical Affairs Branch 1-800-368-2777
Manpower and Reserve Affairs	www.people.mil
U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps	Defense Health Agency—Great Lakes 1-888-647-6676
U.S. Coast Guard	Coast Guard Benefits Line 1-800-942-2422

Resources for Getting and Staying Healthy

The Department of Defense (DoD) and TRICARE have programs designed to help you get and stay healthy. Programs include:

Operation Live Well: The DoD Operation Live Well initiative aims to improve healthy living throughout the defense community by promoting healthy eating, physical activity, tobacco-free living, sleep and mental and spiritual well-being. Go to www.tricare.mil/livewell for wellness resources from the military, government and TRICARE in one location.

Obesity prevention: Weight-loss resources, as well as materials to educate you and your family about the risks of being overweight. For details, go to www.tricare.mil/getfit.

Alcohol awareness: Go to www.tricare.mil/alcoholawareness for more information about alcohol awareness and preventing alcohol abuse. TRICARE offers coverage for treatment of certain substance use disorders. For more information, see *Covered Services*.

Quitting tobacco: TRICARE and DoD have several resources for helping you live tobacco-free. To learn more, go to www.tricare.mil/quittobacco.

Reporting Suspected Fraud and Abuse

Report suspected fraud and abuse to your regional contractor. You can also report fraud or abuse issues directly to TRICARE at www.tricare.mil/fraud.

Getting Help in an Emergency

Medical Emergency

TRICARE defines an emergency as a serious medical condition that the average person would consider to be a threat to life, limb, sight or safety. In an emergency, call 911 or go to the closest emergency room. If you are admitted, you may need an authorization for a continued stay. If you are enrolled in a TRICARE Prime option, your primary care manager or regional contractor should be notified about your emergency room visit within 24 hours of your visit.

Psychiatric Emergency

A psychiatric emergency is when a person is an immediate danger to self or others because of a mental disorder and requires immediate, continuous skilled observation. Seek immediate care for a psychiatric emergency at a hospital or emergency room.

If you or one of your dependents has a psychiatric emergency, you don't need prior authorization before admission to an inpatient unit. However, your regional contractor must be notified within 72 hours of admission. A continued stay will require authorization.

National Suicide Prevention Lifeline

If you or your family member is in crisis and needs immediate help, call the National Suicide Prevention Lifeline/Military Crisis Line at **1-800-273-TALK** (**1-800-273-8255**), option 1 for free and confidential support 24/7. You can also send a text message to **838255** or start an online chat at www.militarycrisisline.net.

Natural Disaster

In the event of a natural disaster (for example, a hurricane, tornado, earthquake or tidal wave), you can get emergency updates from www.tricare.mil/disasterinfo or your regional contractor's website. You can also call your regional contractor. Emergency drug refill procedures and blanket waivers may go into effect. If this occurs, you can fill your prescriptions at any TRICARE retail network pharmacy. Instructions for nonemergency care will be sent via disaster alert.

About TRICARE

TRICARE is the health care program for 9.4 million active duty service members, retired service members, certain National Guard and Reserve members, Medal of Honor recipients, family members, survivors and eligible former spouses. TRICARE is for eligible members from the seven uniformed services:

- U.S. Army
- U.S. Navy
- U.S. Air Force
- U.S. Marine Corps
- U.S. Coast Guard
- Commissioned Corps of the U.S. Public Health Service
- National Oceanic and Atmospheric Administration

TRICARE is managed by the Defense Health Agency under leadership of the Assistant Secretary of Defense for Health Affairs. Eligibility for TRICARE is determined by law and the services, and this information is shown in the Defense Enrollment Eligibility Reporting System (DEERS).

Our Mission

Enhance the Department of Defense (DoD) and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

Our Vision

Be a world-class health care system that supports the military mission by fostering, protecting, sustaining and restoring health.

Eligibility

You are eligible for different TRICARE programs and benefits based on your beneficiary category, where you live and whether you are entitled to Medicare.

To use TRICARE, first make sure your Defense Enrollment Eligibility Reporting System (DEERS) record is up to date.

Defense Enrollment Eligibility Reporting System

DEERS is a database of service members and dependents worldwide who are eligible for military benefits, including TRICARE. DEERS serves as the central source of identity, enrollment and eligibility verification for members of the uniformed services and their eligible family members. Sponsors are active duty service members, retired service members and National Guard and Reserve members. Sponsors are automatically registered in DEERS, but must register family members in DEERS for them to show as TRICARE-eligible.

Sponsors, or a sponsor-appointed individual with power of attorney, can add family members, including newborns, in DEERS in person at a uniformed services ID card office. To add a family member, you must present appropriate paperwork, such as:

- A marriage certificate
- A birth certificate
- Adoption papers

For a full list of required documents based on the change you're making to your record and to find a uniformed services ID card office near you, go to www.dmdc.osd.mil/rsl. Be sure to include the Social Security numbers for each of your dependents in DEERS. This ensures TRICARE coverage is accurately reported so that you don't have to pay a penalty for not maintaining minimum essential coverage as required by the Affordable Care Act.

Keep Your DEERS Information Up To Date

Once you and your family members are registered in DEERS, be sure to keep addresses and all other contact information up to date. Update your records when you have a life event or your personal information changes, including military career status and family status (for example, moving, marriage, divorce, birth or adoption). Family members age 18 and older may update their own contact information.

Up-to-date DEERS records are vital to accessing your TRICARE benefit for health appointments, prescriptions and claims payments.

Failure to update DEERS to accurately reflect your and your family members' residential address and/or the ineligibility of a former dependent could be considered fraud and result in administrative, disciplinary or other appropriate action.

The following table describes how to add a family member in DEERS or update your contact information.

ADD A FAMILY MEMBER OR UPDATE CONTACT INFORMATION:	
In Person	Go to a uniformed services ID card office. Find an office near you at www.dmdc.osd.mil/rsl.
UPDATE CONTACT INFORMATION:	
Online	http://milconnect.dmdc.osd.mil www.dmdc.osd.mil/appj/bwe
Phone	1-800-538-9552 (TDD/TTY: 1-866-363-2883)
Fax	1-831-655-8317
Mail	Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955

USING milCONNECT

Eligible TRICARE beneficiaries can use the milConnect website at http://milconnect.dmdc.osd.mil to update and view DEERS information. You can access your contact information, health and dental enrollments, personnel information, eCorrespondence, Servicemembers Group Life Insurance and other benefits, including transferring education benefits. You can log in to milConnect's secure site using a Common Access Card, Defense Finance and Accounting Service myPay PIN or a DoD Self-Service Logon (DS Logon).

For information on signing up for a DS Logon, go to https://myaccess.dmdc.osd.mil. Benefit notifications from the Defense Manpower Data Center will be posted in your milConnect account at http://milconnect.dmdc.osd.mil. You will get an email directing you to milConnect when you have a new notification.

You must have your email address on file in milConnect to get email notifications. If you don't want to get email notifications of benefit changes, you may opt out. If you don't have an email address on file or if you opt out of email notifications, you will get a postcard in the mail whenever your benefit information changes. The postcard will direct you to log in to milConnect to access your personal information with details about benefit changes.

Note: Separating service members and their family members can obtain a DS Logon for six months after separation, even though they are no longer affiliated with the military. This is available to those who no longer have military benefits and allows extended access to milConnect to view benefit correspondence after separation. This doesn't affect retired service members.

DEERS Verification For Former Spouses Who Have Not Remarried

If you are a former spouse who has not remarried, DEERS shows TRICARE eligibility using your own Social Security number (SSN) or DoD Benefits Number (DBN), not your former sponsor's. Health care information is filed under your name and SSN or DBN, and you will use this information to schedule medical appointments and file TRICARE claims.

Program Eligibility by Sponsor Status

Your TRICARE program options depend on your sponsor's status, your beneficiary status and where you live. The following table shows stateside TRICARE program options that may be available to you. Your options may change if you move, if your sponsor changes location or status or if you have a life event.

THOSE ELIGIBLE FOR TRICARE	TRICARE PROGRAM OPTIONS
Active duty service members (ADSMs). Includes service members from any of the seven uniformed services, and National Guard and Reserve members activated for more than 30 days.	• TRICARE Prime • TRICARE Prime Remote • TRICARE Active Duty Dental Program
Active duty family members (ADFMs). Includes spouses and dependents of ADSMs, including National Guard and Reserve members activated for more than 30 days.	• TRICARE Prime • TRICARE Prime Remote • TRICARE Standard and TRICARE Extra • TRICARE For Life (TFL) • US Family Health Plan (USFHP) • TRICARE Young Adult (TYA) • TRICARE Dental Program (TDP)
National Guard and Reserve members of the Selected Reserve, Retired Reserve and their family members.	• TRICARE Reserve Select • TRICARE Retired Reserve • TYA • TDP
Retired service members and their family members, retired National Guard and Reserve members (at age 60) and their family members,[1] Medal of Honor recipients and their family members, survivors and eligible former spouses.	• TRICARE Prime • TRICARE Standard and TRICARE Extra • TFL • USFHP • TYA • TRICARE Retiree Dental Program (TRDP)

1. *Retired National Guard and Reserve members under age 60 are eligible for the TRDP. Former spouses are not.*

TRICARE Eligibility by Beneficiary Type

Active Duty

Active Duty Service Members

Active Duty Service Members (ADSMs) include service members from any of the seven uniformed services: the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service and the National Oceanic and Atmospheric Administration (includes National Guard and Reserve members called or activated for more than 30 days).

Eligibility for TRICARE is determined by the services and information is maintained in DEERS.

Spouses and children of ADSMs

Spouses and children of ADSMs are eligible for benefits as active duty family members (ADFMs).

For children, certain other provisions may apply:

- The sponsor's children remain eligible even if parents divorce or remarry; however, the sponsor's stepchildren lose eligibility.
- Children placed in the custody of an ADSM or former service member, either by a court or by a recognized adoption agency in anticipation of legal adoption by the member, may be eligible.

The sponsor's children's eligibility continues until at least age 21 (or age 23 if certain criteria are met). Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TRICARE Young Adult (TYA) program. For more information, see *TRICARE Young Adult*.

Surviving spouses and surviving children

Surviving spouses and surviving children continue to get benefits after their sponsor's death.

- Surviving spouses will have ADFM benefits and costs for three years after the sponsor's death. After that they get benefits at the retiree rate. Surviving spouses who have not remarried remain eligible (eligibility for surviving spouses who remarry can't be regained later, even in the case of divorce or death of the new spouse).
- Surviving unmarried children remain eligible with ADFM benefits and costs until at least age 21 (or age 23 if certain criteria are met). Certain qualified dependents may extend TRICARE coverage until age 26 with the premium-based TYA program, but with deductibles, cost-shares, or copayments at the retiree rate.

Retired

Retired service members, their spouses and their children

Retired service members, their spouses and their children are eligible for benefits and are responsible for paying any applicable enrollment fees, deductibles, cost-shares or copayments at the retiree rate.

For children, certain other provisions may apply:

- The sponsor's children remain eligible even if parents divorce or remarry; however, the sponsor's stepchildren lose eligibility.
- Children placed in the custody of a retired service member, either by a court or by a recognized adoption agency in anticipation of legal adoption by the member, may be eligible.
- The sponsor's children's eligibility continues until at least age 21 (or age 23 if certain criteria are met). Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TRICARE Young Adult (TYA) program.

Survivors of retirees

Survivors of retirees remain eligible with the same TRICARE options and costs they had before the sponsor died.

- Surviving spouses who have not remarried remain eligible (eligibility for surviving spouses who remarry can't be regained later, even in the case of divorce or death of the new spouse).
- Surviving unmarried children remain eligible until at least age 21 (or age 23 if certain criteria are met). Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TYA program.

Activated National Guard and Reserve

Active National Guard and Reserve Members

The National Guard and Reserve includes service members from the Army National Guard, Army Reserve, Navy Reserve, Air National Guard, Air Force Reserve, Marine Corps Reserve and Coast Guard Reserve. Members activated for more than 30 days are covered as active duty service members (ADSMs) and their eligible family members are covered as active duty family members (ADFMs). Members activated for 30 days or less (including active duty training/drill, yearly training, and individual duty training) and their family members may qualify to continue or purchase coverage under TRICARE Reserve Select (TRS).

Survivors of National Guard and Reserve sponsors

- **Survivors of National Guard and Reserve sponsors who died while serving on active duty for 30 days or more** continue to get benefits after the sponsor's death.
  - Surviving spouses will have ADFM benefits and costs for three years after the sponsor's death. After that they get benefits at the retiree rate. Surviving spouses who have not remarried remain eligible (eligibility for surviving spouses who remarry can't be regained later, even in the case of divorce or death of the new spouse).
  - Surviving unmarried children remain eligible with ADFM benefits and costs until at least age 21 (or age 23 if certain criteria are met). Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TRICARE Young Adult (TYA) program, but with deductibles, cost-shares or copayments at the retiree rate.

- **Survivors of National Guard and Reserve sponsors who died while serving on active duty for 30 days or less** (including active duty training/drill, yearly training and individual duty training) get benefits at the retiree rate.
  - Surviving spouses who have not remarried remain eligible (eligibility for surviving spouses who remarry can't be regained later, even in the case of divorce or death of the new spouse).
  - Surviving unmarried children remain eligible with retiree benefits and costs until at least age 21 (or age 23 if certain criteria are met). Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TYA program.

National Guard and Reserve Members Released from a Period of Activation of More than 30 Days in Support of a Contingency Operation

National Guard and Reserve members may qualify for the Transitional Assistance Management Program (TAMP) following an activation period of more than 30 days. TAMP provides 180 days of transitional TRICARE coverage for eligible sponsors and their eligible family members. Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TYA program.

Qualifying sponsors may purchase Continued Health Care Benefit Program (CHCBP) coverage within 60 days of the end of TRICARE eligibility or TAMP coverage, whichever is later. Though not a TRICARE program, CHCBP provides up to 18 months of premium-based health coverage. Qualifying family members may be included in CHCBP family coverage purchased by their sponsors.

Non-Activated National Guard and Reserve

Non-Activated National Guard and Reserve Members

Non-Activated National Guard and Reserve members may qualify to purchase TRS coverage if they are both:

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

Family members of National Guard and Reserve Members

Family members of National Guard and Reserve members qualify for comprehensive coverage if the sponsor purchases TRS member-and-family coverage. Former spouses don't qualify to purchase TRS. Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TRICARE Young Adult (TYA) program.

Survivors of Selected Reserve Members

Survivors of Selected Reserve members may qualify to continue or purchase TRS coverage for up to six months from the date of the sponsor's death if all of the following apply:

- The deceased sponsor was covered by TRS on the date of his or her death
- The survivors are currently immediate family members of the deceased sponsor (spouses can't have remarried)

Note: Surviving family members who are eligible for or enrolled in the FEHB Program may purchase TRS. Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TYA program.

Retired Reserve

Retired Reserve Members

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

- Members of the Retired Reserve who qualify for non-regular retirement
- Under age 60
- Not eligible for the Federal Employees Health Benefits (FEHB) Program

Family Members of Retired Reserve Members

Family members of Retired Reserve members qualify for comprehensive coverage if the sponsor purchases TRR member-and-family coverage. Former spouses don't qualify to purchase TRR. Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TRICARE Young Adult (TYA) program.

Survivors of Retired Reserve Members

Survivors of Retired Reserve members may qualify to continue or purchase TRR coverage until the day the sponsor would have turned 60 if all of the following apply:

- The deceased sponsor was covered by TRR on the date of his or her death
- The survivors are immediate family members of the deceased sponsor (spouses can't have remarried)
- TRR coverage would begin before the date the deceased sponsor would have turned age 60

Note: Surviving family members who are eligible for or enrolled in the FEHB Program may purchase TRR. Certain qualified dependents may extend TRICARE coverage up to age 26 with the premium-based TYA program.

Medicare-Eligible

If you are entitled to premium-free Medicare Part A:

- Medicare Part B coverage is required to remain TRICARE-eligible when you are a(n):
  - Retired service member (including retired National Guard and Reserve members drawing retirement pay)
  - Family member of a retired service member
  - Medal of Honor recipient or eligible family member
  - Survivor of a deceased sponsor
  - Eligible former spouse
- Medicare Part B coverage isn't required to keep your current TRICARE coverage if:
  - You are an active duty service member (ADSM) or active duty family member (ADFM) (ADSMs and ADFMs remain eligible for TRICARE Prime or TRICARE Standard and TRICARE Extra options while the sponsor is on active duty. However, when the sponsor retires, you must have Medicare Part B to remain TRICARE-eligible)
  - You are enrolled in TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA) or the US Family Health Plan (USFHP) (while you aren't required to have Medicare Part B to remain eligible for TRS, TRR or USFHP, you are strongly encouraged to sign up for Medicare Part B when first eligible to avoid paying a premium surcharge if you enroll at a later date)

Dependent Parents and Parents-In-Law

Dependent parents and parents-in-law are eligible for care only in military hospitals and clinics and can enroll in TRICARE Plus based on space/resource availability. TRICARE Plus allows dependent parents the same access standards as beneficiaries in TRICARE Prime. TRICARE Plus doesn't cover specialty care.

Enrollment in TRICARE Plus at one military hospital or clinic doesn't mean you have TRICARE Plus enrollment at another military hospital or clinic. Dependent parents and parents-in-law aren't eligible for any other TRICARE programs. TRICARE Plus doesn't meet requirements under the Affordable Care Act (ACA) that require you to maintain basic health care coverage, called minimum essential coverage. For more information about minimum essential coverage, see *TRICARE Meets the Minimum Essential Coverage Requirement under the Affordable Care Act*.

Eligible Former Spouses

To maintain eligibility, former spouses:

- Must not have remarried (if a former spouse remarries, benefits are lost even if the remarriage ends in death or divorce)
- Must not be covered by an employer-sponsored health plan
- Must not be the former spouse of a North Atlantic Treaty Organization or Partners for Peace nation member
- Must meet the requirements listed in either Situation 1 or Situation 2 as follows:
  - **Situation 1:** The former spouse must have been married to the same service member or former member for at least 20 years, and at least 20 of those years must have been creditable in determining the member's eligibility for retirement pay. If this requirement is met, the former spouse is eligible for TRICARE coverage after the date of the divorce, dissolution or annulment. Eligibility continues as long as the preceding requirements continue to be met and the former spouse does not remarry.
  - **Situation 2:** The former spouse must have been married to the same service member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. If this requirement is met, the former spouse is eligible for TRICARE coverage for only one year from the date of the divorce, dissolution or annulment.

Note: Former spouses who remarry after age 55 and who were enrolled in the Continued Health Care Benefit Program (CHCBP) for the 18 months before the end of the marriage may still be eligible to continue coverage under CHCBP.

Adult-Age Children

Children who age out of regular TRICARE coverage may qualify to purchase premium-based TRICARE Young Adult (TYA). TYA offers TRICARE Prime and TRICARE Standard coverage worldwide. TYA includes medical and pharmacy benefits, but excludes dental coverage.

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

- A dependent of a TRICARE-eligible sponsor
- Unmarried
- At least age 21 (or age 23 if certain criteria are met), but not yet age 26
- Not eligible for or enrolled in employer-sponsored health care coverage
- Not a uniformed service sponsor (for example, a member of the Selected Reserve) For more information, see *TRICARE Young Adult*.

Disabled Veteran, Family of a Disabled Veteran or Former Spouse Who Lost TRICARE Eligibility

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is administered by the Department of Veterans Affairs (VA). Veterans may contact the VA toll-free at **1-800-827-1000** for information. Details on possible CHAMPVA eligibility for family members are available by calling the VA Health Administration Center toll-free at **1-800-733-8387** or visiting www.va.gov/purchasedcare and clicking "Programs for Dependents."

The following beneficiary categories may be eligible:

- Family members of veterans who have been rated permanently and totally disabled, or of veterans who died from a service-related disability, may be covered by CHAMPVA as long as they aren't eligible for TRICARE.
- Former spouses who, when they remarried, lost their TRICARE eligibility, and whose marriage ended in divorce or death, may also be entitled to CHAMPVA.

Disabled Active Duty Family Member

The TRICARE Extended Care Health Option (ECHO) provides supplemental services to active duty family members (ADFMs) who qualify based on specific mental or physical disabilities. ECHO offers beneficiaries integrated services and supplies beyond those offered by your TRICARE program option (for example, TRICARE Prime or TRICARE Standard). ADFMs must enroll in their service's Exceptional Family Member Program (unless waived in specific situations) and register for ECHO with their regional contractors to be eligible for ECHO benefits. For additional information, go to www.tricare.mil/echo.

Special Circumstances for TRICARE Eligibility

Check with your local ID card office or uniformed services personnel office about your eligibility for the following:

- Certain family members of active duty service members who were discharged as a result of a court-martial conviction or separated for spouse or child abuse
- Certain abused spouses, former spouses and dependent children of service members who were eligible for retirement, but whose retirement was canceled as a result of abuse of the spouse or child
- Spouses and children of representatives of the North Atlantic Treaty Organization and Partners for Peace nations that are signatories to the respective Status of Forces Agreements with the U.S. while stationed in or passing through the U.S. on official business. These family members are eligible for outpatient care only.

Section II

TRICARE PROGRAMS

Introduction to TRICARE Programs

All TRICARE programs include comprehensive health care coverage and a pharmacy benefit. For details on medical program options, like TRICARE Prime, TRICARE Standard and TRICARE Extra and more, refer to plan-specific sections.

TRICARE offers three dental care program options that you can purchase, if eligible. For more information, see *Dental Care Programs*.

TRICARE Programs

Contacts

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

TRICARE South Region
Humana Military
1-800-444-5445
HumanaMilitary.com

TRICARE West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

TRICARE Prime

TRICARE Prime is similar to a managed care or health maintenance organization option, commonly called an HMO.

With TRICARE Prime, you get most of your care from a primary care manager (PCM) who will manage and coordinate your care. The advantage of TRICARE Prime is that you have few out-of-pocket expenses.

TRICARE Prime is available to:

- Active duty service members (ADSMs)
- Active duty family members (ADFMs)
- Retirees
- Retiree family members
- Adult-age dependents who purchase TRICARE Young Adult (TYA) coverage and meet TRICARE Prime eligibility requirements.
- Certain others

Depending on where you live and your sponsor's status, additional TRICARE Prime options may include TRICARE Prime Remote (TPR), the US Family Health Plan (USFHP) and TYA Prime. If you don't want to enroll in a TRICARE Prime option, you are automatically covered by *TRICARE Standard and TRICARE Extra*.

It is important for sponsors to keep DEERS records up to date. Eligibility for TRICARE is determined by law and the services, and information is shown in the Defense Enrollment Eligibility Reporting System (DEERS).

Key Concepts

- You must enroll in TRICARE Prime. Coverage isn't automatic.
- To use TRICARE Prime, you must enroll. You get most of your care from a PCM.
- Get a referral before getting nonemergency care from someone other than your PCM.

Key Terms

- **Primary care manager (PCM):** The health care provider you visit for most care and who gives you referrals to see other providers.
- **Referral:** When your PCM sends you to another provider for care.
- **Prior authorization:** A review of a requested health care service by your regional contractor to see if TRICARE will cover the care.
- **Point-of-service option:** An option under TRICARE Prime that lets you pay extra to get nonemergency care from any TRICARE-authorized provider without a referral.
- **Out-of-pocket cost:** Any costs you are responsible for paying when you get health care services or drugs.

Eligibility for TRICARE Prime

You must live in a Prime Service Area (PSA) to use TRICARE Prime. A PSA is an area near a military hospital or clinic. To find out if you live in an area where TRICARE Prime is available, go to www.tricare.mil/psa.

If you aren't in a PSA, but are still within 100 miles of an available PCM, you might be able to use TRICARE Prime by signing a drive-time waiver. This means you are willing to drive more than 30 minutes from your home to your provider. You can waive your drive-time access standards when you enroll or request a change to your enrollment.

All referrals for specialty care will be made to providers inside the PSA. This means you may have to drive more than one hour from your home for specialty care. For more about waiving drive-time access standards go to www.tricare.mil/primeaccess.

You can use TRICARE Prime if you are a(n):

- ADSM (required to enroll)
- ADFM
- National Guard or Reserve member who is activated for more than 30 days, and eligible family member
- Retiree, retiree family member or survivor
- Transitional survivor
- Former spouse who has not remarried and meets certain criteria
- Medal of Honor recipient and their eligible family members

Depending on your sponsor's category and where you live, you may have several other options, including *TRICARE Prime Remote*, *USFHP* or *TRICARE Standard and TRICARE Extra*.

If you are a retiree or a retiree family member in a PSA, you can use TRICARE Prime or USFHP until you are age 65. If not, you can use TRICARE Standard and TRICARE Extra. If you are under age 65, entitled to Medicare Part A and have Part B, you might have several coverage options, including TRICARE Prime or TRICARE For Life (TFL). At age 65, everyone entitled to premium-free Medicare Part A must have Medicare Part B to remain TRICARE-eligible and use TFL.

TRICARE Prime coverage isn't automatic. If you want to use TRICARE Prime, you must enroll.

If you don't enroll in TRICARE Prime, you are automatically covered by TRICARE Standard and TRICARE Extra.

Enrolling in TRICARE Prime

Follow these steps to get TRICARE Prime coverage for yourself or for eligible family members. Remember, only a sponsor or sponsor-appointed individual with valid power of attorney can add a dependent in DEERS.

Step 1 Update DEERS info online at http://milconnect.dmdc.osd.mil.

Step 2 Enroll online, by phone or mail.

Step 3 Coverage takes effect.

- **ADSMs** Coverage is effective immediately.
- **All others** Coverage follows the 20th-of-the-month rule.

You can enroll in TRICARE Prime anytime by doing one of the following:

- Using the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe
- Calling your regional contractor
- Submitting a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) to your regional contractor. You can find this form at www.tricare.mil/forms.

If you are an ADSM, you are considered enrolled on the day your regional contractor gets your request.

Enrollment requests from non-ADSMs follow the 20th-of-the-month rule. This means enrollment requests received by the 20th of the month become effective at the beginning of the following month (a request received by Dec. 20 becomes effective Jan. 1). If the request is received after the 20th of the month, coverage won't start until the start of the second month after your request is processed (an application received Dec. 27 becomes effective Feb. 1).

Your Primary Care Manager

When you enroll in a TRICARE Prime option, you are assigned to a PCM. You can request a change in PCM by calling your regional contractor. Your PCM will either be:

- At a military hospital or clinic;
- A civilian TRICARE network provider in your enrolled TRICARE region; or
- A primary care provider in USFHP.

Your PCM might be an individual or a facility, such as a clinic or medical practice where several health care providers work.

If you're assigned a PCM at a military hospital or clinic, you don't need to make initial contact with him or her to introduce yourself. If you have health concerns, contact your new PCM through your military hospital or clinic or send a secure message.

If you're assigned a civilian network PCM, you're encouraged to introduce yourself to him or her within 30 days. This helps ensure that if you need a referral from your PCM before your initial health appointment, your provider knows who you are. If you have any questions about your PCM assignment, call your regional contractor.

No matter what type of PCM you have, your PCM must provide services 24/7. To do this, your PCM might designate an on-call provider who will act on your PCM's behalf to support your health care needs. This means that any information, instructions, care or care coordination you get from an on-call provider should be treated the same as if it were from your PCM.

Whether you have a PCM at a military hospital or clinic or a civilian network PCM, having an open and active relationship allows you to work together to meet your health care needs.

Secure messaging is an online system that allows you to contact your health care provider while protecting your privacy. For more information, go to www.tricare.mil/securemessage.

Changing Your Primary Care Manager

You can change your PCM at any time by using the BWE website, calling your regional contractor or completing and submitting *DD Form 2876*. Specific guidelines for switching your PCM depend on the type of PCM you have. If you are enrolled with a:

- Military hospital or clinic PCM, PCM changes are subject to the military hospital or clinic's guidelines.
- Civilian network PCM, you can call your regional contractor for guidance on switching your PCM.

If you are changing your PCM because you're moving, see *Moving*.

Making an Appointment

To make an appointment for routine care, call your PCM's office. Some geographic areas or military hospitals and clinics also have TRICARE appointment centers you can use for help making appointments.

If your PCM is at a military hospital or clinic, you may have the option to make some appointments via www.tricareonline.com. To do that:

1. Go to www.tricareonline.com and login.
2. Click "Appointments" on the home page.
3. Provide the required details.

Getting Care with TRICARE Prime

The table below describes how to get emergency, urgent, routine and specialty care. Your PCM is almost always your first stop for routine or specialty care. Let your PCM know as soon as possible of any emergency or urgent care visits.

TYPE OF CARE	DEFINITION	EXAMPLES	PRIMARY CARE MANAGER ROLE
Emergency	Treatment for a serious medical condition that the average person considers a threat to life, limb, sight or safety. Most dental emergencies, such as going to the emergency room for a severe toothache, are not covered under the TRICARE medical benefit.	No pulse, severe bleeding, spinal cord or back injury, chest pain, broken bone, inability to breathe	You don't need to call your PCM before getting emergency medical care. You must notify your PCM within 24 hours or on the next business day following admission.
Urgent	Treatment for an illness or injury that won't result in further disability or death if not treated immediately, but does require professional attention within 24 hours	Rash, migraine headache, urinary tract infection, sprain, earache, rising fever	Most TRICARE Prime beneficiaries don't need a PCM referral for two urgent primary care visits each fiscal year (Oct. 1–Sept. 30), but you must let your PCM know you got urgent care immediately after your visit. After your two visits, or if you aren't eligible for urgent care visits without a referral, call your PCM for guidance.
Routine	General health care services, including office visits and preventive care	Symptoms of chronic or acute illnesses and diseases, follow-up care for an ongoing medical condition	You will get most of your routine care from your PCM.
Specialty	Medical care from specialists for treatment your PCM can't provide	Cardiology, dermatology, gastroenterology, obstetrics	Your PCM will refer you to another health care provider for care he or she can't provide and will coordinate the referral request with your regional contractor when needed.

Note: If you have an appointment with a civilian health care provider and fail to attend, you may still be charged for the appointment.

Emergency Care

If you have an emergency, call 911 or go to the closest emergency room.

Most dental emergencies, such as going to the emergency room for a severe toothache, are not covered under the TRICARE medical benefit.

Avoid using the emergency room for nonemergency conditions. Doing so can cost you money and time. Your PCM, family provider or urgent care center can usually treat you more quickly.

Urgent Care Pilot

The Urgent Care Pilot is a three-year pilot program that lets most TRICARE Prime beneficiaries get two urgent primary care visits in the U.S. each fiscal year (FY) (Oct. 1–Sept. 30) without a referral or prior authorization. The Urgent Care Pilot began May 23, 2016.

When you need urgent care, you can go directly to any TRICARE-authorized provider without a PCM referral, but you will pay more if the provider doesn't accept TRICARE.

If you're not sure if you need urgent care or if you want to see if you can get an urgent care appointment without using one of your two allowed visits, you can call the Nurse Advice Line (NAL) at **1-800-TRICARE** (**1-800-274-2273**) and choose option 1. Depending on if you're enrolled to a military hospital or clinic PCM or a civilian PCM, the NAL will work with you to get you the right level of care you need and you may be able to save one of your urgent care visits.

Note: ADSMs in TRICARE Prime should seek urgent care at a military hospital or clinic.

"The urgent care pilot is a great idea! Having to take an ill 2-year-old to an ER is a waste of everyone's time."

–S.S., TRICARE beneficiary

TALK DIRECTLY TO A **REGISTERED NURSE 24/7**

1-800-TRICARE
8 7 4 - 2 2 7 3
OPTION 1

Nurse Advice Line

If it's after hours or you aren't sure if you need to see a health care provider, you can call the NAL at **1-800-TRICARE** (**1-800-874-2273**) and choose option 1. You can talk to a registered nurse 24/7 who can help you determine the right level of care you need for yourself or your child, schedule military hospital or clinic appointments and much more. The NAL is not for emergencies. If you have an emergency, call 911 or go to the closest emergency room.

"The Nurse Advice Line keeps me up to date on what helps me with my asthma."

–B.S., TRICARE beneficiary

"They were there for me when I needed them."

–J.C., TRICARE beneficiary

Nonemergency Care

Getting Care with a TRICARE Prime Option (includes TRICARE Prime, TRICARE Prime Remote, USFHP and TYA Prime)

	ACTIVE DUTY SERVICE MEMBERS	ACTIVE DUTY FAMILY MEMBERS	RETIREES AND THEIR FAMILY MEMBERS
Where do I get care?	• Military hospital or clinic • If traveling or between duty stations, you must get all nonemergency care at a military hospital or clinic if one is available; if not available, you need a referral from your PCM	• Military hospital or clinic or civilian network provider in your enrolled TRICARE region • USFHP beneficiaries will only see providers in their designated regional health care system	• Military hospital or clinic or civilian network provider in your enrolled TRICARE region • Retirees who are not Medicare-eligible may enroll in USFHP (depending on location) and see USFHP providers
What do I need to do before I can get care?	• **Military hospital or clinic care:** No referral or prior authorization needed • **Civilian network provider care:** Get a referral from your PCM to see a civilian network provider, and prior authorization from your regional contractor (not for emergencies)	• **Routine care:** See your military hospital or clinic or civilian network PCM • **Specialty care:** Get a referral from your PCM to see a specialty care provider ▪ You may also need prior authorization from your regional contractor for certain types of care (not for emergencies)	• **Routine care:** See your military hospital or clinic or civilian network PCM • **Specialty care:** Get a referral from your PCM to see a specialty care provider ▪ You may also need prior authorization from your regional contractor for certain types of care (not for emergencies)
What will health care cost me?	• No enrollment costs • No out-of-pocket costs when you get covered health care services from your military hospital or clinic PCM, or when you have the appropriate referral and prior authorization	• No enrollment costs • No out-of-pocket cost when you get covered health care services from a network provider in your TRICARE region, or when you have the appropriate referral and prior authorization	• A yearly enrollment fee • Copayments for covered health care services from network providers • When following the rules of your program option, your out-of-pocket expenses will be limited to your catastrophic cap amount for that FY

Care at a Veterans Affairs Facility

All U.S. Department of Veterans Affairs (VA) health care facilities have signed agreements with the regional contractors as TRICARE network providers, agree to accept a negotiated rate as the full fee for services, file claims and handle paperwork for you. While VA facilities may or may not provide primary care, many provide specialty care. If you need care and a participating VA health care facility near you can provide that care (within TRICARE access standards), you may seek care at the VA facility. All ADSMs and other TRICARE Prime beneficiaries who are referred to a VA health care facility for care must have prior authorization.

Each VA facility has established a TRICARE beneficiary point of contact and check-in process. It is important to indicate, before getting care, that you are using your TRICARE benefit. If you don't specify, you could pay more, up to the full cost of care. Medicare-eligible beneficiaries will also have higher costs for non-service connected care at a VA facility. The VA is not a Medicare provider.

Access Standards for Care

TRICARE has access standards to ensure you get timely health care. Your wait time for an appointment depends on the type of care you need.

URGENT CARE APPOINTMENT
Wait time no longer than one day (24 hours)

ROUTINE CARE APPOINTMENT
Wait time no longer than one week (seven days)

SPECIALTY CARE APPOINTMENT
Wait time no longer than four weeks (28 days)

TRICARE also limits how long you should have to travel to get to an appointment. Travel time is limited to 30 minutes for routine care or one hour for specialty care (unless you have waived your access standards).

Referrals

If you need care that your PCM can't give you, he or she will refer you to another provider. A referral is when your PCM sends you to another provider for care. If your provider refers you for specialty care and you live within a one-hour drive of a military hospital or clinic, you might be required to seek care at a military hospital or clinic. This also applies to ancillary services, like laboratories, radiology centers and physical therapy.

However, you may qualify for travel reimbursement if you are referred for specialty care and the closest qualified specialist is over 100 miles (one way) from your referring provider's office. If this situation applies, call your regional contractor for more information.

Your PCM and/or specialty care provider should coordinate required referrals and prior authorizations with your regional contractor. This applies to services you may have to get at a military hospital or clinic.

ADSMs are required to get referrals for all civilian care other than emergencies. This includes mental health care, specialty care and services that don't normally require referrals, like preventive services.

Go to your regional contractor's website for helpful information about topics including referral and prior authorization requirements.

Prior Authorizations

ADSMs need prior authorizations for all inpatient and outpatient specialty services. A prior authorization is a review of a requested health care service, done by your regional contractor, to see if TRICARE will cover the care. You must also get a fitness-for-duty review if you get maternity care, physical therapy, occupational and speech therapy and family counseling, among other services. All other TRICARE Prime beneficiaries must get prior authorizations for the following services:

- Adjunctive dental services (dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition)
- Extended Care Health Option covered services (ADFMs only)
- Home health care services
- Applied Behavior Analysis (ABA) for Autism Spectrum disorder
- Hospice care
- Nonemergency inpatient admissions for substance use disorders or mental health care
- Some mental health care visits and services
- Transplants—all solid organ and stem cell
- Some prescription medications (brand-name medications or those with quantity limitations)

This list is **not** all-inclusive. For more details, see *Covered Services*. Your regional contractor may have additional prior authorization requirements. Go to your regional contractor's website or call their toll-free number for details.

Point-of-Service Option

With TRICARE Prime, you pay more out-of-pocket to get nonemergency care without a referral from any TRICARE-authorized provider. This is called the point-of-service (POS) option.

Out-of-pocket expenses you pay under the POS option aren't applied to your yearly catastrophic cap.

The POS option doesn't apply to:

- Emergency care
- ADSMs
- Children in the first 60 days after birth or adoption
- Clinical preventive care you get from a network provider in your enrolled TRICARE region
- Beneficiaries with other health insurance
- The first eight outpatient mental health care visits per FY to a network provider for a medically diagnosed and covered condition

Getting Care While Traveling

You are covered by TRICARE Prime while traveling in the U.S. or overseas. You should get routine and specialty care before you leave on a trip, but you may need to fill a prescription or get urgent or emergency care while traveling. Stick to these guidelines to save money and get the best care available.

Traveling in the U.S.

Active Duty Service Members

In an **emergency**, call 911 or go to the closest emergency room. Let your PCM know within 24 hours or on the next business day. You don't need prior authorization before getting emergency care. If you are hospitalized, your regional contractor should be notified.

If you need **urgent care** while traveling or between duty stations, you must get treatment at a military hospital or clinic, if one is available. If no military hospital or clinic is available, you must get a PCM referral.

Non-Active Duty Service Members

In an **emergency**, call 911 or go to the closest emergency room. If you are admitted, you must notify your PCM within 24 hours or on the next business day.

For **urgent care** you may be able to use one of your two urgent care visits allowed under the Urgent Care Pilot. This doesn't apply to beneficiaries in USFHP. If you have used both of your visits, call your PCM for guidance.

Paying Up Front for Overseas Care

If you are **traveling overseas** and get care from a **purchased care sector provider (an authorized civilian provider in the overseas area)**, be prepared to pay up front and **file a claim** to get money back. You must submit proof of payment with overseas claims.

Traveling Overseas

Active Duty Service Members

In an **emergency**, go to the closest emergency care facility or call the Medical Assistance number for the area where you are. Contact the TOP Regional Call Center before leaving the facility, preferably within 24 hours or on the next business day. You don't need prior authorization before getting emergency care. If you are hospitalized, your regional contractor should be notified.

For **urgent care** overseas, ADSMs should call the TOP Regional Call Center.

Non-Active Duty Service Members

In an **emergency**, go to the closest emergency care facility or call the TOP Medical Assistance number for the area you're traveling in. Call your PCM and the TOP Regional Call Center before leaving the facility.

For **urgent care**, call your PCM and the local TOP Regional Call Center.

Routine and Specialty Care

You should get all of your routine care from your PCM before you travel in the U.S. or overseas. This includes all general office visits for ongoing care. If you can't get routine care before you travel, delay care until you return. If you get routine or specialty care during travel without a referral, you will pay more out-of-pocket under the *point-of-service option*.

If you seek some types of care, like most care from a specialist, without prior authorization from your regional contractor, your claim may be denied and you will be responsible for paying your entire bill.

Filling Prescriptions

You can use any TRICARE pharmacy option when traveling, but be sure your DEERS information is current. To fill a prescription, you need a valid uniformed services ID card or Common Access Card. If you're overseas and fill your prescription at an overseas civilian pharmacy, you will pay up front for your drug and file a claim with the TOP claims processor to get money back. USFHP enrollees can't use military hospital or clinic pharmacies or TRICARE network pharmacies while traveling, or at home.

Enrollment Portability

If you are traveling for more than 60 days, you may want to consider transferring your TRICARE Prime enrollment. This helps ensure you can easily get nonemergency care where you're traveling. Retirees and their family members are limited to two enrollment transfers each calendar year, but active duty beneficiaries have no limits on enrollment transfers. College students may, but are not required to, transfer enrollment from their sponsor's location to their school's location. Your regional contractor can help you transfer your enrollment.

Costs

TRICARE Prime ADSMs and ADFMs pay nothing to enroll. All other beneficiaries must pay a yearly enrollment fee. This includes:

- Retired service members
- Eligible retiree family members
- Survivors
- Eligible former spouses
- Other eligible TRICARE Prime beneficiaries

If you must pay a yearly enrollment fee, the fee is applied to your catastrophic cap. Your catastrophic cap is the maximum out-of-pocket amount you could pay each FY for TRICARE-covered services. After reaching your catastrophic cap, you don't pay out-of-pocket for additional covered care.

Enrollment fees can change each FY. However, enrollment fees are frozen for some beneficiaries, including survivors and medically retired service members and their dependents.

As long as at least one family member remains enrolled in TRICARE Prime, these beneficiaries continue to pay the same enrollment fee each year as they paid when they first became a survivor, medically retired or a medically retired dependent and enrolled in TRICARE Prime.

The TRICARE Prime enrollment fee is waived for any TRICARE Prime beneficiary who has Medicare Part B, regardless of age.

TRICARE may refund enrollment fees in certain limited cases, such as when a retiree is recalled to active duty, when a beneficiary dies or when a beneficiary becomes eligible for Medicare. In most cases, TRICARE Prime enrollment fees will not be refunded. If you are close to age 65 and nearing eligibility for Medicare, you should not choose the yearly payment option.

TRICARE Prime Enrollment Fee Payment Options

PAYMENT OPTIONS	PAYMENT INSTRUCTIONS
Automated deduction from retirement pay	Complete an *Enrollment Fee Allotment Authorization* available from your regional contractor. You can also contact your regional contractor by phone to establish an allotment. Once authorized, your TRICARE Prime enrollment fee is deducted automatically from your retirement pay on a monthly basis.
Electronic funds transfer (EFT)	To allow time for the EFT to be established, provide your correct banking information to your regional contractor. Once authorized, your TRICARE Prime enrollment fee is deducted automatically from your bank account on a monthly basis.
Visa, MasterCard or Discover (where available)[1]	Your initial and recurring monthly payment will be charged to your credit/debit card. Initial payments can be made through TRICARE's BWE website at www.dmdc.osd.mil/appj/bwe.

1. *Debit/credit card on file must be active (not expired) for payment to process successfully.*

TRICARE Programs

TRICARE Prime Remote

TRICARE Prime Remote (TPR) is similar to TRICARE Prime, but is available to active duty service members (ADSMs) living and working in a remote location that is a TPR-designated ZIP code, as well as active duty family members (ADFMs) living in the same location as their TPR-enrolled sponsor. If a sponsor gets unaccompanied permanent change of assignment orders, their family can stay in TPR if they remain in the location where they first enrolled.

To use TPR, you must enroll. TPR offers the same low out-of-pocket costs as TRICARE Prime.

TPR beneficiaries get care from primary care managers (PCMs) or TRICARE-authorized providers if network providers aren't available.

It is important for sponsors to keep DEERS records up to date. Eligibility for TRICARE is determined by law and the services, and information is shown in the Defense Enrollment Eligibility Reporting System (DEERS).

Contacts

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

TRICARE South Region
Humana Military
1-800-444-5445
HumanaMilitary.com

TRICARE West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Key Concepts

- Beneficiaries who live and work more than 50 miles from a military hospital or clinic may be eligible for TPR.
- To use TPR, you must enroll. Coverage isn't automatic.
- ADSMs who can't enroll in TRICARE Prime, must enroll in TPR.
- Family members must live at the sponsor's TPR-enrolled address to use TPR except if their sponsor gets unaccompanied permanent change of assignment orders and the family stays in the location where they first enrolled. Family members living inside a Prime Service Area aren't eligible for TPR enrollment.

Key Terms

- **Primary care manager (PCM):** The health care provider you visit for most care and who gives you referrals to see other providers.
- **Referral:** When your PCM sends you to another provider for care.
- **Prior authorization:** A review of a requested health care service by your regional contractor to see if TRICARE will cover the care.
- **Point-of-service option:** An option that lets you pay extra to get nonemergency care from any TRICARE-authorized provider without a referral.
- **Out-of-pocket cost:** Any costs you are responsible for paying when you get health care services or drugs.

Eligibility for TRICARE Prime Remote

You are required to use TPR if you are an ADSM (including a National Guard or Reserve member activated for more than 30 days) who:

- Lives and works more than 50 miles (about an hour's drive) from a military hospital or clinic
- Are in a TPR-designated ZIP code

To check your ZIP code, go to www.tricare.mil/tprzipcode and type in your home and work ZIP codes. You can also call your regional contractor.

Note: For family members, your DEERS information is used to determine your residency. If your sponsor is stationed in a remote location and you live with your sponsor, you can use TPR as long as your DEERS information is accurate.

Eligibility Exceptions

If you live or work within 50 miles of a military hospital or clinic, you won't generally be eligible for TPR. However, you can apply for an exception that will allow you to enroll if you are within 50 miles, but geographic boundaries mean you drive more than an hour to get to a military hospital or clinic.

To apply for an exception, submit a *TPR Determination of Eligibility Enrollment Request Form*. The request must be directed through your unit commander to the TRICARE Regional Office in your area. Go to www.tricare.mil/tpr to submit your request online.

Enrolling in TRICARE Prime Remote

To enroll in TPR, you must do one of the following:

- Use the Beneficiary Web Enrollment website at www.dmdc.osd.mil/appj/bwe
- Call your regional contractor
- Submit a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) to your regional contractor. You can find this form at www.tricare.mil/forms.

If you are an ADSM, you are considered enrolled on the day your regional contractor gets your request. Enrollment requests from non-ADSMs are subject to the 20th-of-the-month rule. This means enrollment requests received by the 20th of the month become effective at the beginning of the following month (a request received by Dec. 20 becomes effective Jan. 1). If the request is received after the 20th of the month, coverage won't start until the start of the second month after your request is processed (an application received Dec. 27 becomes effective Feb. 1).

You can stay in TPR as long as your sponsor is in TPR and you live in the same TPR-qualifying location. You can also stay in TPR if your sponsor gets unaccompanied permanent change of assignment orders, but you keep living in the same TPR-qualifying location where you first enrolled.

Family members who don't enroll in TPR will get care under *TRICARE Standard and TRICARE Extra*. You will have to pay applicable cost-shares and deductibles.

Getting Care

With TPR, if you have a PCM, you should follow the same rules for getting care as under *TRICARE Prime*. If you are assigned a PCM, he or she will be a civilian network provider. If more than one network PCM is available, you can choose the one you prefer.

Your PCM will provide routine care for illnesses or injuries and provide you with referrals for care he or she can't provide. If you need specialty care, your network PCM will work directly with your regional contractor for referrals and prior authorizations as needed.

ADSMs are always required to get referrals for all civilian care. This includes mental health care, specialty care and services that don't normally require a referral, like preventive services.

Visit your regional contractor's website for information about referral and prior authorization requirements, and other helpful information.

Note: If you have an appointment with a civilian health care provider and fail to attend, you may still be charged for the appointment.

When You Don't Have an Assigned Primary Care Manager

If a network provider isn't available, call your regional contractor to find a TRICARE-authorized provider or check www.tricare.mil/findaprovider. If you don't have a network PCM, you will coordinate your own specialty care with your regional contractor.

Remember that unlike a PCM who is a TRICARE network provider, some TRICARE-authorized providers don't coordinate referrals or prior authorizations with your regional contractor. You might have to contact your regional contractor directly. For more details, see *Find a Provider*.

Support for Active Duty Service Members in TRICARE Prime Remote

If you need help coordinating your civilian care, you have different options depending on your service branch. Call one of the following.

SERVICE BRANCH	CONTACT INFORMATION
U.S. Army, U.S. Navy, U.S. Air Force and U.S. Marine Corps	Defense Health Agency—Great Lakes 1-888-647-6676
U.S. Coast Guard	Coast Guard Benefits Line 1-800-942-2422
Commissioned Corps of the U.S. Public Health Service and National Oceanic and Atmospheric Administration	Medical Affairs Branch 1-800-368-2777

Your regional contractor will refer all specialty and inpatient care requests to the Defense Health Agency—Great Lakes (DHA-GL). The DHA-GL will review your request and determine if you need a fitness-for-duty determination and where you should get care. DHA-GL makes these determinations based on clinical standards and current service-specific guidelines.

If you have questions for the DHA-GL, call **1-888-MHS-MMSO (1-888-647-6676)**.

Costs

TPR offers the same costs as *TRICARE Prime*. That means out-of-pocket costs, network copayments, cost shares and point-of-service charges apply just as they do with TRICARE Prime. An ADSM or ADFM in TPR will have the same costs as an ADSM or ADFM in TRICARE Prime.

TRICARE Programs

TRICARE Standard and TRICARE Extra

TRICARE Standard and TRICARE Extra are available to TRICARE-eligible beneficiaries who aren't able to, or choose not to, enroll in a TRICARE Prime option. However, active duty service members (ADSMs) can't use TRICARE Standard and TRICARE Extra.

Unlike TRICARE Prime options, enrollment is not required, meaning there are no forms to fill out and no yearly enrollment fees to pay.

With TRICARE Standard and TRICARE Extra, you manage your own health care and may get care from any TRICARE-authorized provider you choose without a referral.

There are additional program options available for purchase that follow the same rules and costs as TRICARE Standard. These include TRICARE Retired Reserve (TRR), TRICARE Reserve Select (TRS), TRICARE Young Adult (TYA) Standard, and TRICARE For Life (TFL).

It is important for sponsors to keep DEERS records up to date. Eligibility for TRICARE is determined by law and the services, and information is shown in the Defense Enrollment Eligibility Reporting System (DEERS).

Contacts

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

TRICARE South Region
Humana Military
1-800-444-5445
HumanaMilitary.com

TRICARE West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Key Concepts

- You can get care from any TRICARE-authorized provider under TRICARE Standard.
- You save money by seeing providers in the TRICARE network (TRICARE Extra).
- Referrals aren't required, but you may need prior authorization for certain services.

Key Terms

- **Deductible:** A fixed amount you pay for covered services each fiscal year (Oct. 1–Sept. 30) before TRICARE pays anything.
- **Cost-share:** A percentage of the total allowed cost of a covered health care service that you pay.
- **TRICARE-authorized provider:** A provider that TRICARE has approved to give health care services to its beneficiaries.
- **Network provider:** Accepts the TRICARE-allowable charge as the full payment for any covered health care services you get. You can save money by seeing network providers. They also file claims for you.
- **Non-network provider:** Doesn't have an agreement with TRICARE and may not file claims for you.
- **Prior authorization:** A review of a requested health care service by your regional contractor to see if TRICARE will cover the care.
- **TRICARE-allowable charge:** The maximum amount TRICARE will pay for a covered service.

Eligibility for TRICARE Standard and TRICARE Extra

You can use TRICARE Standard and TRICARE Extra if you are a(n):

- Active duty family member (ADFM)
- Family member of a National Guard or Reserve member activated for more than 30 days
- Retiree
- Retiree family member
- Survivor
- ADFM, retired service member or retiree family member who has Medicare Part B, but isn't yet entitled to Part A
- Former spouse who meets certain eligibility requirements
- Medal of Honor recipient

You can't use TRICARE Standard and TRICARE Extra if you are:

- An ADSM, including a National Guard or Reserve member activated for more than 30 days
- In a TRICARE Prime option (you must disenroll before using TRICARE Standard and TRICARE Extra)
- A retired service member or retired family member who is entitled to Medicare
- A dependent parent or parent-in-law

Find a Provider

You can see any TRICARE-authorized provider for care under TRICARE Standard, but you may pay higher costs and have to file your own claims if you go outside the network. When you choose a TRICARE network provider, you are using the TRICARE Extra option, which means lower out-of-pocket costs and the provider files claims for you.

To find a TRICARE network provider, you can search online at www.tricare.mil/findaprovider, go to your regional contractor's website or call your regional contractor. If you plan to use TRICARE Standard and need help choosing a provider, call your regional contractor. Just remember that using a non-network provider means you have higher costs.

You may use TRICARE Standard and TRICARE Extra interchangeably as often as you like.

When you use the TRICARE Extra option, your provider will submit claims on your behalf. If you use the TRICARE Standard option, you may be required to submit your own health care claims.

TRICARE-Authorized Providers

- TRICARE-authorized providers are approved by TRICARE to give health care services to its beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers (for example, laboratories and radiology centers) and pharmacies that meet TRICARE requirements. A provider must be TRICARE-authorized for TRICARE to pay any part of your claim. If you see a provider who is not TRICARE-authorized, you are responsible for the full cost of care. To find a list of TRICARE-authorized providers, go to www.tricare.mil/findaprovider.
- There are two types of TRICARE-authorized providers: **network** and **non-network**.

Network Providers (TRICARE Extra)

- Regional contractors have established networks and you may be assigned a primary care manager (PCM) who is part of the TRICARE network.
- When specialty care is needed, your best option is for your PCM to coordinate the referral with your regional contractor.
- TRICARE network providers:
  - Have a signed agreement with your regional contractor to provide care
  - Accept TRICARE's payment as the full payment for any covered health care services you get
  - Agree to file claims for you

Non-Network Providers (TRICARE Standard)

- Non-network providers don't have a signed agreement with your regional contractor and are considered "out of network." In most cases, you won't get care from non-network providers unless authorized by your regional contractor. You may seek care from a nonnetwork provider in an emergency or if you are using the point-of-service (POS) option (using the POS option results in higher out-of-pocket costs).
- There are two types of non-network providers: **participating** and **nonparticipating**.

Participating Providers

- Using a participating provider is your best option if you are seeing a nonnetwork provider.
- Participating providers:
  - Accept TRICARE's payment as the full payment for any covered health care services you get
  - File claims for you

Nonparticipating Providers

- If you visit a nonparticipating provider, you may have to pay the provider first and later file a claim with TRICARE for reimbursement.
- Nonparticipating providers:
  - Don't accept TRICARE's payment as the full payment for covered health care services or file claims for you
  - Have the legal right to charge you up to 15 percent above the TRICARE-allowable charge for services (you are responsible for paying this amount in addition to any applicable patient costs)[1]

1. *Outside the U.S. and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands), there may be no limit to the amount that nonparticipating non-network providers may bill, and you may be responsible for paying any amount that exceeds the TRICARE-allowable charge. Go to www.tricare.mil/overseas for more information.*

Invite Your Provider To Become TRICARE-Authorized

If your provider isn't TRICARE-authorized, but is interested in treating TRICARE beneficiaries, let your provider know that he or she can treat TRICARE patients without becoming a network provider. Most providers with a valid professional license (issued by a state or a qualified accreditation organization) can become TRICARE-authorized and then TRICARE will pay them for covered services. To invite your provider to become TRICARE-authorized, go to www.tricare.mil/findaprovider and click "Do you want to invite your provider to join TRICARE? Learn More" to download a handout to give to your provider.

Emergency Care

If you have an emergency, call 911 or go to the closest emergency room. If you're admitted, you may need to get an authorization depending on the type of care you need. You or your provider can contact your regional contractor for help.

Most dental emergencies, such as going to the emergency room for a severe toothache, are not covered under the TRICARE medical benefit.

Avoid Using the Emergency Room for Nonemergency Conditions

Using the emergency room for nonemergency conditions can cost you more money and time. Your primary care physician or an urgent care center can usually treat you more quickly.

Types of Care under TRICARE Standard and TRICARE Extra

The table that follows describes emergency, urgent, routine and specialty care.

TYPE OF CARE	DEFINITION	EXAMPLES
Emergency	Treatment for a serious medical condition that the average person considers a threat to life, limb, sight or safety. Most dental emergencies, such as going to the emergency room for a severe toothache, are not covered under the TRICARE medical benefit.	No pulse, severe bleeding, spinal cord or back injury, chest pain, broken bone, inability to breathe
Urgent	Treatment for an illness or injury that won't result in further disability or death if not treated immediately, but does require professional attention within 24 hours.	Rash, Migraine headache, urinary tract infection, sprain, earache, rising fever
Routine	General health care services, including office visits and preventive care.	Symptoms of chronic or acute illnesses and diseases, follow-up care for an ongoing medical condition
Specialty	Medical care from specialists for treatment your PCM can't provide.	Cardiology, dermatology, gastroenterology, obstetrics

Urgent Care

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

Nurse Advice Line

If it's after hours or you aren't sure if you need to see a health care provider, call the Nurse Advice Line (NAL) at **1-800-TRICARE** (**1-800-874-2273**) and choose option 1. You can talk to a registered nurse 24/7 who can help you determine the right level of care you need for yourself or your child. The NAL is not for emergencies. If you have an emergency, call 911 or go to the closest emergency room.

Routine and Specialty Care

For all other care, such as routine physicals, ongoing treatment for a chronic condition, visits to a specialist or covered preventive care, schedule an appointment with a TRICARE-authorized provider (save money by staying in network). Some services may require prior authorization. See *Services Requiring Prior Authorization*.

Getting Care with TRICARE Standard and TRICARE Extra (includes TRICARE Reserve Select, TRICARE Retired Reserve and TRICARE Young Adult Standard)

	TRICARE EXTRA (NETWORK PROVIDERS)	TRICARE STANDARD (NON-NETWORK PROVIDERS)
Where do I get care?	• Get care from TRICARE network providers	• Get care from TRICARE-authorized non-network providers
What do I need to do before I can get care?	• No referrals are required • Some services require prior authorization	• No referrals are required • Some services require prior authorization
What will health care cost me?	• No enrollment costs • A yearly deductible and 5% discounted cost-shares apply • When following the rules of your program option, your out-of-pocket expenses will be limited to your catastrophic cap • Go to www.tricare.mil/costs	• No enrollment costs • A yearly deductible and cost-shares apply • When following the rules of your program option, your out-of-pocket expenses will be limited to your catastrophic cap • Nonparticipating non-network providers may charge up to 15% above the TRICARE-allowable amount (or any amount overseas); you are responsible for this amount, plus your deductible and cost-shares • Go to www.tricare.mil/costs

Note: If you have an appointment with a civilian health care provider and fail to attend, you may still be charged for the appointment.

Care at a Military Hospital or Clinic

Military hospitals and clinics provide medical and/or dental care to eligible individuals, including members of the uniformed services and their dependents. They are usually on or near military installations. You may get care at a military hospital or clinic, but only on a space-available basis. Appointments are limited, and you will have a lower priority for care. See the following figure for appointment priorities at military hospitals and clinics.

Note: If you have TRICARE Young Adult, access to military hospitals and clinics is based on your program option and your sponsor's status.

If you wish to get care at a military hospital or clinic, first check to see if the site can give you the care you need. Go to www.tricare.mil/mtf to find a military hospital or clinic. Otherwise, get care from a civilian TRICARE network or TRICARE-authorized non-network provider.

Note: If you are admitted to a military hospital or clinic and require any service not available within that facility (for example, ambulance, MRI, CT scan or specialist appointment), those services will be covered by your TRICARE Standard benefit. The military hospital or clinic won't pay for these services.

Care at a Veterans Affairs Facility

All U.S. Department of Veterans Affairs (VA) health care facilities have signed agreements with the regional contractors to be TRICARE network providers, agree to accept a negotiated rate as the full fee for services, file claims and handle paperwork for you. While VA facilities may or may not provide primary care, many provide specialty care. If you need care and a participating VA health care facility near you can provide that care (within TRICARE access standards), you may seek care at the VA facility.

Each VA facility has established a TRICARE beneficiary point of contact and check-in process. It is important to indicate, before getting care, that you are using your TRICARE benefit. If you don't specify, you could pay more, up to the full cost of care. Medicare-eligible beneficiaries will also have higher costs for non-service connected care at a VA facility. The VA is not a Medicare provider.

Military Hospital and Clinic Appointment Priorities

1. ADSM
2. ADFM in TRICARE Prime
3. Retired service members, their families and all others enrolled in TRICARE Prime or TRICARE Plus (primary care)
4. ADFMs not in TRICARE Prime and TRS members
5. Retired service members and their families not in TRICARE Prime, TRICARE Plus beneficiaries (specialty care), TRR members and all other eligible beneficiaries

TRICARE Plus

You may be able to sign up for TRICARE Plus. TRICARE Plus is a program that allows beneficiaries who normally are only able to get military hospital and clinic care on a space-available basis to enroll and receive primary care appointments at a military hospital or clinic. TRICARE Plus offers the same primary care access standards as non-active duty beneficiaries in a TRICARE Prime option get. Contact your local military hospital or clinic to see if TRICARE Plus is available and whether you can be in it. Enrollment in TRICARE Plus at one military hospital or clinic doesn't automatically extend TRICARE Plus enrollment to another military hospital or clinic. The military hospital or clinic is not responsible for any costs when a TRICARE Plus beneficiary is referred or seeks care outside the military hospital or clinic.

Services Requiring Prior Authorization

Although you don't need referrals to get care under TRICARE Standard and TRICARE Extra, some services may require prior authorization. Prior authorization is a review of a requested health care service by your regional contractor to see if TRICARE will cover the care. Some providers may contact your regional contractor to get prior authorization for you.

The following services require prior authorization:

- Adjunctive dental services (dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition)
- Extended Care Health Option covered services (ADFMs only)
- Home health care services
- Applied Behavior Analysis (ABA) for Autism Spectrum disorder
- Hospice care
- Nonemergency inpatient admissions for substance use disorders or mental health care
- Some mental health care visits and services
- Transplants—all solid organ and stem cell
- Some prescription medications (brand-name medications or those with quantity limitations)

This list is **not** all-inclusive. Each regional contractor has additional prior authorization requirements. Visit your regional contractor's website or call the toll-free number to learn about your region's requirements, which may change periodically.

Combat-Related Disability Travel Reimbursement

If you are a retiree and your Combat-Related Special Compensation (CRSC) Board has awarded you CRSC, you may be entitled to the CRSC travel benefit. This benefit provides reimbursement for travel-related expenses when you must travel more than 100 miles from your referring provider's location to get medically necessary, nonemergency specialty care for a combat-related disability. For more information, download the *Combat-Related Special Compensation Travel Benefit* fact sheet at www.tricare.mil/publications.

Getting Care While Traveling

Traveling in the U.S.

If you need emergency care while traveling in the U.S., call 911 or visit the closest emergency room. If you seek care from a TRICARE network provider, the provider will file the claim with your regional contractor for you. If you seek care from a TRICARE-authorized non-network provider, you may have to pay up front, save your receipts and file the claim with your regional contractor for reimbursement. Claims are always filed with the regional contractor in the region where you live, not with the regional contractor in the region where you are traveling.

Traveling Overseas

If you need emergency care while traveling overseas, go to the closest emergency care facility or call the Medical Assistance number for the overseas area where you are traveling. If you're admitted, notify the TRICARE Overseas Program (TOP) Regional Call Center before leaving the facility, preferably within 24 hours or on the next business day, to coordinate authorization, continued care and payment. Call the TOP Regional Call Center for urgent care assistance. You can get care from any purchased care sector provider (an authorized civilian provider in the overseas area) when traveling overseas, unless local restrictions apply. TOP Standard, including cost-shares and your deductible, is similar to TRICARE Standard in the U.S. TRICARE Extra is not available overseas. TRICARE nonparticipating non-network providers may charge up to 15 percent above the TRICARE-allowable amount in the U.S. and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands). Outside the U.S. and U.S. territories, there may be no limit to the amount that nonparticipating non-network providers may bill, and you are responsible for paying any amount that exceeds the TRICARE-allowable charge. **Note:** When seeking care from a purchased care sector provider, be prepared to pay up front for services and then file a claim with the TOP claims processor for reimbursement. You must submit proof of payment with all overseas claims. In the Philippines, you must use certified providers. To find a certified provider, go to www.tricare-overseas.com/philippines.htm.

Filling Prescriptions on the Road

You may use your pharmacy benefit when traveling, but be sure your DEERS information is current. To fill a prescription, you need a valid uniformed services ID card or Common Access Card. At overseas pharmacies, you will pay up front and file a claim with the TOP claims processor. **Note:** In the Philippines, you must use a certified pharmacy.

Costs

When using TRICARE Standard and TRICARE Extra, you will have a yearly deductible each FY (Oct. 1–Sept. 30) and pay cost-shares.

The following tables provide a quick comparison of cost-shares you pay when using TRICARE Standard and TRICARE Extra, along with information on the yearly deductible. For cost details, go to www.tricare.mil/costs.

TRICARE Standard and TRICARE Extra Yearly Deductible

BENEFICIARY CATEGORY	OUTPATIENT DEDUCTIBLE	
ADFMs and TRS (pay grades E-4 and below)	$50/Individual	$100/Family
ADFMs and TRS (pay grades E-5 and above)	$150/Individual	$300/Family
Retired service members, their families and all others	$150/Individual	$300/Family
Family members of National Guard and Reserve members activated for more than 30 days in support of a contingency operation	$0	

TRICARE Standard and TRICARE Extra Cost-Shares

	TRICARE STANDARD	TRICARE EXTRA
Provider type	TRICARE-authorized non-network[1]	TRICARE-authorized network
Outpatient cost-share after deductible is met	**ADFMs and TRS:** 20% of the TRICARE-allowable charge	**ADFMs and TRS:** 15% of the negotiated rate
	Retirees, their families, TRR and all others: 25% of the TRICARE-allowable charge	**Retirees, their families, TRR and all others:** 20% of the negotiated rate

1. *Non-network providers may also charge up to 15 percent above the TRICARE-allowable charge. You are responsible for paying this amount. For more information, see Finding a Provider.*

   ***Note:** Outside the U.S. and U.S. territories, there may be no limit to the amount nonparticipating non-network providers may bill, and you are responsible for paying any amount that exceeds the TRICARE-allowable charge. Go to www.tricare.mil/overseas for more information.*

Prohibition on Waiving Cost-Shares and Deductible

When using TRICARE Standard and TRICARE Extra, you are responsible, under law, to pay a yearly deductible and cost-shares associated with your care. The law prohibits health care providers from waiving the deductible or cost-shares and requires providers to make reasonable efforts to collect these amounts. Providers who offer to waive the deductible and cost-shares, or who advertise that they will do so, can be suspended or excluded as TRICARE-authorized providers.

Balance Billing and Violation of Participation Agreements

Nonparticipating providers in the U.S. may charge up to 15 percent above the TRICARE-allowable charge. This amount is your responsibility and won't be reimbursed by TRICARE. Participating providers are prohibited from this practice, which is called balance billing—billing you for any amount in excess of the TRICARE-allowable charge, less any applicable cost-share you pay. Once a participating provider marks "yes" on the claim form for that service, he or she can't later revoke or cancel that decision.

TRICARE Programs

Choices for National Guard and Reserve Members and Their Families

To maintain medical readiness and optimal health, National Guard and Reserve members should maintain continuous health and dental coverage. TRICARE offers coverage options for National Guard and Reserve members and their qualifying family members. These options will vary throughout the sponsor's career based on duty status: not activated, pre-activation/activation, deactivated or retired.

It is important for sponsors to keep DEERS records up to date. Eligibility for TRICARE is determined by law and the services, and information is shown in the Defense Enrollment Eligibility Reporting System (DEERS).

Contacts

TRICARE North Region
Health Net Federal Services, LLC
1-877-TRICARE (1-877-874-2273)
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TRICARE South Region
Humana Military
1-800-444-5445
HumanaMilitary.com

TRICARE West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Key Concepts

- Your coverage options may change as you transition between duty statuses.
- You must qualify for and purchase TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) coverage.

Key Terms

- **Not activated:** Includes National Guard and Reserve members on inactive duty for training, yearly training and otherwise on active service for 30 days or less.
- **Pre-activation/activated:** National Guard and Reserve members activated for more than 30 days in support of a contingency operation may be eligible for active duty health and dental benefits (early eligibility) up to 180 days before active duty begins, as shown in DEERS.
- **Deactivated:** National Guard and Reserve members released from a period of active duty of more than 30 days.
- **Retired:** Includes the period from your retirement date to turning age 60. At age 60, Retired Reserve members become eligible for the same premium-free TRICARE programs as retired active duty service members.
- **Gray area:** The period between retiring from the National Guard or Reserve and turning age 60.

Coverage by Sponsor Status

As a National Guard and Reserve member or family member, your coverage will vary depending on your or your sponsor's duty status: not activated, pre-activation/activated, deactivated or retired. The graphic on the next page summarizes the program options that may be available to you and your family members at each stage.

TRS and TRR are available for purchase by qualified National Guard and Reserve members who aren't activated. Selected Reserve and Retired Reserve members don't qualify to purchase TRS or TRR if they are eligible for or enrolled in the Federal Employees Health Benefits (FEHB) Program. National Guard and Reserve members activated for more than 30 days are covered as ADSMs, and their family members are covered as active duty family members (ADFMs). For more information on enrolling in a TRICARE program option, go to www.tricare.mil/enroll.

This section explains how to qualify for and purchase TRS or TRR coverage and summarizes the programs' benefits and costs. TRS and TRR offer qualified members and survivors:

- Comprehensive health coverage similar to TRICARE Standard and TRICARE Extra. For additional information, see *TRICARE Standard and TRICARE Extra* or go to www.tricare.mil.
- Two types of coverage: member-only and member-and-family
- Care from any TRICARE-authorized provider without a referral
- Access to care at military hospitals and clinics on a space-available basis. TRS members and their families have the same military hospital and clinic appointment priority as ADFMs who aren't in TRICARE Prime. TRR members and their families have the same military hospital and clinic appointment priority as retirees and retiree family members not in TRICARE Prime.

Note: If you have an appointment with a civilian health care provider and fail to attend, you may still be charged for the appointment.

"TRS ensured my son received lifesaving care before he was born and after. He spent the first 7 months of life in the neonatal intensive care unit going through numerous surgeries... We found out last year that he had a brain tumor and he went through yet another surgery... TRICARE has been amazing through all of this! With so many things to take care of, I never had to worry about the insurance side of it."

–C.L., TRICARE beneficiary

Coverage by Sponsor Status

SPONSOR STATUS	HEALTH CARE OPTIONS		
 **Not activated** Includes National Guard and Reserve members on inactive duty for training, yearly training and otherwise on active service for 30 days or less.	**Sponsor options** • TRS • TRICARE Dental Program (TDP)		**Family member options** • TRS • TRICARE Young Adult (TYA) • TDP
 **Pre-activation/activated** Includes National Guard and Reserve members activated for more than 30 days in support of a contingency operation. These service members may be eligible for active duty health and dental benefits (early eligibility) up to 180 days before active duty begins, as shown in DEERS.	**Sponsor options** • TRICARE Prime • TPR • TRICARE Active Duty Dental Program (ADDP)		**Family member options** • TRICARE Prime • TPR • US Family Health Plan (USFHP) (depending on location) • TRICARE Standard and TRICARE Extra • TYA • TDP
 **Deactivated** Includes National Guard and Reserve members released from a period of active duty.	**Sponsor options** • TRS • Transitional Assistance Management Program (TAMP) • Continued Health Care Benefit Program (CHCBP) • TRICARE Prime		**Family member options** • TRS • TYA • TAMP • TDP
 **Retired** Includes retired National Guard and Reserve members.	**BEFORE AGE 60** **Sponsor options** • TRR **Family member options** • TRR • TYA • TRICARE Retiree Dental Program (TRDP)	**AGES 60–64** **Sponsor options** • TRICARE Prime • USFHP (depending on location) • TRICARE Standard and TRICARE Extra • TFL (if entitled to Medicare Part A and have Medicare Part B) **Family member options** • TRICARE Prime • USFHP (depending on location) • TRICARE Standard and TRICARE Extra • TYA • TRICARE For Life (TFL) (if entitled to Medicare Part A and have Medicare Part B) • TRDP	**AGES 65 AND UP** **Sponsor options** • TFL (if entitled to Medicare Part A and have Medicare Part B) **Family member options** • TYA • TFL (if entitled to Medicare Part A and have Medicare Part B) • TRDP

Not Activated

National Guard and Reserve members on inactive duty for training, yearly training and otherwise on active service for 30 days or less may be eligible for line of duty care or TRICARE Reserve Select.

Line of Duty Care

Line of duty (LOD) care covers treatment of an injury, illness or disease incurred or aggravated in the line of duty. Contact your service or Reserve component for an LOD determination. LOD care is not available for family members.

TRICARE Reserve Select®

Description	• Premium-based health care plan that qualified Selected Reserve members may purchase for themselves and/or their family members • Coverage and costs for care similar to TRICARE Standard and TRICARE Extra for ADFMs, except that TRS has monthly premiums
Enrolling	• Enrollment required • Offers member-only and member-and-family coverage • Must qualify for and purchase TRS to participate • Initial two-month premium payment due with enrollment form
Costs	• Monthly premiums, a yearly deductible and cost-shares apply
Getting care	• Get care from any TRICARE-authorized provider (network or non-network) • Get care at a military hospital or clinic on a space-available basis • No referrals required • Some services require prior authorization

Pre-Activation/Activated

National Guard and Reserve members activated for more than 30 days in support of a contingency operation may be eligible for active duty health and dental benefits (early eligibility) up to 180 days before active duty begins, as shown in DEERS. These benefits include TRICARE Prime, TPR, US Family Health Plan (USFHP) and TRICARE Standard and TRICARE Extra.

TRICARE Prime Options

Description	• Includes TRICARE Prime, TPR and USFHP (ADSMs are not eligible for USFHP) • Similar to a managed-care option, available in specific geographic areas • ADSMs, or National Guard and Reserve members activated for more than 30 days, must enroll in a TRICARE Prime option; their family members may choose to enroll in a TRICARE Prime option or use TRICARE Standard and TRICARE Extra
Enrolling	• Enrollment required
Costs	• ADSMs, ADFMs, surviving spouses (during the first three years) and surviving dependent children have no enrollment costs • ADSMs and ADFMs have no premiums, no deductible and no out-of-pocket costs (when following the rules of your TRICARE Prime option)
Getting care	• Get most care from a military hospital or clinic or civilian network primary care manager (PCM) • Referrals and/or prior authorizations required for specialty care • If traveling or between duty stations, you must get all nonemergency care at a military hospital or clinic if one is available, or get a referral from your PCM

TRICARE Standard and TRICARE Extra

Description	• Manage your own health care and get care from any TRICARE-authorized provider without a referral
Enrolling	• No enrollment required
Costs	• No enrollment costs • No premiums • A yearly deductible and cost-shares apply
Getting care	• No referrals required • Some services require prior authorization • **TRICARE Standard:** Get care from TRICARE-authorized non-network providers • **TRICARE Extra:** Get care from TRICARE network providers • Get care at a military hospital or clinic on a space-available basis

Note: For family members whose sponsor is activated in support of a contingency operation for more than 30 days, the TRICARE Standard and TRICARE Extra deductible is waived and TRICARE will pay up to 115 percent of the TRICARE-allowable charge for care received from providers who are not part of the TRICARE network of civilian providers.

Deactivated

National Guard and Reserve members who separate from active duty, or are deactivated, may be eligible to continue TRICARE coverage.

Transitional Assistance Management Program

TAMP provides 180 days of transitional health care benefits to help certain service members and their families transition to civilian life. For more information, see *Transitional Assistance Management Program*.

TRICARE Reserve Select

Description	• Premium-based health care plan that qualified Selected Reserve members may purchase for themselves and/or their family members • Coverage and costs for care similar to TRICARE Standard and TRICARE Extra for ADFMs, except that TRS has monthly premiums
Enrolling	• Enrollment required • Offers member-only and member-and-family coverage • Must qualify for and purchase TRS to participate • Initial two-month premium payment due with enrollment form
Costs	• Monthly premiums, a yearly deductible and cost-shares apply
Getting care	• Get care from any TRICARE-authorized provider (network or non-network) • Get care at a military hospital or clinic on a space-available basis • No referrals required • Some services require prior authorization

Extended TRICARE Reserve Select and TRICARE Dental Program Coverage Following Involuntary Separation

Certain members who are involuntarily separated from the Selected Reserve under other than adverse conditions may have access to extended TRS and TDP coverage up to 180 days from their separation date. For more information, contact your service personnel unit.

Continued Health Care Benefit Program

CHCBP is a premium-based health care program administered by Humana Military. Though not a TRICARE program, CHCBP offers continued health coverage (18–36 months) after TRICARE coverage ends and is considered minimum essential coverage under ACA. Certain former spouses who have not remarried before age 55 may qualify for an unlimited duration of coverage. If you qualify, you can purchase CHCBP coverage within 60 days of loss of TRICARE or TAMP coverage, whichever is later. Visit www.tricare.mil/chcbp for more information.

Note: You're not legally entitled to space-available care at military hospitals or clinics while in CHCBP. For more information, see *Continued Health Care Benefit Program Coverage*.

Retired

After retirement, your options change as you age.

TRICARE Retired Reserve® (up to age 60)

Description	• Premium-based health care plan for qualified Retired Reserve members and/or their family members until the sponsor turns age 60
Enrolling	• Enrollment required • Offers member-only and member-and-family coverage • Must qualify for and purchase TRR to participate • Initial two-month premium payment due with enrollment form
Costs	• Monthly premiums, a yearly deductible and cost-shares apply
Getting care	• Get care from any TRICARE-authorized provider (network or non-network) • Get care at a military hospital or clinic on a space-available basis • No referrals required • Some services require prior authorization

After TRICARE Retired Reserve Ends (ages 60–64)

Retired Reserve members ages 60–64 and their family members are eligible for premium-free TRICARE Standard and TRICARE Extra, or may enroll in TRICARE Prime (if in a PSA), which requires payment of the yearly TRICARE Prime enrollment fee. Beneficiaries who are entitled to premium-free Medicare Part A and also have Medicare Part B become eligible for TFL. In general, if you become entitled to Medicare Part A, you must also have Medicare Part B to remain eligible for TRICARE. If you sign up for Medicare Part B after your initial enrollment period, you may have to pay higher monthly premiums for as long as you have Medicare Part B.

Note: If you become eligible for retirement pay before age 60, you still aren't eligible for premium-free TRICARE program options (for example, TRICARE Prime or TRICARE Standard) until age 60.

TRICARE For Life

Description	• TRICARE's Medicare-wraparound coverage available to TRICARE beneficiaries entitled to Medicare Part A and who have Medicare Part B, regardless of age or where you live
Enrolling	• No enrollment required • Must be entitled to premium-free Medicare Part A and have Medicare Part B
Costs	• No enrollment fees • No monthly premiums
Getting care	• Get care from Medicare-participating, Medicare-nonparticipating or opt-out providers. Participating providers agree to accept the Medicare-approved amount as payment in full. Medicare-nonparticipating providers don't accept the Medicare-approved amount as payment in full. They may charge up to 15 percent above the Medicare-approved amount, a cost that will be covered by TFL. **Note:** You will have significant out-of-pocket costs if you get services from opt-out providers. • Includes TRICARE pharmacy benefits

Medicare-eligible beneficiaries will have higher costs for non-service connected care from a VA facility. The VA is not a Medicare provider.

Qualifying for TRS or TRR

To purchase TRS or TRR, use the Defense Manpower Data Center (DMDC) Reserve Component Purchased TRICARE Application at www.dmdc.osd.mil/appj/reservetricare:

- Select "Purchase Coverage" and follow the steps.
- Print and sign the completed *Reserve Component Health Coverage Request Form* (DD Form 2896-1). Those who don't qualify won't be able to complete or print the form.

For technical problems, call **1-800-477-8227**.

Purchasing TRS or TRR

You may purchase TRS or TRR coverage to begin in any month of the year.

- **Deadline:** Your application must be postmarked or received no later than the last day of the month before coverage is to begin.
- **Effective date:** Coverage begins the first day of the next month or the first day of the second month as indicated on *DD Form 2896-1*.

If you have a qualifying life event that affects your coverage (for example, marriage, birth, a child aging out), you may request changes to your TRS or TRR coverage. Your application must be postmarked or received no later than 60 days after the date of the event and premium payments are made. Your coverage date will coincide with the date of the event.

1

Am I Eligible?

To qualify for TRS or TRR, you must not be:

- On active duty orders for more than 30 days
- Covered under TAMP
- Eligible or enrolled in the FEHB Program directly or through a family member

Make sure you've registered and updated your and your dependents' information in DEERS (www.tricare.mil/deers).

2

Log in to the Defense Manpower Data Center (DMDC) Reserve Component Purchased TRICARE Application (www.dmdc.osd.mil/appj/trs) using your Common Access Card, Defense Finance Accounting Service myPAY PIN or Department of Defense Self-Service Logon.

3

Select "Purchase Coverage" and fill out the *Reserve Component Health Coverage Request Form* (DD 2896-1)

Print and sign *DD Form 2896-1*.

4

Set up your TRICARE payments online through your regional contractor or by filling out the *Electronic Funds Transfer (EFT)/Recurring Credit Card (RCC) Form* for your TRICARE region (North, South, West).

Print and sign the EFT and RCC forms.

TRICARE Payment Options

When purchasing TRS or TRR, the initial two-month premium payment can be made by check, money order, cashier's check or a debit/credit card. All following premium payments must be made by EFT or RCC.

5

Mail or fax your *DD 2896-1* and payment forms (if applicable) to your TRICARE regional contractor.

Make sure to submit an initial two-month premium payment with your completed EFT/RCC form to enroll.

Not sure who your TRICARE regional contractor is?

See *TRICARE Stateside Regions*.

Termination of TRS or TRR Coverage

REASON YOUR COVERAGE IS ENDING	IMPACT ON YOUR COVERAGE
Choosing to end coverage	You can end your coverage at any time. To end your coverage: • Go to www.dmdc.osd.mil/appj/trs to log in to the Defense Manpower Data Center (DMDC) Reserve Component Purchased TRICARE Application, and follow the instructions to disenroll. • Print, sign and mail or fax your completed *DD Form 2896-1* to your regional contractor. The coverage end-date is effective the last day of the month your request is postmarked or received. For TRR members, a 12-month purchase lockout will occur if you voluntarily choose to end your coverage. TRS members will have their coverage suspended.
Nonpayment	If your automated TRS or TRR premium payment is not received by the end of the current month a premium is due, your coverage may be suspended or terminated, and you may be subject to a 12-month lockout. **Note for TRS members:** If your TRS coverage is suspended, call your regional contractor for information about the possibility of having your coverage reinstated.
Leaving the Selected Reserve	Your TRS coverage will end automatically. You may purchase TRS coverage again if you requalify, and a purchase lockout won't apply.
Change in status	If you are ever activated for more than 30 days: • You and your family may become eligible for premium-free TRICARE program options. • Your TRS or TRR coverage automatically ends and unused premiums already paid will be refunded. • The 12-month purchase lockout doesn't apply. If you want TRS or TRR coverage to continue after losing your other TRICARE coverage with no break in coverage, you must qualify for and buy TRS or TRR coverage again no later than 30 days after the other TRICARE coverage ends.
Change in FEHB Program eligibility or enrollment	Disenroll from TRS or TRR if you become eligible for or enrolled in the FEHB Program. No purchase lockout will go into effect. If you fail to end coverage as required, your Reserve component may terminate your coverage and you will be responsible for any health care costs after the effective date of termination.

TRICARE Programs

Contacts

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

TRICARE South Region
Humana Military
1-800-444-5445
HumanaMilitary.com

TRICARE West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Medicare
www.medicare.gov

Social Security Administration
1-800-772-1213
www.ssa.gov

Additional Programs and Health Care Coverage

Several other programs support service members and their families. These are optional programs that are available to you and your family if you qualify for these benefits.

Other TRICARE programs include:

- TRICARE Young Adult (TYA)
- TRICARE For Life (TFL)
- US Family Health Plan (USFHP)
- Supplemental Health Care Program (SHCP)
- Transitional Assistance Management Program (TAMP)
- Continued Health Care Benefit Program (CHCBP)
- Comprehensive Autism Care Demonstration
- Extended Care Health Option (ECHO)

TRICARE Young Adult

TYA is a premium-based health care plan qualified adult-age dependents may purchase. TYA offers TRICARE Prime and TRICARE Standard coverage worldwide that only includes medical and pharmacy benefits. TYA Prime or TYA Standard must be offered in your area and you must meet all criteria to enroll.

TRICARE Young Adult Eligibility

Your physical location, your sponsor's status and your sponsor's TRICARE coverage determine your eligibility for TYA Prime and/or TYA Standard. Special eligibility situations may exist. Generally, you can purchase TYA coverage if you are all of the following:

- A dependent of a TRICARE-eligible uniformed service sponsor
- Unmarried
- At least age 21, but not yet age 26

You can't purchase TYA coverage if you are:

- Eligible for an employer-sponsored health plan
- Otherwise eligible for TRICARE program coverage
- Married
- A uniformed service sponsor (for example, a member of the Selected Reserve)

Adult-age dependents are encouraged to evaluate all health care coverage options after aging out of TRICARE. While you may qualify to purchase TYA coverage, it isn't your only health care coverage option. Financial assistance to purchase commercial health care coverage may be available through the Health Insurance Marketplace at www.health.gov. You may also be eligible for Medicaid coverage depending on your status and the state you live in.

Qualification to Purchase TRICARE Young Adult Coverage Based on Sponsor Status

SPONSOR STATUS	TRICARE PRIME	TRICARE PRIME REMOTE	TRICARE STANDARD	USFHP
Active duty	✔	✔	✔	✔
Retired	✔	✘	✔	✔
Selected Reserve	✘	✘	✔	✘
Retired Reserve	✘	✘	✔	✘
TAMP	✔	✘	✔	✔

Buying TRICARE Young Adult

You may buy TYA coverage at any time. If you aren't already registered in the Defense Enrollment Eligibility Reporting System (DEERS), your sponsor must add you to the system before you can enroll.

If you enroll in TYA Standard, your coverage begins the first day of the next month after your enrollment request is processed and payment is received. If you enroll in TYA Prime, your coverage follows the 20th-of-the-month rule:

- As long as your *TRICARE Young Adult Application* (DD Form 2947) is received by the 20th of the month, coverage begins on the first day of the next month (for example, an enrollment received by Dec. 20 becomes effective Jan. 1).
- If it is received after the 20th of the month, coverage won't start until the start of the second month after your request is processed (for example, an enrollment received on Dec. 27 becomes effective Feb. 1).

TRICARE Young Adult Enrollment Options:

- **Online:** Log in to the Beneficiary Web Enrollment website at www.dmdc.osd.mil/appj/bwe.
- **Phone:** Call your regional contractor.
- **Mail or Fax:**
  1. Download *DD Form 2947* for your TRICARE region from www.tricare.mil/plans/enroll/tya.
  2. Complete and sign the form.
  3. Confirm you're unmarried, not eligible for an employer-sponsored health plan and not otherwise TRICARE-eligible.
  4. Send the form by mail or fax along with two months of premium payments (personal check, cashier's check, money order or credit/debit card). You can find mailing addresses and fax numbers on the form.

After Buying TRICARE Young Adult

After enrolling in TYA and getting confirmation from your regional contractor that your application processed, you and your sponsor will need to go to a uniformed services ID card office to get your ID card.

Get A Uniformed Services ID Card

1. Go to www.dmdc.osd.mil/rsl to find a uniformed services ID card office near you.
2. See if an appointment is required.
3. If your sponsor can't go with you, visit www.dmdc.osd.mil/rsl to find the local office phone number and find out what documentation is required.

Getting Care under TRICARE Young Adult

TYA covers medical and pharmacy benefits. If you have TYA Prime, you have TRICARE Prime access to care through your assigned military or civilian primary care manager (PCM).

If you have TYA Standard, you can get care at military hospitals and clinics on a space-available basis.

If you are pregnant, the TYA program provides maternity care for you throughout your pregnancy. Your child won't be covered by TRICARE unless the other parent is an eligible sponsor or the child is adopted by an eligible sponsor.

For more information, see *Covered Services*.

TRICARE Young Adult Costs

After the initial payment, monthly premiums must be paid in advance by automated electronic payment. Your premium payment is due no later than the last day of the month for the next month's coverage. TYA premiums are adjusted yearly and become effective Jan. 1. Copayments and cost-shares count toward your deductible or catastrophic cap. Go to www.tricare.mil/costs for more information on costs.

- **TYA Prime:** Copayments are the same as for TRICARE Prime in the U.S.
- **TYA Standard:** Cost-shares are the same as for TRICARE Standard and TRICARE Extra in the U.S. and count toward individual and family deductibles. Your deductible amount depends on your sponsor's category.

Ending TRICARE Young Adult Coverage

Choosing To End Coverage

You may end your TYA coverage at any time. To end coverage, complete the fields related to terminating coverage on *DD Form 2947* and submit it to your regional contractor. When you end TYA coverage, you will be locked out from purchasing TYA coverage for 12 months starting on the date of termination. There is no lockout if you end TYA coverage because you gain access to an employer-sponsored health plan or another TRICARE program.

Nonpayment

If you don't pay your total premium amounts or fees owed, your TYA coverage will end. You will then be locked out from purchasing TYA coverage for 12 months after TYA ends.

Change in Status

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

Your TYA coverage ends when any of the following occurs:

- You reach age 26
- You get married
- You become eligible for an employer-sponsored health plan
- You get or become eligible for another TRICARE program
- Your sponsor ends TRICARE coverage

You may qualify for CHCBP after your TYA coverage ends. See *Continued Health Care Benefit Program*, for more information or go to the Health Insurance Marketplace at www.health.gov to explore your health coverage options.

Changing Your TRICARE Young Adult Options

If you have TYA and want to change your TYA program option, you can make changes online, by phone or by mail or fax.

If you switch programs within the same region, your regional contractor will adjust your future premium payments by applying any overages to future premium payments. Your regional contractor will also adjust the automated electronic payments to prevent overcharges or undercharges.

If you want to change your TYA program option and you are also transferring to a new region, your monthly premium payments must be up-to-date to make this change. It will take up to 10 calendar days for your transfer request to be processed and your automated electronic payments to be adjusted.

Make Changes to Your TRICARE Young Adult Coverage:

Online: Visit www.dmdc.osd.mil/appj/bwe.

Phone: Call your regional contractor.

Fax or Mail: Send your completed *DD Form 2947* to the fax number or mailing address listed on the form.

TRICARE For Life

TFL is Medicare-wraparound coverage for individuals who have Medicare Part A and Medicare Part B, regardless of age or where you live. TFL is managed by the Department of Defense. Medicare is managed by the Centers for Medicare & Medicaid Services. With TFL, you can go to:

- Medicare-participating providers
- Medicare-nonparticipating providers
- Military hospitals and clinics on a space-available basis

If you see Medicare-participating providers, they will file claims with Medicare for you. Medicare and TRICARE coordinate benefits. Medicare pays its part and automatically sends the claim to TRICARE for processing. If you have other health insurance (OHI), Medicare forwards the claim to your OHI and you are responsible for submitting a claim with TRICARE if there is any remaining balance after your OHI pays. TRICARE pays after Medicare and OHI for TRICARE-covered services.

Note that some providers opt out of Medicare. That means they can't bill Medicare and can charge any amount for your care. When you see an opt-out provider, Medicare pays nothing and TRICARE is the second payer, unless you have OHI. TRICARE pays up to 20 percent of the amount allowed by TRICARE for that service and you are responsible for the rest of the bill. This rule also applies to any care you get from a U.S. Department of Veterans Affairs provider for an injury or illness that is not connected to your military service.

"TFL has been a lifesaver for us; it takes care of what Medicare does not, and helps with medications."

–L.S., TRICARE beneficiary

Medicare

Medicare is a federal entitlement health insurance program for people:

- Age 65 or older
- Under age 65 with certain disabilities
- With end-stage renal disease, Lou Gehrig's Disease (also called amyotrophic lateral sclerosis or ALS) or mesothelioma in limited cases

Medicare offers several plans to cover different types of health care services. Most health care is covered under Medicare Part A or Medicare Part B.

Medicare Part A: The SSA determines your entitlement to Part A. You're entitled to premium-free Medicare Part A at age 65 if you or your spouse (former or deceased spouse) has 40 quarters or 10 years of Social Security-covered employment.

Medicare Part B: Medicare Part B has a monthly premium that may change yearly and varies based on your income. If you sign up after your initial enrollment period for Medicare Part B, you may have to pay a higher monthly premium for as long as you have Medicare Part B.

MEDICARE PART A (HOSPITAL INSURANCE)	MEDICARE PART B (MEDICAL INSURANCE)
• Inpatient hospital care • Hospice care • Inpatient skilled nursing facility care • Some home health care	• Provider services • Outpatient care • Home health care • Durable medical equipment • Some preventive services

US Family Health Plan

USFHP is a TRICARE Prime option. Care is provided through networks of community-based not-for-profit health care systems in six areas of the U.S. You must be in DEERS and live within one of the six designated USFHP service areas to enroll.

USFHP coverage is available to active duty family members (ADFMs), retirees and retiree family members until becoming entitled to Medicare at age 65. If you are under age 65 and are entitled to Medicare Part A, you can participate in USFHP. Contact a Beneficiary Counseling and Assistance Coordinator (BCAC) for more information regarding USFHP eligibility.

US Family Health Plan Info

www.usfhp.com

1-800-74-USFHP (1-800-748-7347)

Supplemental Health Care Program

The SHCP is a program for eligible service members and certain others who need medical care that isn't available at a military hospital or clinic. The SHCP allows care to be purchased from civilian providers. Approval to get SHCP is required from the Defense Health Agency—Great Lakes, a military hospital or clinic commander or the director of the Defense Health Agency, as required. Call your regional contractor for more information.

Transitional Assistance Management Program

TAMP offers 180 days of health care benefits to help certain service members and their families switch to civilian life.

Eligibility for Transitional Assistance Management Program

The services determine TAMP eligibility, which is shown in DEERS. If you have questions about your eligibility, call your personnel office and/or command unit representative. For more information, go to www.tricare.mil/tamp.

You and your eligible family members may get TAMP health care benefits when active duty ends if you:

- Involuntarily separate from active duty under honorable conditions. This includes service members who receive a voluntary separation incentive or voluntary separation pay and aren't entitled to retirement pay.
- Are a National Guard or Reserve member separating from a period of active duty that was more than 30 days in support of a contingency operation
- Separate following involuntary retention (stop-loss) in support of a contingency operation
- Separate following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation
- Separate and agree to immediately become a member of the Selected Reserve with no gap in service
- Separate due to a sole-survivorship discharge

You aren't eligible for TAMP while on:

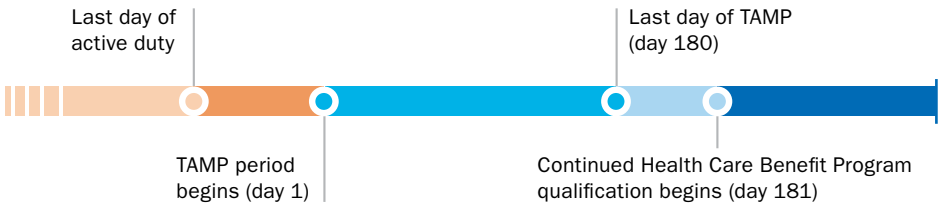
- Terminal leave
- Authorized excess leave
- Permissive temporary duty (PTDY)

Coverage under the Transitional Assistance Management Program during Leave

During terminal leave, authorized excess leave or PTDY, you are still considered an active duty service member (ADSM) and must get or coordinate your care with your last duty station. During this time, you can't change your PCM, even if you move. Your family can switch PCMs if you move, but your TRICARE Prime option may not be available in your new location. If you and your family stay in the same place during leave or PTDY, you and your family members can keep using your TRICARE Prime option. If you were stationed overseas and you move back to the U.S., coordinate referrals and prior authorizations with International SOS Government Services, Inc., the TOP contractor.

When Does the Transitional Assistance Management Program Start and End?

If eligible, TAMP starts the day after you separate from active duty. You and your family are automatically covered by TRICARE Standard and TRICARE Extra. You may continue using TRICARE Standard and TRICARE Extra or you can enroll or reenroll in TRICARE Prime. ADSMs must reenroll in TRICARE Prime to avoid a break in coverage.



You can enroll or reenroll in TRICARE Prime if you:

- Live in a Prime Service Area, which is a geographic area where TRICARE Prime is offered. It is typically near a military hospital or clinic.
- Live or work within 100 miles of an available PCM and waive your drive-time access standards.

You may have new costs when you leave active duty, but your family's benefit remains unchanged with the same rules and costs. Be aware that TRICARE Prime Remote (TPR) isn't available under TAMP. For cost information, go to www.tricare.mil/costs.

To make sure you're covered during your entire TAMP period, you must keep your and your family's information current in DEERS.

Getting Care for a Service-Related Condition

If you have TAMP and are newly diagnosed with a medical condition related to your active duty service, you may qualify for the Transitional Care for Service-Related Conditions (TCSRC) program. The program gives you up to 180 days of care for your condition with no out-of-pocket costs.

Learn more about applying for TCSRC at www.tricare.mil/tcsrc.

Enrolling in TRICARE Prime During the Transitional Assistance Management Program

WHAT PROGRAM WERE YOU ENROLLED IN WHEN YOU SEPARATED?	CAN YOU GET TRICARE PRIME?
You and your family had TRICARE Prime up until your separation date.	You can keep TRICARE Prime with no break in coverage by: • Reenrolling online at www.dmdc.osd.mil/appj/bwe • Calling your regional contractor • Completing a new *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) Any of the above must be done before the TAMP period ends.
You and your family didn't have TRICARE Prime up until your separation date.	You can still get TRICARE Prime • **To have TRICARE Prime on day 1 of TAMP:** Your enrollment request (online, by phone or by mail) must be processed by the 20th of the month before your TAMP coverage begins. • **If your request isn't processed by the 20th of the month:** Your TRICARE Prime coverage won't start until the start of the second month after your request is processed (for example, a request received Dec. 27 becomes effective Feb. 1). This means you won't have TRICARE Prime on day 1 of TAMP. **Note:** You'll be covered under TRICARE Standard and TRICARE Extra until your TRICARE Prime enrollment is processed.
You and your family had TPR in the U.S.	TPR in the U.S. isn't available during TAMP, but you can enroll in TRICARE Prime online, by phone or by mail. **Note:** You'll be covered under TRICARE Standard and TRICARE Extra until your TRICARE Prime enrollment is processed.

Note: You may have the option to enroll in USFHP if you live in one of the plan's service areas. For more information, go to www.usfhp.com.

Dental Care During the Transitional Assistance Management Program

During TAMP, service members can get dental care from military dental clinics on a space-available basis. When needed, they can also see civilian providers through the TRICARE Active Duty Dental Program.

Family members' eligibility for the TRICARE Dental Program (TDP) depends on the sponsor's status in DEERS. If your sponsor is:

- **Leaving active duty:** Family members are no longer eligible for TDP coverage once their sponsor's status in DEERS changes. You can get dental care at a military dental clinic on a space-available basis.
- **Transitioning from active duty directly into the National Guard or Reserve:** Family members can buy or continue TDP coverage.
- **A National Guard or Reserve member returning to non-activated status after activation for more than 30 days:** Family members can enroll in the TDP at any time or continue current coverage. Family members who enroll in the TDP must agree to be in the program for at least 12 months. For more information, go to www.tricare.mil/dental and www.tricare.mil/costs.

TRICARE Reserve Select or TRICARE Retired Reserve during the Transitional Assistance Management Program

If you transition to or retire from the National Guard or Reserve, you may be able to buy health care coverage under TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) after your TAMP period ends. Both of these programs require monthly premium payments.

To avoid a break in coverage after your TAMP period ends, complete these steps up to 60 days before, but no later than 30 days after TAMP ends:

1. Log in to the Defense Manpower Data Center (DMDC) Reserve Component Purchased TRICARE Application at www.dmdc.osd.mil/appj/reservetricare.
2. Submit a *Reserve Component Health Coverage Request* form (DD Form 2896-1) available on the site.
3. Pay the first two months of premium payments. You must then set up automatic payments for future premiums using either an electronic funds transfer or recurring debit/credit card payment.

For more information, go to www.tricare.mil/trs or www.tricare.mil/trr.

TRICARE Young Adult and the Transitional Assistance Management Program

Your adult children may be able to buy TYA during the TAMP period. TYA is a premium-based health care plan for adult-age dependents who are at least age 21, but not yet age 26. It offers TRICARE Prime and TRICARE Standard coverage worldwide, including medical and pharmacy benefits. TYA doesn't include dental coverage. Your status after the TAMP period ends determines your child's TYA eligibility and if he or she is able to remain covered. For more information, see *TRICARE Young Adult*.

Continued Health Care Benefit Program Coverage

If you're not continuing service or you're retiring from the National Guard or Reserve after TAMP, you may qualify to buy temporary health care coverage under CHCBP. CHCBP is a premium-based health care program administered by Humana Military. It offers an extra 18–36 months of coverage. CHCBP isn't a TRICARE benefit, but it is considered minimum essential coverage under the Affordable Care Act. For more information, go to www.tricare.mil/chcbp or call Humana Military at **1-800-444-5445**.

Civilian Health Care Coverage Options

While you may qualify to buy premium-based TRICARE programs, as well as CHCBP coverage, these aren't your only health care options. You should evaluate all of your options before deciding which coverage is best for you and your family. You can get coverage through your employer or your spouse's employer, or through the Health Insurance Marketplace. You may qualify for financial aid on the Health Insurance Marketplace or for Medicaid depending on your situation and the state you live in. To find other health care coverage options, go to www.healthcare.gov.

Extended Care Health Option

ECHO gives supplemental services to ADFMs who qualify based on specific intellectual or physical disabilities. ECHO offers services and supplies beyond those offered under your regular TRICARE program option (for example, TRICARE Prime or TRICARE Standard).

If you are an active duty sponsor with family members seeking ECHO registration, you must enroll in your service's Exceptional Family Member Program (EFMP) (unless waived in specific situations) and register for ECHO with your regional contractor to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. You must get prior authorization from your regional contractor for all ECHO services.

Questions about ECHO and EFMP?

Call your service branch's EFMP representative or go to www.militaryonesource.mil/efmp.

Learn more about ECHO at www.tricare.mil/echo.

Extended Care Health Option Eligibility

ECHO benefits are available to ADFMs with a qualifying condition, including:

- TRICARE-eligible ADFMs, including family members of National Guard and Reserve members activated for more than 30 days
- Family members who are eligible for continued coverage under TAMP
- Children or spouses of former service members who are victims of physical or emotional abuse
- Deceased active duty sponsor (ADFM eligible for ECHO during the period they are in transitional survivor status)

Conditions to qualify for ECHO coverage may include:

- Autism spectrum disorder (applied behavior analysis is covered separately under the Autism Care Demonstration)
- Moderate or severe intellectual disability
- Serious physical disability
- Extraordinary physical or psychological condition of such complexity that you're homebound
- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (up to age 3) that is expected to precede a diagnosis of moderate or severe intellectual disability or a serious physical disability
- Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems

- Children may remain eligible for ECHO benefits beyond the usual TRICARE eligibility age limit of age 21 (or age 23 if certain criteria are met), if the following is true:
  - The sponsor remains on active duty
  - The child is incapable of self-support because of an intellectual or physical disability that occurs before the loss of eligibility
  - The sponsor is responsible for over 50 percent of the child's financial support

Extended Care Health Option Benefits

All ECHO services require prior authorization from your regional contractor. ECHO provides coverage for the following products and services:

- Assistive services (for example, those from a qualified interpreter or translator)
- Durable equipment, including adaptation and maintenance equipment
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC) (limited to the U.S., the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands)
- Rehabilitative services
- ECHO respite care: up to 16 hours of care in any calendar month in which any other ECHO-authorized benefit other than the EHHC benefit is used (only available in the U.S., the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands)
- EHHC respite care: up to eight hours per day, five days per week (for those who qualify)
- Training to use special education and assistive technology devices
- Institutional care when a residential environment is required
- Transportation to and from institutions or facilities in certain circumstances

TRICARE doesn't pay for services provided by family members, trainers or other individuals who aren't TRICARE-authorized providers. For more information, go to www.tricare.mil/echo.

Extended Care Health Option Coverage Limit

There is a coverage limit of $36,000 for all ECHO benefits combined, excluding EHHC, per beneficiary, per fiscal year (Oct. 1–Sept. 30). ECHO-allowable amounts aren't subject to a deductible. The cost-share for every month you use ECHO benefits is based on the sponsor's pay grade. For more information on costs, go to www.tricare.mil/echo.

Comprehensive Autism Care Demonstration

TRICARE covers medical and behavior modification services for autism spectrum disorder (ASD). Medical services covered under your TRICARE benefit include occupational therapy, physical therapy, physician services, psychological services, psychological testing, prescription drugs and speech therapy.

Applied behavior analysis (ABA) is also covered, but under the Autism Care Demonstration, which is separate from the medical benefit that covers the services previously listed. ABA uses behavior modification principles, like positive reinforcement, to increase or decrease targeted behaviors. ABA can help develop skills, such as speech, self-help and play. It can also help to decrease certain behaviors, such as aggression or self-injury.

Autism Care Demonstration Eligibility

ABA services are covered for all qualifying dependents of ADSMs, retirees and certain National Guard and Reserve members. You can get ABA services if you have one of the following programs:

- A TRICARE Prime option
- TRICARE Standard and TRICARE Extra
- TRS (member-and-family coverage)
- TRR (member-and-family coverage)
- TFL
- TYA
- TAMP
- CHCBP (if you aren't eligible for TRICARE)

To qualify for covered ABA services under the Autism Care Demonstration, your dependent or child must also:

- Have been diagnosed with ASD by a TRICARE-authorized approved ASD-diagnosing provider
- Be enrolled in EFMP and registered in ECHO (unless waived) if the sponsor is an ADSM

For more information about this demonstration, see the *Autism Care Demonstration* fact sheet at www.tricare.mil/autism.

TRICARE Programs

Contacts

www.tricare.mil/dental

TRICARE Active Duty Dental Program
United Concordia Companies, Inc.
1-866-984-2337
www.tricare.mil/addp

TRICARE Dental Program
MetLife
1-855-MET-TDP1 (1-855-638-8371)
1-855-MET-TDP3 (1-855-638-8373) (TDD/TTY)
www.tricare.mil/tdp

TRICARE Retiree Dental Program
Delta Dental of California
1-888-838-8737 (current beneficiaries)
1-855-827-6436 (prospective beneficiaries)
www.tricare.mil/trdp

Dental Care Programs

TRICARE offers a number of dental care programs that are separate from your TRICARE health care options. Active duty service members (ADSMs) get automatic coverage at military dental clinics. Active duty family members (ADFMs), retirees and National Guard and Reserve members can purchase coverage.

Dental options include:

- TRICARE Active Duty Dental Program (ADDP)
- TRICARE Dental Program (TDP) (for purchase)
- TRICARE Retiree Dental Program (TRDP) (for purchase)

Your costs for these programs don't count toward your TRICARE catastrophic cap.

The table on the following page outlines eligibility rules for these dental options and provides more information on each of these programs.

Dental Program Eligibility by Beneficiary Type

DENTAL PROGRAM OPTION	BENEFICIARY TYPES	DESCRIPTION OF PROGRAM OPTION
ADDP	• ADSMs • National Guard and Reserve members activated for more than 30 days	• Benefit administered by United Concordia • For ADSMs who are either referred for care by a military dental clinic to a civilian dentist or have a duty location and live greater than 50 miles from a military dental clinic
TDP	• Eligible ADFMs • Survivors • National Guard and Reserve members and their family members • Individual Ready Reserve members and their family members	• Benefit administered by MetLife • Voluntary enrollment and worldwide portable coverage • Single and family plans with monthly premiums • Lower specialty care cost-shares for pay grades E-1 through E-4 • Comprehensive coverage for most dental services, but yearly limits apply to some services • Coverage for most preventive and diagnostic services
TRDP	• Retired service members and their eligible family members worldwide • Retired National Guard and Reserve members and their eligible family members • Certain survivors • Medal of Honor recipients and their immediate family members and survivors	• Benefit administered by Delta Dental • Voluntary enrollment and worldwide portable coverage • Single, dual and family plans • Monthly premiums vary by ZIP code • Comprehensive coverage for most dental services, but yearly limits apply to some services; go to any dental provider within the TRDP service area or go to a network dental provider for maximum cost savings • Coverage for most preventive and diagnostic services; deductible and cost-shares may apply to other services • Limited services available during first 12 months of enrollment

TRICARE Active Duty Dental Program

ADSMs generally get care at military dental clinics, but may sometimes use the ADDP. It is available to ADSMs of the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard and the National Oceanic and Atmospheric Administration (NOAA). The United States Public Health Service covers dental care for its members.

The ADDP is administered by United Concordia Companies, Inc. (UCCI). For more information, visit www.tricare.mil/addp or www.addp-ucci.com.

The following table explains ADDP eligibility by sponsor category.

SPONSOR CATEGORY	ELIGIBILITY REQUIREMENTS
ADSMs	• Referred for care by a military dental clinic to a civilian dentist or live and work more than 50 miles from a military dental clinic
National Guard and Reserve members	• Serving on active duty for more than 30 days
Service members with delayed-effective-date active duty orders or enrolled in the Transitional Assistance Management Program (TAMP)	• Members of the National Guard and Reserve who are issued delayed-effective-date active duty orders for more than 30 days in support of a contingency operation • Completed activation in support of a contingency operation for more than 30 days

Eligibility for ADDP must be shown in DEERS and include one of the following:

- Service members who live and work more than 50 miles from a military dental clinic
- Service members in TAMP after completing activation for a contingency operation for more than 30 days
- Service member with an approved line-of-duty dental determination
- Early-eligible National Guard and Reserve members activated for more than 30 days in support of a contingency operation
- Wounded Warriors
- Uniformed members of NOAA
- Certain foreign military members

For a list of covered services, go to www.addp-ucci.com.

TRICARE Dental Program

ADFMs and National Guard and Reserve members can purchase TDP coverage. The benefit is administered by MetLife and gives you access to a network of civilian dental providers around the world. The TDP features:

- Voluntary enrollment
- Worldwide coverage
- Single and family plans
- Monthly premiums
- Low specialty care cost-shares for pay grades E-1 through E-4
- Comprehensive coverage for most dental services, but yearly limits apply to some services
- Coverage for most preventive and diagnostic services

Eligibility

To be eligible for the TDP, a sponsor must have at least 12 months remaining on his or her military service commitment at the time of enrollment. This service commitment is based on the time remaining in any single status or in any uninterrupted combination of active duty or National Guard or Reserve status.

Additionally, you must be one of the following:

- Family member or legal dependent of an ADSM
- Family member of a National Guard or Reserve member
- National Guard or Reserve member not on active duty
- Transitional survivor
- Surviving child

Note: Former spouses and remarried surviving spouses don't qualify for the TDP unless the new spouse is a sponsor.

ADFMs and National Guard and Reserve member family members include:

- Spouses
- Unmarried children up to age 21 (or age 23 if certain criteria are met. This includes stepchildren, adopted children (both pre-adoptive and finalized adoption) and court-ordered wards.

Dental Care

For more information about the TDP benefit, see the *TRICARE Dental Program Benefit Booklet* at www.tricare.mil/publications. You can also visit www.metlife.com/tricare.

Enroll in the TRICARE Dental Program

Online: www.tricare.mil/bwe

Phone: Call MetLife

- Stateside: 1-855-MET-TDP1 (1-855-638-8371)
- Overseas: 1-855-MET-TDP2 (1-855-638-8372)
- TDD/TTY: 1-855-MET-TDP3 (1-855-638-8373)

Mail:

1. Go to www.tricare.mil/forms

   Download and complete the *Enrollment/Change Authorization For TRICARE Dental Program* form

2. Send form along with the initial premium payment (check, money order or credit card) to the address on the form.

TRICARE Retiree Dental Program

The TRDP is a voluntary dental program managed by Delta Dental of California. The TRDP requires a 12-month minimum commitment and limited services are available during this time. After an initial 12-month period you can continue the program on a month-to-month basis and access all TRDP benefits. New retirees who enroll within four months after retirement don't have to wait the 12-month period to get all TRDP benefits. The TRDP features:

- Voluntary enrollment and worldwide coverage
- Single, dual and family plans
- Monthly premiums (your cost depends on your ZIP code and plan)
- Comprehensive coverage for most dental services, but yearly limits apply to some services
- Coverage for most preventive and diagnostic services with no deductible or cost-shares when care is provided by a TRDP network dental provider

Eligibility

The TRDP is available worldwide. You are eligible to enroll in the TRDP if you are:

- Entitled to uniformed services retired pay, including those age 65 and older
- A National Guard or Reserve member in Retired Reserve status, even if you are entitled to retired pay, but won't get it until age 60
- A current spouse of an enrolled member
- An unmarried child of an enrolled member up to age 21, or age 23 if certain criteria are met, or older if disabled before losing TRDP eligibility
- A surviving spouse who hasn't remarried or surviving child of a service member who died while in retired status or while on active duty for more than 30 days
- A Medal of Honor recipient or eligible immediate family member
- A spouse and/or eligible child of certain non-enrolled members with documented proof the non-enrolled member is:
  - Eligible to get ongoing, comprehensive dental care from the U.S. Department of Veterans Affairs
  - Enrolled in a dental plan through other employment that isn't available to family members
  - Unable to get TRDP benefits because of a current and enduring medical or dental condition
  - If you are a non-enrolled member who meets any one of the previous three criteria, you may enroll a family member without enrolling in the TRDP. You may be required to submit written documentation with your enrollment form, as applicable. Go to www.trdp.org for more information.

Former spouses of eligible members, remarried surviving spouses of deceased members and family members of non-enrolled members who don't meet one of the three criteria previously noted aren't eligible for the TRDP.

Dental Care

For more information about the TRDP dental coverage, go to www.trdp.org.

Enroll in the TRICARE Retiree Dental Program

Online:

- Enroll online using a credit card for the initial premium payment on the Beneficiary Web Enrollment website at www.tricare.mil/bwe.

Mail:

1. Download the *TRDP Enrollment Application* from www.trdp.org.
2. Complete and sign the application.
3. Send the application along with the initial premium payment (credit card or money order) to the address listed on the form.

TRICARE Programs

TRICARE Pharmacy Program

Express Scripts, Inc.
1-877-363-1303
1-877-363-1433 (set up home delivery)
1-877-540-6261 (TDD/TTY)

www.tricare.mil/pharmacy
www.express-scripts.com/TRICARE
DOD.customer.relations@express-scripts.com

TRICARE Pharmacy Program

The TRICARE Pharmacy Program provides prescription drug coverage for TRICARE beneficiaries. Your pharmacy contractor is Express Scripts, Inc. (Express Scripts). This means that Express Scripts will help you with coverage reviews (some drugs are only covered in certain cases); submitting claims to get money back from up-front payments and other pharmacy needs. Your beneficiary status and the type of drug you are prescribed determine how you fill prescriptions. This includes what you pay and which type of pharmacy fills your prescription.

You have the same prescription drug coverage with any TRICARE health plan, such as TRICARE Prime or TRICARE Standard and TRICARE Extra. If you use the US Family Health Plan, you have separate pharmacy coverage. Go to www.usfhp.com for details.

This section provides an overview of the pharmacy benefit. For more details, see the *TRICARE Pharmacy Program Handbook* at www.tricare.mil/pharmacy.

Getting Prescription Drugs

TRICARE offers several options for getting prescription drugs. To fill a prescription, you need a prescription and a valid uniformed services ID card or Common Access Card. Your options for filling prescriptions depend on the type of drug you need.

To promote patient safety, prescriptions filled through military pharmacies, TRICARE Pharmacy Home Delivery and TRICARE retail network pharmacies are checked against your TRICARE prescription history for potential drug interactions.

Some nonformulary drugs are only covered through home delivery. Check with Express Scripts before filling prescriptions for nonformulary drugs at a TRICARE retail network pharmacy.

OPTIONS FOR FILLING PRESCRIPTIONS	DESCRIPTION OF OPTIONS
Military pharmacies	• Usually in military hospitals or clinics • Don't charge for a 90-day supply of most drugs • Usually accept prescriptions from military and civilian providers • Accept electronic prescriptions • Usually don't carry tier 3 (nonformulary) drugs, so call your local military pharmacy to see if they carry your drug
TRICARE Pharmacy Home Delivery	• No costs for active duty service members (ADSMs) • No costs for all others for generic tier 1 drugs • Copayments for tier 2 (brand-name) and tier 3 (nonformulary) drugs • No need to file claims • Get up to a 90-day supply • Your drugs are mailed to you using free standard shipping • Refills can be easily ordered online, by phone or by mail Go to www.express-scripts.com/TRICARE or call Express Scripts to switch to home delivery. Some drugs can't be sent by mail.
TRICARE retail network pharmacies	• Fill your prescriptions without having to file a claim • Pay one copayment for each 30-day supply • You must show your uniformed services ID card or Common Access Card, along with your prescription • Save money by using a pharmacy that is also in-network with your other health insurance, if you have it • Access to TRICARE retail network pharmacies in the U.S. and the U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands. Currently there are no TRICARE retail network pharmacies in American Samoa. To find a TRICARE retail network pharmacy near you, go to www.tricare.mil/networkpharmacy.
Non-network pharmacies	• Pay full price for your drug and file a claim to get money back • The amount of money you get back depends on your deductible, out-of-network cost-shares and TRICARE pharmacy copayments • All deductibles must be met before you can get money back

You may be required to use the home delivery option for some drugs. For example, unless you are an ADSM, you must fill select brand-name maintenance drugs through military pharmacy or home delivery. Maintenance drugs are those you take on a regular basis, such as birth control or drugs that control blood pressure or cholesterol. Controlled substances can't be shipped to P.O. boxes.

FILLING YOUR PRESCRIPTION DRUGS

Look up your drug at:

- www.express-scripts.com/tricareformulary
  for information about filling your prescriptions

You will need to know:

- Name and strength of the drug prescribed

The online tool will tell you:

- If you need a coverage review from Express Scripts
- Whether you need a request form from your provider (usually applies to tier 3 drugs)
- Where you can fill your prescription

Types of Prescription Drugs

The TRICARE Pharmacy Program provides outpatient coverage to beneficiaries for medications that are approved for marketing by the U.S. Food and Drug Administration (FDA) and that generally require prescriptions.

There are several types of prescription drugs. The kind you get can affect how much you pay and how you get your prescription drugs.

Tiers of Covered Prescription Drugs

Drugs that are covered by TRICARE are grouped into three tiers.

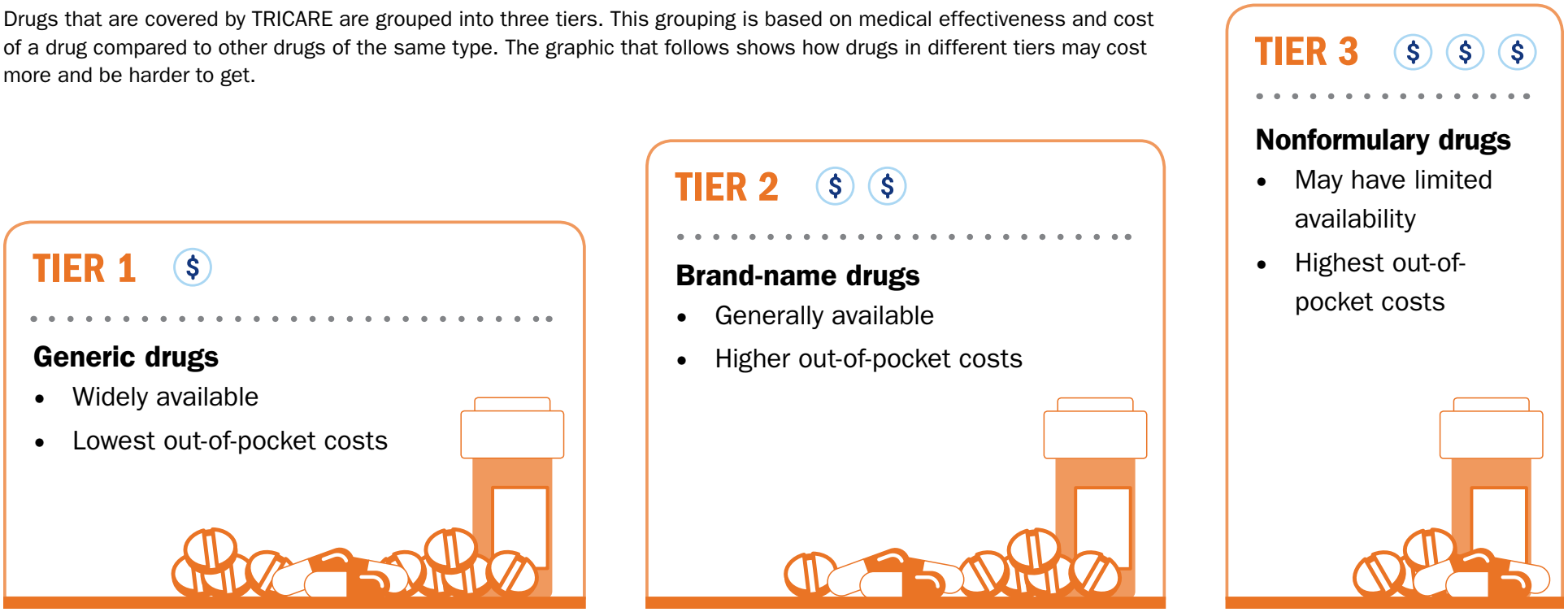
- **Tiers 1 and 2:** These drugs are the most common generic and brand-name drugs.
- **Tier 3:** These nonformulary drugs may be harder to find and cost the most. You may need a request form from your provider to get these drugs. For an additional cost, third-tier drugs are available through TRICARE Pharmacy Home Delivery and most are available through TRICARE retail network pharmacies.

The graphic that follows outlines the main features of each tier of drugs. Some special groups of drugs have other rules that aren't shown below.

It is Department of Defense policy to use generic medications instead of brand-name medications whenever possible. If a generic-equivalent drug doesn't exist, the brand-name drug is filled at the brand-name copayment. If you get a brand-name drug that is not considered medically necessary when a generic equivalent is available, you are responsible for the entire cost. Your provider can complete a clinical assessment that shows the brand-name drug is medically necessary so that you can fill the brand-name drug. Express Scripts must grant approval. Forms and medical-necessity criteria are available online at www.express-scripts.com/tricareformulary.

Formulary and Nonformulary Prescription Drugs

Drugs that are covered by TRICARE are grouped into three tiers. This grouping is based on medical effectiveness and cost of a drug compared to other drugs of the same type. The graphic that follows shows how drugs in different tiers may cost more and be harder to get.



Medical Necessity for Nonformulary Prescription Drugs

There are medical-necessity criteria for each nonformulary drug. If your drug meets the criteria, you can get the nonformulary drug through TRICARE Pharmacy Home Delivery or at a TRICARE retail network pharmacy at a lower copayment. Your provider can establish medical necessity by completing and submitting a TRICARE pharmacy medical-necessity form.

Did you know?

Some drugs require prior authorization. Call Express Scripts, Inc. at **1-877-363-1303** for more information.

Compound Prescription Drugs

Compound drugs are made by a pharmacist mixing multiple ingredients to create a drug that is specific to your needs.

Your provider may prescribe a compound drug if you:

- Have an allergy to a commercially available drug
- Need a unique amount or type of a drug (for example, a liquid version of a drug or a different dosage because of age or weight)
- Need an alternative to other commercial options

Compound drugs are subject to limitations. See the *TRICARE Pharmacy Program Handbook* at www.tricare.mil/publications for more information.

Tobacco-Cessation Products

TRICARE covers drugs and over-the-counter products to help you quit tobacco. Tobacco-cessation products don't cost you anything if you get them at a military pharmacy or through TRICARE Pharmacy Home Delivery. You can get these products if you are age 18 and older and not eligible for Medicare. For more information on quitting tobacco, go to www.tricare.mil/quittobacco.

Pharmacy Costs

Pharmacy costs are based on whether your drug is a generic formulary (tier 1), brand-name formulary (tier 2) or nonformulary (tier 3) and where you fill your prescriptions.

Copayments

Copayments are the fixed amount those with TRICARE Prime (who are not active duty) pay for a covered drug. You may have to pay a copayment for your prescription depending on where you get your drug. ADSMs have no pharmacy copayments when using military pharmacies, TRICARE Pharmacy Home Delivery or TRICARE retail network pharmacies.

Yearly Deductible

Your yearly deductible is a fixed amount you pay for covered services each fiscal year (FY) (Oct. 1–Sept. 30) before TRICARE pays anything. You may have a deductible if you use TRICARE Standard or if you have TRICARE Prime and use a non-network pharmacy. If you have TRICARE Prime and use a non-network pharmacy, this is sometimes called the point-of-service deductible.

Cost-Share

A cost-share is a percentage of the total cost of your prescription that you pay at non-network pharmacies after you meet your yearly deductible.

Catastrophic Cap

The catastrophic cap is the most you pay each FY for TRICARE-covered services. The cap is $1,000 for ADFMs and TRICARE Reserve Select families, and $3,000 for retiree families and others.

Section III

COVERED SERVICES

TRICARE Providers

Medical Covered Services

TRICARE Vision Benefit

TRICARE Providers

There are many types of providers, but it is important that you see TRICARE-authorized providers for all your health care needs. While the specific type of provider you see may depend on the type of care you need, seeing TRICARE-authorized providers will save you money and help protect the quality of treatment you get.

It is also important to know that there are different types of TRICARE-authorized providers. They include network and non-network providers. Which type you see can affect how much you pay and how you file claims.

Contacts

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

TRICARE South Region
Humana Military
1-800-444-5445
HumanaMilitary.com

TRICARE West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Key Concepts

- Always see a TRICARE-authorized provider or you might pay your entire bill.
- The type of provider you see can greatly affect convenience and how much you pay.
- There are four main types of care that you can get from a TRICARE provider: routine, specialty, urgent and emergency. Knowing which you need can save you time and money and ensure you get the best care.

Key Terms

- **Provider:** A provider can include a person, like a doctor, or an organization, like a hospital.
- **TRICARE-authorized provider:** A provider who is approved by TRICARE to give health care services to its beneficiaries.
- **Network provider:** A provider who has a signed agreement with your regional contractor, accepts TRICARE's payment as full payment and files claims for you.
- **Non-network provider:** A provider who is TRICARE-authorized, but doesn't have a written agreement with your regional contractor. They may be able to charge you more than the TRICARE-allowable charge for services and might not file claims for you.

Provider Types

You can visit several types of providers when you need care. Providers include people, like doctors, or organizations and institutions, like ambulance companies and hospitals.

The type of provider you see can greatly affect convenience and how much you pay. This is why it is important to know which type of provider is best for you based on your coverage and the type of care you need.

If you are enrolled in TRICARE For Life (TFL) and need information about Medicare providers, military hospitals and clinics or U.S. Department of Veterans Affairs (VA) health care facilities, see *TRICARE For Life*.

TRICARE-Authorized Providers

- TRICARE-authorized providers are approved by TRICARE to give health care services to its beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers (for example, laboratories and radiology centers) and pharmacies that meet TRICARE requirements. A provider must be TRICARE-authorized for TRICARE to pay any part of your claim. If you see a provider who is not TRICARE-authorized, you are responsible for the full cost of care. To find a list of TRICARE-authorized providers, go to www.tricare.mil/findaprovider.
- There are two types of TRICARE-authorized providers: network and non-network.

Network Providers

- Regional contractors have established networks and you may be assigned a primary care manager (PCM) who is part of the TRICARE network.
- When specialty care is needed, your best option is for your PCM to coordinate the referral with your regional contractor.
- TRICARE network providers:
  - Have a signed agreement with your regional contractor to provide care
  - Accept TRICARE's payment as the full payment for any covered health care services you get
  - Agree to file claims for you

Non-Network Providers

- Non-network providers don't have a signed agreement with your regional contractor and are considered "out of network." In most cases, you won't get care from non-network providers unless authorized by your regional contractor. You may seek care from a nonnetwork provider in an emergency or if you are using the point-of-service (POS) option (using the POS option results in higher out-of-pocket costs).
- There are two types of non-network providers: participating and nonparticipating.

Participating Providers

- Using a participating provider is your best option if you are seeing a nonnetwork provider.
- Participating providers:
  - Accept TRICARE's payment as the full payment for any covered health care services you get
  - File claims for you

Nonparticipating Providers

- If you visit a nonparticipating provider, you may have to pay the provider first and later file a claim with TRICARE for reimbursement.
- Nonparticipating providers:
  - Don't accept TRICARE's payment as the full payment for covered health care services or file claims for you
  - Have the legal right to charge you up to 15 percent above the TRICARE-allowable charge for services (you are responsible for paying this amount in addition to any applicable patient costs)[1]

1. *Outside the U.S. and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands), there may be no limit to the amount that nonparticipating non-network providers may bill, and you may be responsible for paying any amount that exceeds the TRICARE-allowable charge. Go to www.tricare.mil/overseas for more information.*

Military Hospitals and Clinics

Military hospitals and clinics are medical providers. They give medical and dental care to those eligible for TRICARE, including uniformed service members and their eligible families. Military hospitals and clinics are usually on or near military installations. To find a military hospital or clinic near you, go to www.tricare.mil/mtf.

Veterans Affairs Health Care Facilities

VA health care facilities are TRICARE network providers. That means they agree to accept TRICARE's payment as the full payment for any covered health care services you get. VA facilities will also file your claims and handle paperwork for you. Some VA facilities, however, only offer specialty care.

If you are a TRICARE Prime beneficiary, you should seek care from your primary care manager (PCM) first. If your PCM refers you to a VA facility under TRICARE Prime, you must get prior authorization from your regional contractor. If you are a TFL beneficiary, you will have significant out-of-pocket costs if you get care from a VA provider for an injury or illness that is not connected to your military service. See *TRICARE For Life* for more information.

Each VA facility has a TRICARE beneficiary point of contact and check-in process. It's important that you tell them you are using your TRICARE benefit before you get care. If you don't, you may end up paying more out of pocket or TRICARE may not pay for the services you get.

Military Hospital and Clinic Appointment Priorities

1. ADSM
2. ADFM enrolled in TRICARE Prime
3. Retired service members, their families, and all others enrolled in TRICARE Prime or TRICARE Plus (primary care)
4. ADFMs not enrolled in TRICARE Prime and TRS members
5. Retired service members and their families not enrolled in TRICARE Prime, TRICARE Plus beneficiaries (specialty care), TRR members and all other eligible beneficiaries

Types of Care

There are four different types of care covered by TRICARE. It is important that you seek the right kind for your safety, convenience and to avoid paying extra.

The following table provides definitions and examples of emergency, urgent, routine and specialty care.

Most dental emergencies, such as going to the emergency room for a severe toothache, are not covered under the TRICARE medical benefit.

Definitions and Examples of Types of Care

TYPE OF CARE	DEFINITION	EXAMPLES
Emergency	Treatment for a serious medical condition that the average person considers a threat to life, limb, sight or safety. Most dental emergencies, such as going to the emergency room for a severe toothache, are not covered under the TRICARE medical benefit.	No pulse, severe bleeding, spinal cord or back injury, chest pain, severe eye injury, broken bone, inability to breathe
Urgent	Treatment for an illness or injury that won't result in further disability or death if not treated immediately, but does require professional attention within 24 hours	Rash, migraine headache, urinary tract infection, sprain, earache, rising fever
Routine	General health care services, including office visits and preventive care	Symptoms of chronic or acute illnesses and diseases, follow-up care for an ongoing medical condition
Specialty	Medical care from specialists for treatment your PCM can't provide	Cardiology, dermatology, gastroenterology, obstetrics

Medical Covered Services

TRICARE covers most care that is medically necessary and proven regardless of which TRICARE program you are enrolled in. This includes many preventive health services that help keep you healthy.

However, there are special rules and limitations for some types of care. Other types of care aren't covered at all. That is why it is important to understand your TRICARE coverage before you get care.

Contacts

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

TRICARE South Region
Humana Military
1-800-444-5445
HumanaMmilitary.com

TRICARE West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Key Concepts

- If you get care that TRICARE doesn't cover, you will pay the entire bill.
- Get referrals and prior authorizations, when required, to avoid paying extra out-of-pocket costs.

Key Terms

- **Referral:** When your primary care manager sends you to another provider for care. Only applies to those with a TRICARE Prime option.
- **Prior authorization:** A review of a requested health care service done by your regional contractor, to see if the care will be covered by TRICARE.
- **Point-of-service option:** An option under TRICARE Prime that lets you pay extra to get nonemergency care from any TRICARE-authorized provider without a referral.
- **Out-of-pocket cost:** Any costs you are responsible for paying.
- **Copayment:** The fixed amount those with TRICARE Prime (who are not active duty) pay for a covered health care service or drug.
- **Cost-share:** A percentage of the total cost of a covered health care service that you pay.

Clinical Preventive Services

TRICARE covers many preventive health care services with no out-of-pocket cost to you. Preventive services include vaccines, exams and screenings to keep you healthy by preventing diseases or by detecting problems early when they are most treatable. The following section describes what TRICARE covers and how you can get preventive care.

Medicare-eligible TRICARE beneficiaries are not eligible for no-cost preventive services, including vaccines, from TRICARE. For these beneficiaries, deductibles and cost-shares apply when getting covered clinical preventive services.

GETTING PREVENTIVE CARE

How you get preventive care depends on your beneficiary category and your TRICARE program option.

TRICARE Prime	TRICARE Standard and TRICARE Extra	TRICARE Prime Remote
You don't need a referral if you get preventive care from: • Your PCM • Any TRICARE network provider in your enrolled region or US Family Health Plan (USFHP) service area. **Note:** ADSMs always need a referral to see a civilian provider.	You can get covered preventive care without a referral with no out-of-pocket cost by visiting any TRICARE-authorized provider. This includes network providers, non-network participating providers and non-network nonparticipating providers.	You don't need a referral if you get preventive care from: • Your PCM • Any TRICARE network provider in your enrolled region or a USFHP service area. **Note:** ADSMs always need a referral to see a civilian provider.

Comprehensive Health Promotion and Disease Prevention Exams

Adult

All TRICARE program options cover a comprehensive clinical preventive exam if the exam also includes one of the following:

- A vaccine
- A breast cancer screening
- A cervical cancer screening
- A colon cancer screening
- A prostate cancer screening

TRICARE Prime beneficiaries in age groups 18–39 or 40–64 can get one comprehensive clinical preventive exam without a vaccine or cancer screening. This means you can get one comprehensive clinical preventive exam while you are in the age range of 18–39 without getting a vaccine or cancer screening. The same applies while you are in the age range of 40–64.

Pediatric

All TRICARE program options cover preventive services from birth up to age 6 under the well-child care benefit. For more information, see *Well-Child Care*.

For children age 6 and older, TRICARE covers a comprehensive clinical preventive exam if it includes a vaccine. TRICARE Prime beneficiaries in age groups 6–11 or 12–17 can get one comprehensive clinical preventive exam without a vaccine. For example, you can get one comprehensive clinical preventive exam while you are in the age range of 6–11. You can get one more while you are in the age range of 12–17.

School physicals are covered for children ages 5–11 when required by the school. Sports physicals are never covered.

Targeted Health Promotion and Disease Prevention Services

TRICARE covers the following screenings if you get them during a comprehensive clinical preventive exam or other health visit.

CANCER SCREENINGS

Breast Cancer	• Clinical breast exam: Women up to age 40 during a preventive health visit. Women age 40 and older get a yearly exam. • Mammograms: Yearly for women starting at age 40, or age 30 for women with certain risk factors. • Breast screening MRI: Yearly starting at age 30 for women with certain risk factors.
Cervical Cancer	• Pap tests: Yearly for women starting at age 18, or younger if sexually active. Women may be screened less often, but should be screened at least once every three years. • Human papillomavirus (HPV) DNA testing: Covered for women age 30 and older as a cervical cancer screening when performed at the same time as a Pap test.
Colorectal Cancer	• Colonoscopy: Once every 10 years starting at age 50. Colonoscopies are covered more often and/or at an earlier age for people with certain risk factors. • Fecal occult blood testing: Yearly starting at age 50. • Proctosigmoidoscopy or sigmoidoscopy: Once every three to five years starting at age 50. Proctosigmoidoscopy or sigmoidoscopy screenings are covered more often and/or at an earlier age for people with certain risk factors.
Lung Cancer	• Low-dose computed tomography screenings are covered yearly if you are a TRICARE Prime beneficiary between ages 55 and 80 who: ▪ Used to smoke at least 30 packs of cigarettes per year ▪ Currently smokes ▪ Quit within the past 15 years • Screenings should stop once you haven't smoked for 15 years or you develop a health problem that significantly limits your life expectancy or your ability or willingness to have curative lung surgery.
Prostate Cancer	• A digital rectal exam and prostate-specific antigen screening is covered yearly for certain high-risk men ages 40–49 and all men age 50 and older.
Skin Cancer	• You can get an exam at any age if you are at high risk due to family history, frequent sun exposure or clinical evidence of precursor lesions.

Cardiovascular Disease Screening

Blood pressure screening: Yearly for children age 3 up to age 6 and at least every two years beginning at age 6 through adulthood.

Cholesterol screening: Age-specific, periodic lipid panel once every five years beginning at age 18, as recommended by the National Heart, Lung, and Blood Institute.

Vaccines

TRICARE covers age-appropriate doses of vaccines that are recommended for use in the U.S. by the Centers for Disease Control and Prevention (CDC). Coverage is effective the date the recommendations for a particular vaccine are published in the CDC's *Morbidity and Mortality Weekly Report*. For more information, go to www.cdc.gov.

GETTING VACCINES

TRICARE Program	Vaccine Provider	
TRICARE Prime options	PCM or network provider without a referral or prior authorization at no cost	Pharmacist at a TRICARE retail network pharmacies (vaccines at no cost for the flu, measles, mumps, shingles and more)
TRICARE Standard and TRICARE Extra	Any TRICARE-authorized provider at no cost	

If you want to get a vaccine at a TRICARE retail network pharmacy, keep in mind:

- Which vaccines can be administered in pharmacies depends on the state where the pharmacy is. Contact your pharmacist for more information.
- There is no copayment or cost-share for covered vaccines that you get at a TRICARE retail network pharmacy.
- TRICARE retail network pharmacies nationwide can give covered vaccines using the Express Scripts, Inc. (Express Scripts) vaccination program.
- Vaccines must be administered by a pharmacist at a TRICARE retail network pharmacy to be covered under the TRICARE pharmacy benefit.

For more information, including a complete list of vaccines that are covered at pharmacies, please go to www.tricare.mil/vaccines or call Express Scripts at **1-877-363-1303**. To find a TRICARE retail network pharmacy near you, call Express Scripts or use the pharmacy locator at www.express-scripts.com/TRICARE/pharmacy.

Coverage of Specific Vaccines

For a current list of recommended vaccines, go to the CDC's website at www.cdc.gov. TRICARE coverage of vaccines is as follows:

Flu Vaccine

TRICARE covers the flu vaccine at no cost. For more information, visit www.cdc.gov.

Human Papillomavirus Vaccine

TRICARE covers the Human Papillomavirus (HPV) vaccine for beneficiaries who haven't already been vaccinated or completed the HPV vaccine series and fall into one of the following categories:

- Females, ages 11–26. The series of injections may begin as early as age 9, but must be completed before age 27.
- Males, ages 11–21 and certain males ages 22–26.

Shingles Vaccine

TRICARE covers a single dose of the shingles vaccine for beneficiaries age 60 and older.

Non-Covered Vaccines

Vaccines for travel outside the U.S. aren't covered, unless you are an active duty family member (ADFM) and your sponsor has permanent change-of-station orders to an overseas location. These vaccines are covered as outpatient office visits.

If you are being vaccinated due to your sponsor's permanent change of station, include a copy of the sponsor's change-of station orders when filing the claim.

Patient and Parent Education Counseling

TRICARE covers patient and parent education counseling services during a routine office visit at no extra cost. Examples include counseling on dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol and substance abuse; dental health promotion; accident and injury prevention; stress; bereavement; and suicide risk assessment.

Well-Child Care (birth up to age 6)

Well-child care guards your young child's health by preventing disease and tracking growth and development. Well-child care covers:

- Routine newborn care
- Comprehensive health promotion and disease prevention exams
- Vision and hearing screenings
- Height, weight and head circumference measurements
- Routine vaccines
- Developmental and behavioral appraisal

TRICARE's well-child care coverage follows guidelines from the American Academy of Pediatrics (AAP) and CDC. Your child can go to well-child visits as often as the AAP recommends. However, TRICARE will only cover up to nine well-child visits in two years. The limit doesn't include visits for diagnosis or treatment of an illness or injury. Those are covered separately under outpatient care.

Well-Child Care Eye Exams (birth up to age 6)

- **Infants (up to age 3):** One eye and vision screening at birth and at 6 months.
- **Children (age 3 up to age 6):** One routine eye exam every two years. ADFM children can get one routine eye exam each year.

Well-Child Care Hearing Exams

TRICARE only allows preventive hearing exams under the well-child care benefit (birth up to age 6). Hospitals should perform a newborn audiology screening before discharge or within the first month after birth. Evaluative hearing tests can be performed at other ages during routine exams.

School Physicals

School physicals are covered for children ages 5–11 when required by a school. Sports physicals are never covered.

Outpatient Services

Ambulance Services

TRICARE covers ambulance services including:

- Emergency transport to a hospital
- Transfers between hospitals
- Transfers from a hospital-based emergency room to a hospital that can better provide required care
- Transfers between a hospital or skilled nursing facility (SNF) and another hospital-based or freestanding outpatient therapeutic or diagnostic department/facility

The following isn't covered:

- Use of an ambulance instead of a taxi when a patient's condition permits use of regular transportation
- Transport or transfer of a patient primarily so he or she can be closer to his or her home, family, friends or health care provider
- Medicabs or ambicabs that are used mostly as public transportation to take patients to and from their medical appointments

Air or boat ambulance is only covered when one of the following is true:

- The pickup point can't be reached by a land vehicle
- The patient's condition requires prompt care and great distance or obstacles prevent speedy transportation to the closest hospital with appropriate facilities
- Transfer by other means is not advisable

Breast Pumps, Breast Pump Supplies and Breast-Feeding Counseling

If you plan to breast-feed, TRICARE covers breast pumps, breast pump supplies and breast-feeding counseling.

You must get a prescription from a TRICARE-authorized provider for your pump to be covered. In certain situations, TRICARE will cover a heavy-duty hospital-grade breast pump. You may get your pump and supplies from any TRICARE-authorized provider, retail store or pharmacy.

Outpatient breast-feeding counseling from a TRICARE-authorized provider is covered for up to six sessions per birth or adoption. This is in addition to counseling services you get during your inpatient maternity stay or other health care visits.

You pay no cost-shares or copayments for breast-feeding services and supplies.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

TRICARE covers durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) if they are directly related to a medical condition and prescribed by a health care provider, dentist or any TRICARE-authorized provider when acting within the scope of their license or certification.

Covered DMEPOS include:

- DMEPOS that are medically necessary, appropriate and prescribed for a beneficiary's specific use.
- Duplicate DMEPOS that provide a fail-safe, in-home life-support system. In this case, "duplicate" means an item that meets the definition of DMEPOS and serves the same purpose, but isn't an exact duplicate. For example, a portable oxygen concentrator may be covered as a backup for a stationary oxygen generator.

Note: Prosthetic devices must be approved by the U.S. Food and Drug Administration (FDA).

Home Health Care

Home health care is covered for beneficiaries who are confined to the home. It includes part-time or intermittent skilled nursing services and home health care services. All care must be provided by a participating home health care agency and be authorized in advance by your regional contractor.

Services for Wounded Service Members

Respite care is covered for active duty service members (ADSMs) who are homebound because of a serious injury or illness they got while serving on active duty. It is available if the ADSM's plan of care includes frequent interventions by the primary caregiver. This means more than two interventions are required each day during the eight-hour period when the ADSM's primary caregiver would normally sleep.

The following respite care limits apply:

- Five days per calendar week
- Eight hours per calendar day

Respite care must be provided by a TRICARE-authorized home health care agency. It also requires prior authorization from your regional contractor and the ADSM's approving authority. Approving authorities include Defense Health Agency—Great Lakes or a referring military hospital or clinic. The ADSM isn't required to enroll in the Extended Care Health Option (ECHO) program to get the respite care benefit.

Additional benefits may be available to injured homebound service members and their caregivers. These benefits include:

- Inpatient, outpatient and comprehensive home health care supplies and services
- Training, rehabilitation, special education, and assistive technology and services
- Long-term care in private, not-for-profit, public, and state institutions and facilities and transportation to and from such institutions and facilities (when appropriate)
- Respite care, or temporary relief, for the primary caregiver of the injured service member

Individual Provider Services

Individual provider services are services provided during a medical appointment or hospitalization. They include:

- Office visits
- Outpatient, office-based medical and surgical care
- Consultation, diagnosis and treatment by a specialist
- Allergy tests and treatment
- Osteopathic manipulation
- Rehabilitation services (for example, physical and occupational therapy and speech pathology services)
- Medical supplies used within the office

Laboratory and X-Ray Services

Laboratory and X-ray services are generally covered if prescribed. Laboratory-developed tests (LDTs) must be medically necessary and FDA-approved. Non-FDA-approved LDTs may be covered under the Non-FDA Approved LDTs Demonstration Project. For more information, go to www.tricare.mil/ldt.

Inpatient Services

Hospitalization

Hospitalization coverage (semiprivate room or special care units when medically necessary) includes:

- General nursing
- Hospital, health care provider and surgical services
- Meals (including special diets)
- Medications
- Operating and recovery room care
- Anesthesia
- Laboratory tests
- X-rays and other radiology services
- Medical supplies and appliances
- Blood and blood products

Note: Surgical procedures designated "inpatient only" are only covered when performed in an inpatient setting.

Skilled Nursing Care and Custodial Care

Knowing the difference between skilled nursing care and custodial care can help you and your family understand which services are covered under your TRICARE benefit.

Skilled Nursing Facilities

SNFs provide skilled nursing, rehabilitation and other care like medication administration. SNFs aren't nursing homes or intermediate facilities.

Skilled Nursing Facility Admission Criteria

TRICARE will only cover admission to a SNF that is Medicare- and TRICARE-authorized. You must also:

- First be treated in a hospital for at least three consecutive days, not including the day of discharge
- Be admitted to a SNF within 30 days of your hospital discharge (with some exceptions)
- Have a provider treatment plan that shows your need for skilled nursing services

Skilled Nursing Care

Skilled nursing care must be given by or under the supervision of a registered nurse. Skilled nursing care includes services like intravenous and intramuscular injections or catheter insertion. TRICARE doesn't cover purely custodial care (for example, personal hygiene or cooking). If custodial care is provided in conjunction with medically necessary skilled nursing care, TRICARE may cover that care.

TRICARE typically covers:

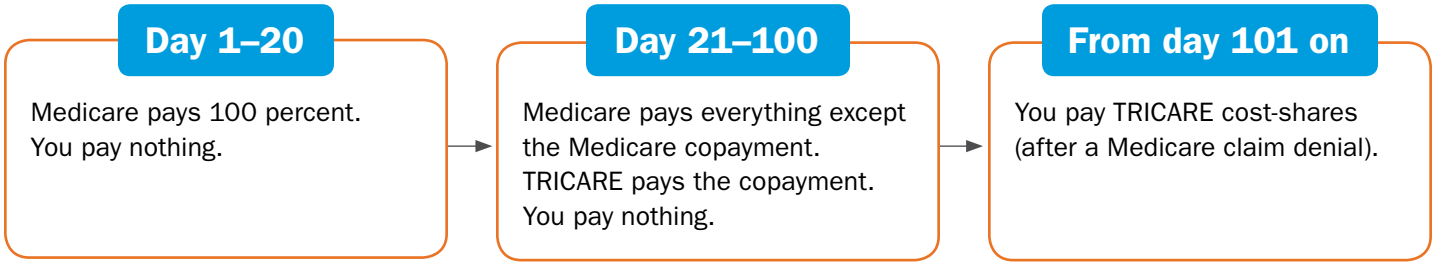
- Medically necessary skilled nursing care
- Rehabilitative therapies
- Room and board
- Prescription drugs
- Laboratory work
- Supplies
- Appliances
- Medical equipment

Medicare and TRICARE Coverage of Skilled Nursing Facility Benefits

Medicare and TRICARE give the same SNF benefits, but Medicare limits coverage to 100 days. The following graphic shows how Medicare, TRICARE and you share SNF costs.

Note: TRICARE is the primary payer for SNF care beyond Medicare's 100-day limit as long as the patient still needs SNF services and doesn't have other health insurance.

When TRICARE becomes the primary payer on day 101, SNF care requires prior authorization from the TRICARE For Life contractor, Wisconsin Physicians Service (WPS)—Military and Veterans Health in the U.S.



Specialized Services

Mental Health Care Services

For full coverage details on mental health care services, go to www.tricare.mil/mentalhealth. For information about covered and non-covered mental health care services and how to access care, contact your regional contractor.

Outpatient Mental Health Care Services

Some outpatient mental health care services require referrals and prior authorizations. However, TRICARE beneficiaries who aren't ADSMs don't need referrals or prior authorizations for the first eight outpatient mental health care visits per fiscal year (FY) (Oct. 1–Sept. 30) to a network provider for a medically diagnosed and covered condition. Prior authorization from your regional contractor is required beginning with the ninth outpatient mental health care visit in a FY. Access to care and rules vary by beneficiary type, location and TRICARE program option.

Active Duty Service Members

If you are an ADSM, always get nonemergency mental health care at a military hospital or clinic, when available. If nonemergency services aren't available, you must get a referral from your military hospital or clinic before getting civilian care. This ensures that your condition doesn't affect your health or your ability to perform worldwide duty. Your primary care manager will coordinate all of your mental health care referrals and prior authorizations.

Mental Health Emergencies:

If you have a mental health emergency, call 911 or go to the closest emergency room.

Psychotherapy

The following outpatient limits apply:

- **Psychotherapy:** Two sessions per week in any combination of the following:
  - **Individual (adult or child):** 60 minutes per session; may extend to 120 minutes for crisis intervention
  - **Family or conjoint:** 90 minutes per session; may extend to 180 minutes for crisis intervention
  - **Group:** 90 minutes per session
- **Collateral visits:** Up to 60 minutes per visit are covered. Collateral visits are counted as individual psychotherapy sessions. You can combine collateral visits with other individual or group psychotherapy visits.

Psychoanalysis

Psychoanalysis is long-term mental health therapy that explores unconscious thoughts to gain insight into behaviors and symptoms. You must always get prior authorization and receive treatment from an approved provider who is trained in psychoanalysis.

Psychological Testing and Assessment

TRICARE covers psychological testing and assessment when medically or psychologically necessary and given with covered psychotherapy. Testing and assessment is also covered for applied behavior analysis under the Autism Care Demonstration. Go to www.tricare.mil/autism for details about autism care services.

Psychological tests are diagnostic services and aren't counted toward the limit of two psychotherapy visits per week.

Limitations

Testing and assessment is generally limited to six hours per FY. Any testing beyond six hours must be reviewed for medical necessity. Psychological testing can't be for educational purposes.

Exclusions

Psychological testing is not covered for:

- Academic placement
- Job placement
- Child custody disputes
- General screening in the absence of specific symptoms
- Teacher or parental referrals
- Testing to determine whether a beneficiary has learning disabilities
- Diagnosed specific learning disorders or learning disabilities

Medication Management

If you take prescription medications for a mental health disorder, you must be under the care of a provider who is authorized to prescribe those medications. Your provider will manage the dosage and duration of your prescription. Medication management appointments don't count toward your first eight outpatient mental health care visits per FY.

Telemental Health Program

The Telemental Health program uses secure audio-visual conferencing to provide some mental health care services to beneficiaries. The Telemental Health program has the same limitations and requirements for referrals and prior authorizations as mental health care services. For more information, go to www.tricare.mil/mentalhealth or contact your regional contractor.

Inpatient Mental Health Care Services

You need prior authorization from your regional contractor for all nonemergency inpatient mental health care services. You don't need prior authorization for an inpatient admission that is because of a psychiatric emergency. However, if you are admitted, you must notify your regional contractor within 72 hours. The inpatient unit and your regional contractor will coordinate authorization for a continued stay.

ADSMs who get care at military hospitals and clinics don't need prior authorization. TRICARE only considers emergency and inpatient hospital services medically necessary when a patient's condition requires the services of hospital personnel and facilities. These services may be medically necessary to stabilize a medical condition or in certain detoxification circumstances.

Acute Inpatient Psychiatric Care

A health care provider can refer a patient for acute inpatient psychiatric care if the provider believes psychiatric care is needed on a 24-hour-a-day basis for safety and stabilization when a patient is a threat to the physical well-being of self or others.

Acute inpatient psychiatric care may be covered for emergency or nonemergency conditions, but prior authorization is always required for nonemergency inpatient admissions. In emergency situations, authorization is required for a continued stay.

Psychiatric Residential Treatment Center Care

Psychiatric residential treatment centers (RTCs) give extended care to children and adolescents up to age 21 diagnosed with mental health disorders—not including substance use disorders—that require 24-hour-a-day treatment. Residential treatment may be required if a patient is stable enough to not need acute inpatient hospitalization, but requires a structured, therapeutic, residential setting to stabilize the condition to be able to function at home and in an outpatient setting in the future.

The following rules apply:

- Care must be recommended and directed by a psychiatrist or clinical psychologist.
- Facilities must be TRICARE-authorized.
- The family and/or guardian should actively participate in the patient's continuing care unless their involvement impedes therapy.
- Prior authorization is always required.
- RTC care is elective and not considered an emergency.
- Admission primarily for substance use rehabilitation is not authorized.
- In an emergency, you must get psychiatric inpatient hospitalization first, because the patient must be stable enough to benefit from RTC care.
- RTC care is only covered for beneficiaries up to age 21.

Psychiatric Partial Hospitalization Program

A psychiatric partial hospitalization program (PHP) is recommended when a mental health provider believes it is necessary to stabilize a critical mental health disorder that doesn't require 24-hour-a-day care in an inpatient psychiatric setting, or to transition from an inpatient program to an outpatient program.

PHPs provide therapeutic services at least three hours a day, five days a week. Those services may be provided during the day, evening, night or weekend. The following rules apply:

- You must get prior authorization from your regional contractor.
- Facilities must be TRICARE-authorized.
- PHPs must agree to participate in TRICARE.
- PHP care is limited to 60 treatment days (whether full- or partial-day treatment) per FY. TRICARE may waive limitations if medically or psychologically necessary.

Substance Use Disorder Services

Substance use disorders include alcohol or drug abuse or dependence. TRICARE only reimburses the cost of care if you visit a TRICARE-authorized institutional provider. A TRICARE-authorized institutional provider is defined as an authorized hospital or a dedicated substance use disorder rehabilitation facility (SUDRF). This can be either a freestanding facility or inside a hospital.

TRICARE covers substance use disorder services for up to three episodes per beneficiary, per lifetime. An episode is defined as 365 days from the first day treatment begins.

Inpatient Detoxification

TRICARE covers emergency and inpatient hospital services when hospitals or SUDRF facilities and personnel are medically necessary for detoxification.

Limitations:

- Treatment at a freestanding SUDRF is limited to seven days for each detoxification episode.
- Detoxification at a freestanding SUDRF doesn't count toward the limit of three episodes of care per lifetime.
- TRICARE may waive limitations if medically or psychologically necessary.

Rehabilitation

TRICARE covers 21 days of rehabilitation in a TRICARE-authorized SUDRF per benefit period (begins with the first day of covered treatment and ends 365 days later). This can include inpatient care, partial hospitalization or a combination of both. TRICARE may waive limitations if medically or psychologically necessary.

Substance Use Disorder Rehabilitation Facility Outpatient Care

Outpatient substance use treatment must be provided by an authorized SUDRF.

Limitations:

- **Individual or group therapy:** 60 visits per benefit period (begins with the first day of covered treatment and ends 365 days later)
- **Family therapy:** 15 visits per benefit period (begins with the first day of covered treatment and ends 365 days later)
- **SUDRF residential or partial hospitalization care:** 21 treatment days per FY
- TRICARE may waive limitations if medically or psychologically necessary.

Quit Tobacco

TRICARE is dedicated to helping ADSMs, veterans, retirees and their families succeed in the attempt to quit tobacco. Below are several ways you can get assistance to quit:

- TRICARE-covered tobacco-cessation products
- Tobacco-cessation counseling services
- TRICARE's Tobacco Quitline
- The Department of Defense's website, www.ucanquit2.org

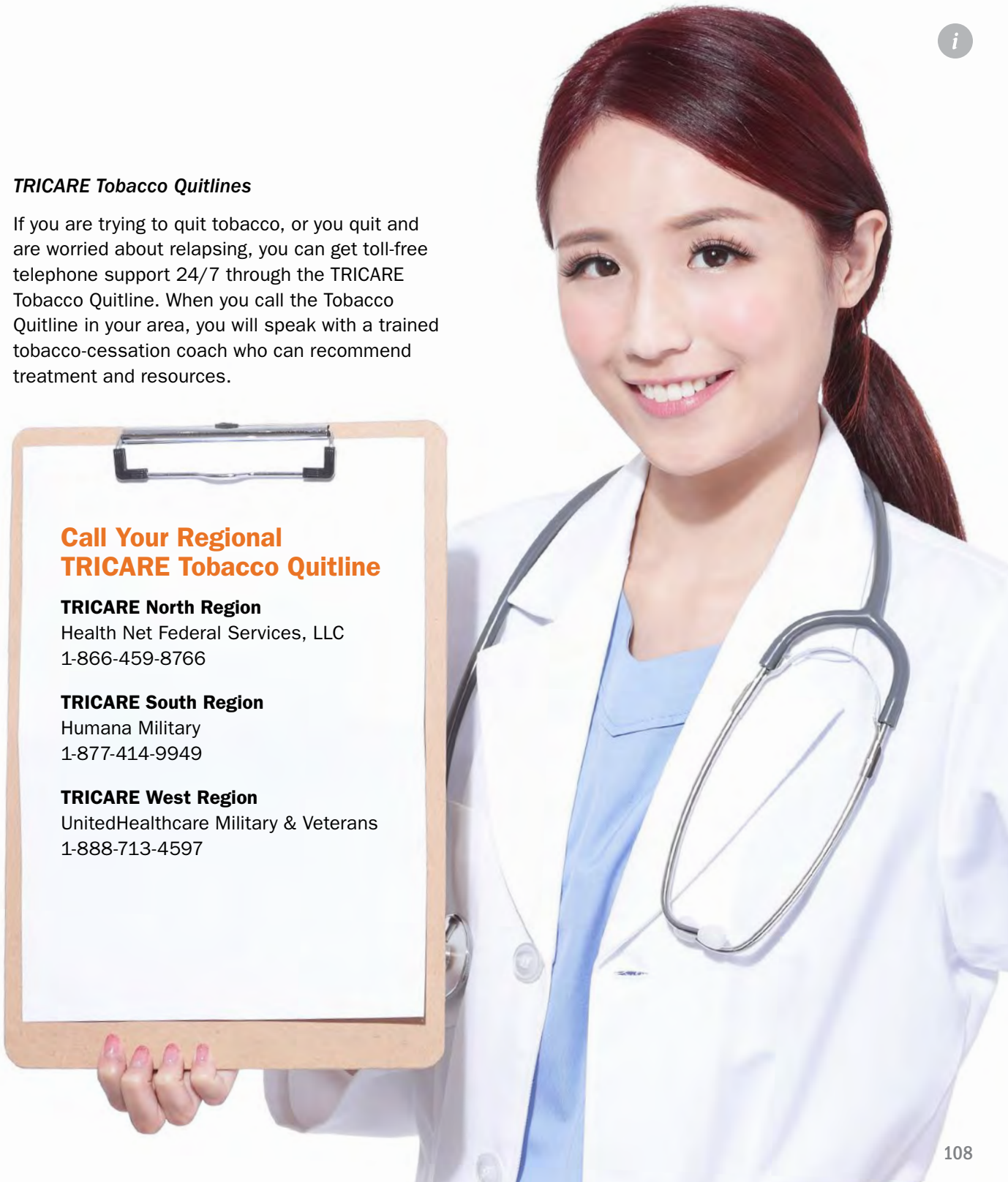
For details on covered no-cost tobacco-cessation products, see *TRICARE Pharmacy Program*. To learn more, go to www.tricare.mil/quittobacco.

Tobacco-cessation counseling is covered for all TRICARE beneficiaries who are:

- Age 18 and older
- Not Medicare-eligible
- Live and get counseling in a U.S. state or the District of Columbia.

TRICARE Tobacco Quitlines

If you are trying to quit tobacco, or you quit and are worried about relapsing, you can get toll-free telephone support 24/7 through the TRICARE Tobacco Quitline. When you call the Tobacco Quitline in your area, you will speak with a trained tobacco-cessation coach who can recommend treatment and resources.



Maternity Care

If you are pregnant, your care before, during and after childbirth and your associated costs are determined by:

- Your beneficiary status
- How close you live to a military hospital or clinic that provides obstetric and gynecological services
- Your choice of TRICARE program and provider

Maternity Care Coverage

TRICARE covers the following maternity care services if medically necessary:

- Obstetric visits throughout your pregnancy
- Fetal ultrasounds
- Hospitalization for labor, delivery and postpartum care
- Anesthesia for pain management during labor and delivery
- Cesarean sections
- Management of high-risk or complicated pregnancies
- Deliveries at TRICARE-certified/authorized birthing centers
- Breast pumps, breast pump supplies and breast-feeding counseling

TRICARE doesn't cover:

- Fetal ultrasounds that aren't medically necessary (for example, to determine your baby's sex), including three and four-dimensional ultrasounds
- Management of uterine contractions with drugs that aren't approved for that use by the FDA
- Home uterine-activity monitoring and related services
- Private hospital rooms, unless a provider orders a private room for medical reasons or a semiprivate room is not available
- Unproven procedures (for example, lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent miscarriages or salivary estriol test for preterm labor)
- Umbilical cord collection and storage, except for patients who undergo a covered umbilical cord blood transplant
- Non-registered nurse midwives
- Non-medical support during labor and childbirth (for example, doulas or labor coaches)

Note: Some providers offer their patients routine ultrasound screenings after 16–20 weeks of pregnancy. TRICARE doesn't cover this service. TRICARE only covers medically necessary maternity ultrasounds.

Provisional Coverage for Emerging Services and Supplies

TRICARE covers emerging health care services and supplies, like surgery for femoroacetabular impingement. Provisional coverage requires prior authorization. For more information, go to www.tricare.mil/provisionalcoverage.

Assisted Reproductive Services

Generally, TRICARE doesn't cover assisted reproductive services and noncoital reproductive procedures like:

- Artificial insemination, including intrauterine insemination and any costs related to donors and sperm banks
- In vitro fertilization
- Zygote intrafallopian transfer
- Tubal embryo transfer
- Gamete intrafallopian transfer
- Reversal of tubal ligation or vasectomy
- Medications, hormones, lab work and ovulation stimulation used in conjunction with the previously listed services and procedures also aren't covered

However, TRICARE does cover some infertility assessments, tests and care when used in conjunction with natural conception including:

- Services and supplies needed to diagnose and treat an illness or injury involving the female or male reproductive system. This includes correction of any physical cause of infertility. This doesn't include artificial insemination or assisted reproductive technology procedures, which aren't covered.
- Diagnostic services. This includes semen analysis, hormone evaluation, chromosomal studies, immunologic studies, special and sperm function tests and/or bacteriologic investigation
- Medically necessary care for erectile dysfunction that is due to an organic cause. This includes a vascular condition, diabetic neuropathy, a spinal cord injury and thyroid disease. TRICARE doesn't cover psychological or psychiatric causes of erectile dysfunction like depression, anxiety and stress.

You must get prior authorization from your regional contractor or military hospital or clinic before getting any reproductive services.

Exceptions for Wounded, Ill and Injured Service Members

TRICARE may cover assisted reproductive services for service members who lose their natural reproductive ability due to a serious injury or illness sustained while serving on active duty. Injuries that qualify for this exception include, but aren't limited to, neurological, physiological and/or anatomical injuries. For more information, go to www.tricare.mil/coveredservices.

Hospice Care

You can get hospice care under TRICARE if you or a TRICARE-eligible family member suffers a terminal illness. Hospice care provides supportive services like pain management rather than treatment to cure a condition. With TRICARE hospice care, patients who are expected to live six months or less can get personal care and home health aide services. Otherwise, these services are limited under TRICARE's basic program options. Your regional contractor can work with you to begin hospice care.

The hospice benefit covers an initial consultation with a health care provider in a Medicare-certified hospice program. During the consultation, the patient and his or her family can learn more about a specific program.

A hospice care team and the patient's provider will manage the hospice care. Four levels of care are covered by the hospice benefit:

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

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

Care may include:

- Counseling services like dietary and bereavement counseling
- Durable medical equipment
- Home health aide services
- Medical supplies, including medications
- Medical social services
- Medically necessary short-term inpatient care
- Nursing care
- Physical therapy, occupational therapy and speech language pathology services for symptom control or to maintain basic functional skills
- Physician services

Hospice care may be provided in a number of settings, including the patient's home, a Medicare-certified hospice facility, or an authorized inpatient acute care facility. Hospice care may also be provided to patients residing in nursing homes. Care may shift among settings without affecting the benefit or requiring additional authorization.

All care is subject to medical review by the regional contractor.

Note: *Respite care* is covered when necessary, but is limited to no more than five consecutive days at a time.

Initiating Hospice Care

The patient, his or her health care provider, or a family member can request hospice care. To ensure hospice care eligibility, the patient's information must be up to date in the Defense Enrollment Eligibility Reporting System (DEERS). A referral from the primary care manager (for beneficiaries in TRICARE Prime options), notification to the regional contractor by the hospice program, and certification of the terminal illness are required. Contact your regional contractor for more information on requirements.

Before beginning care, the patient or an appropriate representative must complete and sign a hospice election statement that indicates his or her full understanding of hospice care. By signing this statement, the patient waives his or her right to cure-oriented treatment of the illness and acknowledges that he or she may not get certain medical services offered through the basic TRICARE program. The hospice program will provide the statement, which must be filed by the hospice program with the regional contractor once it is completed and signed.

Hospice Benefit Periods

There are two initial 90-day benefit periods followed by an unlimited number of 60-day periods. Each period requires prior authorization from your regional contractor.

- The first 90-day period begins after the patient signs a hospice election statement and the attending provider and hospice medical director both sign a provider certificate of terminal illness.
- The second 90-day period and subsequent 60-day periods require recertification of the terminal illness by the hospice medical director or the hospice care team provider.

A patient may change from one hospice program to another once during each benefit period.

Cure-Oriented Treatment

A hospice patient can receive treatment designed to cure his or her illness at any time by revoking his or her hospice care election. The patient must submit a signed, dated statement to the hospice provider and forfeit any remaining days in that election period. If eligible for another election period, the patient may receive hospice care at a later time.

Costs

There is no deductible for hospice care. TRICARE pays for all covered services.

However, your hospice provider may charge you for items not covered by the benefit, like outpatient medications. Charges for medical care not related to a terminal illness will be processed under your TRICARE plan (like TRICARE Prime or TRICARE Standard). For specific cost information, contact your regional contractor or hospice provider.

Other Options

You and your family members may be eligible for care options other than hospice care. Alternatives include skilled nursing and home health care. For more information, visit www.tricare.mil.

Hospice Benefit Exclusions

The following are not covered under the hospice benefit:

- Room and board for hospice care received at home
- Room and board for hospice care received in a nursing home
- Room and board related to custodial care
- Cure-oriented treatment of the terminal illness

Services or Procedures with Significant Limitations

TRICARE doesn't cover the following services except under exceptional circumstances.

Abortion

By law, TRICARE only covers abortion when:

- The mother's life is endangered if the pregnancy is carried to term
- The pregnancy is from rape or incest

Services and supplies related to spontaneous, missed or threatened abortions and abortions related to ectopic pregnancies may be cost-shared. All medically and psychologically necessary services and supplies related to a covered abortion are covered.

Bariatric Surgery

Only covered for treatment of morbid obesity in limited circumstances. For more information, call your regional contractor.

Botulinum Toxin (Botox) Injections

Not covered for cosmetic use. Can be covered for FDA-approved uses and for off-label use when medically necessary and supported by medical literature as safe and effective.

Cardiac and Pulmonary Rehabilitation

Covered only for certain conditions. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.

Cosmetic, Plastic or Reconstructive Surgery

Covered only when medically necessary or used to:

- Restore function
- Correct a serious birth defect
- Restore body form after a serious injury
- Improve appearance of a severe disfigurement after cancer surgery
- Reconstruct the breast after cancer surgery

Dynamic Orthotic Cranioplasty Band

The Dynamic Orthotic Cranioplasty Band, known as the DOC Band, is covered postoperatively for infants ages 3–18 months whose synostosis has been surgically corrected, but who still have moderate to severe cranial deformities. Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery.

Diagnostic Genetic Testing

Covered when medically proven and the results of the test will influence the medical management of the patient. The test must be FDA-approved. Routine genetic testing isn't covered.

Note: Non-FDA-approved laboratory-developed tests (LDTs) may be covered under the Non-FDA Approved LDTs Demonstration Project. For more information, go to www.tricare.mil/ldt.

Education and Training

Your TRICARE program option covers education and training for diabetic outpatient self-management as long as the training is from a program approved by the American Diabetes Association. Some education and training may also be covered under ECHO and the Autism Care Demonstration.

If you use your TRICARE program option—for example, TRICARE Prime or TRICARE Standard—to get training, you can submit a claim to get money back. You must include the training provider's "Certificate of Recognition" from the American Diabetes Association with your claim.

Facility Charges for Non-Adjunctive Dental Services

Dental care isn't usually covered as a TRICARE medical benefit. This includes situations that are dental emergencies. Dental care is mostly covered under separate dental-specific programs. However, hospital and anesthesia charges for routine dental care for children under age 5 or with disabilities may be covered as a TRICARE medical benefit if the dental care is related to a medical condition. Prior authorization is required.

Food, Food Substitutes and Supplements and Vitamins

TRICARE covers medically necessary nutritional formulas when they are a patient's primary source of nutrition for enteral, parenteral or oral nutritional therapy. Coverage extends to intraperitoneal nutrition therapy for malnutrition as a result of end-stage renal disease. Also, the following may be cost-shared:

- Ketogenic diets if part of a medically necessary admission for epilepsy
- Vitamins when used as a specific treatment of a medical condition
- Prenatal vitamins that require a prescription may be cost-shared, but are covered for prenatal care only.

Hearing Aids

Hearing aids are only covered for some beneficiaries under limited circumstances.

- **ADFMs:** Hearing aids are covered only if you meet specific hearing loss requirements.
- **Retirees, retiree family members, TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR):** Hearing aids are excluded in all circumstances.
- **TRICARE Young Adult:** Hearing-aid coverage depends on your sponsor's status. If your sponsor is an ADSM, your coverage is the same as an ADFM. If your sponsor is a retiree or uses TRS or TRR, hearing aids are excluded.

Private Hospital Rooms

Private rooms aren't covered unless you need one for medical reasons or because a semiprivate room is unavailable. Hospitals that are subject to the TRICARE Diagnostic-Related Group (DRG) payment system can give you a private room, but the hospital will be paid only the standard DRG amount.

If you get a private room because you request one, the hospital can bill you for the extra charges.

Shoes, Shoe Inserts, Shoe Modifications and Arch Supports

Covered in limited circumstances. TRICARE might cover orthopedic shoes if they are a permanent part of a brace. If you have diabetes, TRICARE might cover extra-depth shoes with inserts or custom-molded shoes with inserts.

TRICARE Covered Services Exclusions

This section lists many of the services that TRICARE never covers.

It's important to know that if you need medical care as a direct result of getting an excluded medical service, TRICARE won't cover follow-on services, even if they would normally be covered.

The following list is **not** all-inclusive. Check your regional contractor's website for more information.

- Acupuncture (unless approved for an ADSM and offered at a military hospital or clinic)
- Alterations to living spaces
- Autopsy services or post-mortem exams
- Birth control/contraceptives (non-prescription)
- Camps (for example, for weight loss)
- Charges that providers may apply to missed or rescheduled appointments
- Chiropractors and naturopaths
- Counseling services that aren't medically necessary for the treatment of a diagnosed medical condition (for example, educational, vocational and socioeconomic counseling; stress management; lifestyle modification)
- Custodial care
- Diagnostic admissions
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chair lifts
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships or other such charges or items
- Experimental or unproven procedures (unless authorized under specific exceptions in TRICARE regulations)
- Foot care (routine), unless needed because of a systemic medical disease affecting the lower limbs, like diabetes
- General exercise programs, even if recommended by a provider and rendered by an authorized provider
- Inpatient stays:
  - For rest or rest cures
  - To control or detain a runaway child, even if admitted to an authorized institution
  - To perform diagnostic tests, exams and procedures that could have been and are performed routinely on an outpatient basis
  - In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- Learning-disability services
- Medications:
  - Drugs prescribed for cosmetic purposes
  - Fluoride preparations
  - Food supplements
  - Homeopathic and herbal preparations
  - Multivitamins
  - Weight reduction products
- Megavitamins and orthomolecular psychiatric therapy
- Mind-expansion and elective psychotherapy
- Surgical and non-surgical services and supplies exclusively for obesity, weight reduction or weight control, except under limited circumstances
- Personal, comfort or convenience items, such as beauty and barber services, radio, television and phone

- Postpartum inpatient stay for:
  - A mother to stay with a newborn infant when only the infant requires the extended stay
  - A newborn infant to stay with the mother when only the mother requires the extended stay
- Psychiatric treatment for sexual dysfunction
- Services and supplies:
  - Given under a scientific or medical study, grant or research program
  - Given or prescribed by an immediate family member
  - That the beneficiary is not legally obligated to pay or would not have to pay if they or the sponsor weren't TRICARE-eligible
  - Given free of charge
  - For the treatment of obesity, like diets, weight-loss counseling, weight-loss medications, wiring of the jaw or similar procedures
  - Inpatient stays directed or agreed to by a court or other governmental agency, unless medically necessary
  - Required because of a job-related disease or injury that is covered by workers' compensation or similar law, unless the workers' benefits are exhausted
  - That can be fully paid under another medical insurance or program whether private or governmental; includes coverage through employment or Medicare
- Sex changes or sexual inadequacy treatment except for treatment of ambiguous genitalia that was documented at birth
- Sterilization reversal surgery
- Surgery performed primarily for psychological reasons
- Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE
- Transportation, except by ambulance
- X-ray, laboratory and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer screening and other tests allowed under the clinical preventive services benefit

TRICARE Vision Benefit

TRICARE offers vision coverage to diagnose or treat an eye condition. Eye exams, lenses and glasses, some surgeries and more are covered.

Eye Exams

Your eye exam coverage depends on your beneficiary status, your age and your TRICARE program option. You can also check with your local military hospital or clinic to see if they have eye care services. One eye exam each year is recommended. Eye exams for those with diabetes aren't limited. For details on your vision benefit, see the tables that follow.

If you are an active duty service member (ADSM) in TRICARE Prime, you must get all vision care at military hospitals or clinics unless your primary care manager (PCM) refers you to a civilian network provider or non-network provider if a network provider is not available.

For details on well-child eye exams for children from birth up to age 6, see *Well-Child Care*.

Helpful Website

TRICARE Vision Care
www.tricare.mil/vision

TRICARE Eye Exam Coverage for Those Age 6 and Older

BENEFICIARY TYPE	TRICARE PROGRAM OPTION	EYE EXAM COVERAGE	PROVIDER TYPE
ADSMs	TRICARE Prime	As needed to maintain fitness-for-duty status	Military hospital or clinic, unless referred to a network or non-network provider
	TRICARE Prime Remote (TPR)	As needed to maintain fitness-for-duty status	Network provider without prior authorization
Active Duty Family Members (ADFMs) or TRICARE Reserve Select (TRS) members	TRICARE Prime or TPR	One eye exam each year	Network provider without referral or prior authorization
	TRICARE Standard and TRICARE Extra or TRS	One eye exam each year	Any TRICARE-authorized provider (network or non-network, with cost-shares)
Retirees, their families and others	TRICARE Prime	One eye exam every two years	Network provider without referral or prior authorization
	TRICARE Standard and TRICARE Extra, TRICARE Retired Reserve (TRR)	None	Doesn't apply

TRICARE Eye Exam Coverage under the Well-Child Benefit For Children up to Age 6

BENEFICIARY TYPE	TRICARE PROGRAM OPTION	EYE EXAM COVERAGE	PROVIDER TYPE
Infants (up to age 3)	All programs	One eye and vision screening at birth and at around 6 months	PCM or primary care provider
ADFMs or TRS children (age 3 up to age 6)	TRICARE Prime or TPR	One eye exam each year	Network provider
	TRICARE Standard and TRICARE Extra or TRS	One eye exam each year	Any TRICARE-authorized provider (network or non-network)
Non-ADFM children (age 3 up to age 6)	TRICARE Prime	One eye exam every two years	Network provider
	TRICARE Standard and TRICARE Extra or TRICARE Retired Reserve	One eye exam every two years	Any TRICARE-authorized provider (network or non-network)

Lenses and Glasses

Except for ADSMs, lenses (implanted in the eye or contacts) or glasses are only cost-shared for the following conditions:

- Contact lenses for treatment of infantile glaucoma
- Corneal or scleral lenses for treatment of keratoconus
- Scleral lenses for moisture when there is no or not enough normal tearing
- Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism
- Intraocular lenses, contact lenses or glasses to perform the function of the human lens lost as the result of intraocular surgery or ocular injury or congenital absence (coverage for this condition is limited to standard fixed non-accommodating monofocal lenses)

Laser/Lasik/Refractive Corneal Surgery

Surgery is only covered to relieve astigmatism following a corneal transplant or for the treatment of retinoblastoma.

Vision Coverage Limits

You are limited to one set of intraocular lenses needed to restore vision. A set may include a combination of intraocular lenses and glasses. If you have a prescription change related to your covered eye condition, a new set of lenses may be cost-shared (after a medical review). Replacement lenses for those that are lost, have worn out or have become unusable due to physical growth aren't covered. Adjustments, cleanings and repairs of glasses aren't covered. Some intraocular lenses are excluded from coverage including Astigmatism-Correcting Intraocular Lenses and Presbyopia-Correcting Intraocular Lenses.

For more information about your vision benefit, call your regional contractor. Special programs may exist at local military hospitals and clinics. Call your local military hospital or clinic for details.

Section IV

CLAIMS AND APPEALS

Introduction to Claims and Appeals

In some situations, you may have to submit claims for medical, pharmacy or dental services. This section explains how and when to submit claims. If you aren't satisfied with how a claim or prior authorization was handled, you have the right to appeal the decision.

Helpful Websites

Learn more about claims or download claim forms
www.tricare.mil/claims

Submit proof of payment with your overseas claim
www.tricare.mil/proofofpayment

Appeal a claim or prior authorization decision
www.tricare.mil/appeals

Download authorization or appeal forms and other worksheets
www.tricare.mil/Resources/Forms/DHA-GL

Report other health insurance (OHI) online
www.dmdc.osd.mil/appj/bwe

Learn more about OHI
www.tricare.mil/ohi

Key Concepts

- TRICARE Prime and TRICARE Prime Remote beneficiaries usually don't need to file claims for health care services.
- TRICARE Standard and TRICARE Extra beneficiaries may have to submit their own health care claims.
- If you use TRICARE Extra, health care providers will submit claims for you.
- You should submit all your claims to the TRICARE regional contractor where you live except for overseas and TRICARE For Life (TFL) claims.
- Claims must be submitted within a certain time frame (one year for services in the U.S. and three years for services overseas).

Key Terms

- **Claim:** A request for payment from TRICARE that goes to your regional contractor after you get a covered health care service.
- **Copayment:** The fixed amount those with TRICARE Prime (who are not active duty) pay for a covered health care service or drug.
- **Cost-share:** A percentage of the total cost of a covered health care service that you pay.
- **Explanation of benefits:** A statement summarizing the treatment/services that were paid by TRICARE, Medicare or other health insurance (OHI).
- **Deductible:** A fixed amount you pay for covered services each fiscal year before TRICARE pays anything.
- **Medical necessity:** When care is appropriate, reasonable and adequate for a certain health condition.
- **Prior authorization:** A review of a requested health care service done by your regional contractor to see if TRICARE will cover the care.

Medical Claims

Sometimes you will need to pay up front for a health care service and file a claim to get money back. Depending on your TRICARE program option and the type of health care service you get, the amount of money you get back is subject to copayments, cost-shares and deductibles.

Submit all stateside claims to the claims processor for the region where you live. If you have TRICARE For Life (TFL) claims, see *TRICARE For Life Claims*, for more information.

TRICARE Standard and TRICARE Extra beneficiaries: When you use the TRICARE Extra option, your provider submits claims for you. If you use the TRICARE Standard option, you may be required to submit your own claims.

When do I need to submit my claim?

LOCATION OF CARE PROVIDED	TIME FRAME	CLOCK STARTS FROM	SEND CLAIM TO
U.S.	Within one year	Date of service or the date of inpatient discharge	Regional contractor where you live
Overseas	Within three years		TRICARE Overseas Program claims processor based on your beneficiary status and where you got care

Submit a Medical Claim

You are responsible for making sure your claims are delivered. If you have questions about submitting claims or need help with submitting and checking claims online, call your regional contractor or go to www.tricare.mil/claims.

Step 1: Complete a Claim Form

You can download the *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request for Medical Payment* form (DD Form 2642) and instructions from the TRICARE claims webpage or from your regional contractor's website listed in the *Introduction* of this guide.

Beneficiaries (age 18 and older), spouses, parents or guardians may sign the initial claim form. However, additional forms must be signed by the beneficiary or parent/guardian if the patient is under age 18. Attach a readable copy of the provider's itemized bill and include:

- Patient's name
- Sponsor's Social Security number (SSN) or Department of Defense (DoD) Benefits Number (eligible former spouses should use their own SSNs, not the sponsor's)
- Provider's name and address (if more than one provider's name is on the bill, circle the name of the provider who performed the service)
- Date, place, description and cost of each service
- Description of each service or supply furnished
- Diagnosis (if the diagnosis is not on the bill, complete block 8a on the form)

Line of Duty Conditions

Civilian providers must submit claims for line of duty (LOD) medical care for you. LOD medical care claims should go to the TRICARE region where you live.

LOD claims processing and payment is separate from any other TRICARE coverage you may get under:

- The Transitional Assistance Management Program
- TRICARE Reserve Select

Note for National Guard and Reserve Members

Emergency care medical claims for National Guard and Reserve members on active duty for 30 days or less will be paid after a *Medical Eligibility Verification Reserve Component* worksheet is completed.

The worksheet is available on the Defense Health Agency–Great Lakes (DHA–Great Lakes) TRICARE webpage listed under *Helpful Websites*. The service member's unit representative must submit the worksheet to the address or fax number provided on the worksheet.

All paperwork must be submitted as soon as possible. The service member's unit must contact DHA-Great Lakes if the LOD determination was not submitted before getting emergency medical care.

"Every time I call with questions about medical bills we receive, I am treated with professionalism."

–C.L., TRICARE beneficiary

Step 2: Submit Proof of Payment with Overseas Claims

If you travel and get care outside the U.S. or overseas, be prepared to pay up front for services and file a claim to get money back.

You must submit proof of payment with all claims for care you get overseas. Proof of payment may include one or more of the following:

- A receipt
- Canceled check
- Credit card statement
- Invoice from the provider showing payment was made
- Proof of cash withdrawal from your financial institution (if you paid cash) and receipt from your provider

A canceled check or credit card receipt showing payment for medical supplies or services is usually enough for proof of payment.

Submit *DD Form 2642* and proof of payment to the TRICARE Overseas Program (TOP) claims processor. Be sure to include the following:

- An itemized bill or invoice
- A diagnosis describing why you got medical care
- An explanation of benefits (EOB) from your other health insurance (OHI) (if applicable)

If you paid the provider, write "Paid Provider" at the top of *DD Form 2642*.

Submit claims to the TOP claims processor.

Note: After submitting the documents listed, you may be asked to provide additional documentation. Call the TOP Regional Call Center where you got overseas care and choose option 2 for claims assistance.

Step 3: Coordinate with Other Health Insurance

If you have OHI, you need to keep your regional contractor informed so they can better coordinate your benefits and prevent claims delays or denials. National health insurance programs overseas are considered OHI. If you are enrolled in such programs, call your TOP Regional Call Center before getting care from a civilian overseas provider.

Reporting Other Health Insurance

You can report your OHI through the following:

- **Online:** Fill out the *TRICARE Other Health Insurance Questionnaire* at www.tricare.mil/forms or enter the information on the Beneficiary Web Enrollment website at www.dmdc.osd.mil/appj/bwe.
- **By phone:** Call your regional contractor.
- **In person:** Go to your military hospital or clinic or a uniformed services ID card office.

TRICARE and Other Health Insurance for Medical Claims

TRICARE is the primary payer for active duty service members. For all other beneficiaries, TRICARE is the last payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service or another program or plan identified by the Defense Health Agency.

Follow your OHI's rules for filing claims and file the claim with your OHI first. Your OHI is considered your primary insurance and pays before TRICARE. You or your provider must file health care claims with your OHI before filing with TRICARE. If there is an amount your OHI doesn't cover, you can file a claim with TRICARE to get money back. After your OHI pays its portion, submit a copy of your EOB and the itemized bill with your TRICARE claim.

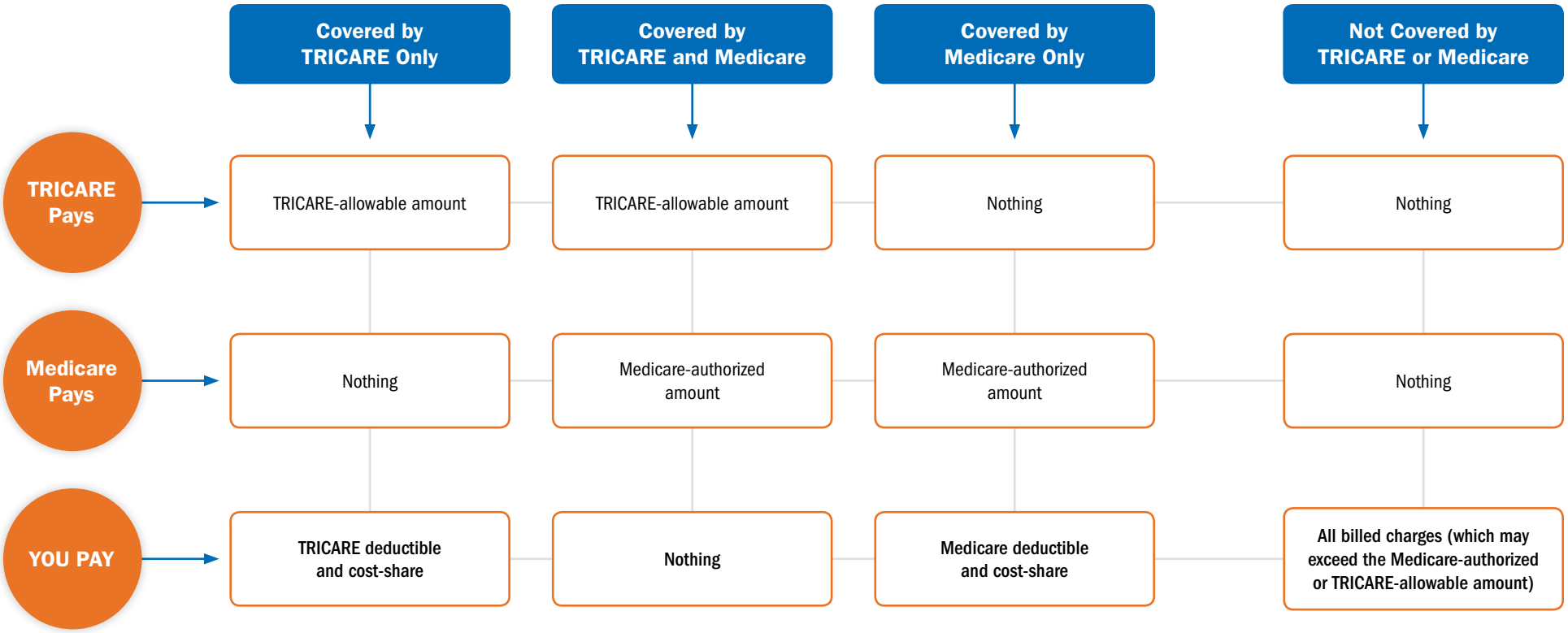
If your OHI denies a claim for failure to follow its rules, such as getting care without authorization or using a non-network provider, TRICARE may also deny your claim.

TRICARE For Life Claims

Wisconsin Physicians Service (WPS)—Military and Veterans is the TFL claims processor for all care in the U.S. TFL is your primary payer for health care you get overseas, unless you have OHI.

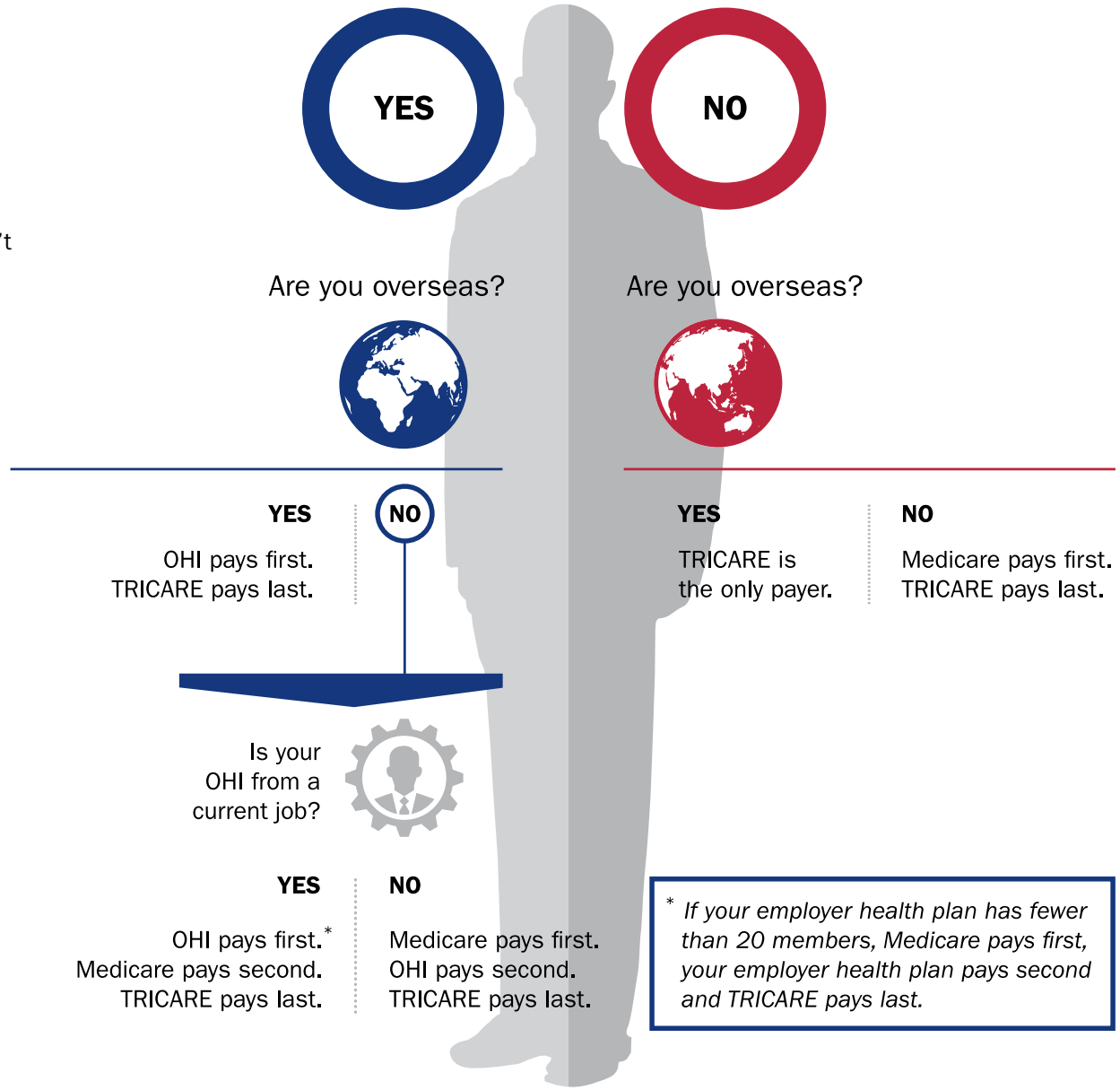
For more information on TFL, see *TRICARE For Life* or the *TRICARE For Life Handbook* at www.tricare.mil/publications.

TRICARE For Life Out-Of-Pocket Costs



How Does TRICARE For Life Work with Other Health Insurance?

Like Medicare, OHI normally processes and pays claims before TFL. The order in which Medicare and OHI process claims depends on whether your OHI is based on current employment or not. Payment of your claim also depends on whether or not you're outside the U.S. when you get care. Your OHI and TFL may pay for care overseas, but Medicare doesn't cover care outside the U.S. or aboard ships outside U.S. territorial waters.



Pharmacy Claims

If you fill prescriptions at a military pharmacy, through TRICARE Pharmacy Home Delivery or at a TRICARE retail network pharmacy you don't need to file pharmacy claims.

When do I need to file a pharmacy claim?

IF YOU FILL A PRESCRIPTION AT	YOU PAY	FILE CLAIM WITH
Non-network pharmacy	Full price	Express Scripts, Inc.
Overseas pharmacy	Full price	TRICARE Overseas Program claims processor

Note About Non-Network Pharmacies

When filling prescriptions at non-network pharmacies:

- Active duty family members are using the point-of-service option
- Active duty service members (ADSMs) may be required to pay the full price of prescriptions up front and submit a claim to get money back

Submit a Pharmacy Claim:

1. Download and complete *TRICARE DoD/CHAMPUS Claim Form—Patient's Request for Medical Payment* form (DD Form 2642) at www.tricare.mil/forms.
2. Attach additional paperwork as described on the form.
3. Send the form and paperwork to the mailing address listed on the form.

Prescription claims must include the following information for each drug:

- Patient's name
- Drug name, strength, date filled, days' supply, quantity dispensed and cost
- National Drug Code (if available)
- Prescription number
- Name and address of the pharmacy
- Name and address of the prescribing health care provider

TRICARE and Other Health Insurance for Prescriptions

TRICARE is the primary payer for ADSMs. For all other beneficiaries, TRICARE is the last payer to all pharmacy benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service or any other plan identified by the Department of Defense.

Follow your Other Health Insurance's (OHI's) rules for filing claims and file the claim with your OHI first. Your OHI is considered your primary insurance and pays before TRICARE. You must file pharmacy claims with your OHI before filing with TRICARE. If there is an amount your OHI doesn't cover, you can file a claim with TRICARE to get money back. After your OHI pays its portion, submit a copy of your payment determination and a copy of the provider's bill with your TRICARE claim.

If your OHI denies a claim for failure to follow its rules, such as getting care without authorization or using a non-network provider, TRICARE may also deny your claim.

To save money, fill prescriptions at a TRICARE retail network pharmacy that your OHI also covers. If you have OHI prescription coverage, you can't use TRICARE Pharmacy Home Delivery unless the drug is not covered by your OHI or you have met the OHI benefit cap.

Dental Claims

The dental program you have and whether you go out-of-network for dental services will determine if you need to submit a dental claim to get money back.

TRICARE Active Duty Dental Program Claims

To get Active Duty Dental Program (ADDP) coverage for dental care, you must use a United Concordia network dentist. A network dentist will submit claims for you and you won't have any out-of-pocket expenses. If a network dentist is not available in your area, call United Concordia for assistance.

If you use a non-network dentist without prior authorization, you will be responsible for paying for the cost of dental care.

Go to www.addp-ucci.com for more information.

TRICARE Dental Program Claims

With the TRICARE Dental Program (TDP), you can go to any authorized or licensed dentist of your choice. A network dentist will submit claims for you. If the dentist is a non-network dentist, you may need to file your own claim. Claims should be submitted as soon as possible after you get dental care. Claims submitted after 12 months of getting dental care will be denied. Go to www.tricare.mil/publications and download the *TRICARE Dental Program Benefit Booklet.* You can also go to www.metlife.com/tricare for more information.

TRICARE Retiree Dental Program Claims

With the TRICARE Retiree Dental Program (TRDP), you can go to any authorized or licensed dentist of your choice. A network dentist will submit claims for you. If you see a non-Delta Dental dentist, you may need to file your own claim. Claims should be submitted as soon as possible after you get dental care. Claims submitted after 12 months of getting dental care will be denied. Go to www.trdp.org for details on the claims process.

Filing an Appeal

As a TRICARE beneficiary, if you disagree with a benefit-related decision made by the Defense Health Agency or by a TRICARE contractor, you have the right to appeal that decision. When you get a written decision, you will also get information about the appeals process. The appeals process varies depending on whether the denial of benefits involves a medical-necessity determination, factual determination, provider authorization, provider sanction and/or a dual-eligible determination.

All initial determination and appeal denials explain how, where and when to file the next level of appeal. Submit appeals to your regional contractor.

Who Is Able To Appeal?

- Any TRICARE beneficiary or a parent/guardian of a beneficiary who is under age 18
- The legally-appointed guardian of a beneficiary who is not able to act on his or her own behalf
- A health care provider who has been denied approval as a TRICARE-authorized provider, or who has been suspended, excluded or terminated
- A non-network participating provider. **Note:** Network providers aren't appropriate appealing parties, but may be appointed as a representative, in writing, by you. Providers who don't participate in TRICARE can't usually file appeals—except to appeal a denial to be a participating provider—but they can be appointed as a representative.
- A representative appointed in writing by a beneficiary or provider. Certain individuals may not serve as representatives due to a conflict of interest. An officer or employee of the U.S. government, such as an employee or member of a uniformed services legal office or a Beneficiary Counseling and Assistance Coordinator, may not serve as a representative unless that person is representing an immediate family member.

What Can Be Appealed?

- A decision denying payment for services or supplies you got
- A decision denying authorization for services or supplies
- A decision ending TRICARE payment for services or supplies that were allowed before
- A decision denying a provider's request for approval as a TRICARE-authorized provider or dismissing a provider from TRICARE

What Can't Be Appealed?

- The amount that a TRICARE contractor determines to be an acceptable cost for a health care service. You may ask the TRICARE contractor for an allowable charge review, not an appeal.
- The decision by TRICARE or its contractors to ask for more information before a decision is made on your claim or appeal request
- Decisions relating to the status of TRICARE providers. You can't appeal a decision that denies a provider authorization to be a TRICARE provider, or a decision that suspends, excludes or terminates a provider from TRICARE. The health care provider can appeal on his or her own behalf.
- Decisions relating to eligibility. Eligibility for TRICARE is determined by the services and information is maintained in the Defense Enrollment Eligibility Reporting System (DEERS). You can discuss eligibility concerns with your service branch.

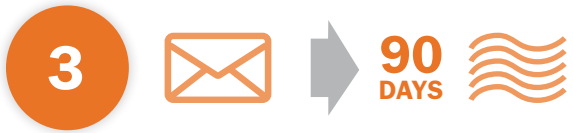
Filing a Medical Necessity Appeal

Medical necessity is when care is appropriate, reasonable and adequate for a certain health condition. You may need to show medical necessity for inpatient, outpatient and specialty care you get. Information included in the denial decision will explain how to file an appeal. To appeal a medical-necessity decision, submit an expedited or non-expedited appeal.

First, send a letter to the TRICARE contractor at the address specified in the notice of the right to appeal. The address is included in the EOB or other decision letter.

The appeal letter must either be postmarked or delivered within 90 days of the date on the EOB or other decision letter. Include a copy of the EOB or other decision letter, and any supporting documents.

If not all of the supporting documents are available, state in the letter your intent to submit additional information. Keep copies of all paperwork.



Send a letter to the TQMC at the address specified in the reconsideration decision. Make sure the letter is either postmarked or delivered within 90 days of the date on the reconsideration decision. Send a copy of the decision and any supporting documents not previously submitted. If not all of the documents are available, state in the letter you will submit additional information. Keep copies of all paperwork.

The TRICARE contractor will review the case and issue a decision. If you disagree with the reconsideration, the next level of appeal is the TRICARE Quality Monitoring Contractor (TQMC).

The TQMC will review the case and issue a second reconsideration decision. If the amount in dispute is less than $300, the reconsideration decision by the TQMC is final. If you disagree and if the disputed services are $300 or more, you may request that the Defense Health Agency (DHA) schedule an independent hearing.

Expedited Appeals

Expedited appeals are usually for requests to reconsider inpatient stays or prior authorization of services. There are requirements for filing an expedited appeal. Within three calendar days of getting the initial denial, you or an appointed representative must submit a request for an expedited review. Contact your regional contractor for more information.

Filing a Factual Determination Appeal

Factual determinations involve issues other than medical necessity. Some examples of factual determinations include coverage issues (for example, determining whether the service is covered under TRICARE), overseas claims and denial of a provider's request for approval as a TRICARE-authorized provider. The following is the appeal process for factual determinations:

1

First, send a letter to the TRICARE contractor at the address specified in the notice of the right to appeal. The address is included in the EOB or other decision letter.

The appeal letter must either be postmarked or delivered within 90 days of the date on the EOB or other decision letter. Include a copy of the EOB or other decision letter, and any supporting documents.

If not all of the supporting documents are available, state in the letter your intent to submit additional information. Keep copies of all paperwork.

2

If the amount in dispute is less than $50, the reconsideration decision from the TRICARE contractor is final.

If you disagree, and if $50 or more is in dispute, you can request a formal review from DHA.

3

To request a formal review, send a letter to DHA, making sure the letter is either postmarked or delivered within 60 days of the date on the initial determination or reconsideration decision.

Include copies of the determination or reconsideration decision, as well as any supporting documents not previously submitted. If not all of the supporting documents are available, state in the letter your intent to submit additional information. Keep copies of all paperwork.

4

DHA will review the case and issue a formal review decision. If the amount in dispute is less than $300, the formal review decision by DHA is final. If the appeal isn't resolved in your favor, there remains a disputed question of fact and the amount in dispute is $300 or more, you may request that DHA schedule an independent hearing.

5

A request for an independent hearing should be sent to DHA, and the request must either be postmarked or delivered within 60 days of the date of the decision being appealed. Include a copy of the decision being appealed and any supporting documents not previously submitted. If not all of the supporting documents are available, state in the letter your intent to submit additional information. Keep copies of all paperwork.

An independent hearing officer will conduct the hearing at a location convenient to both the requesting party and the government. The hearing officer will issue a recommended decision and the DHA director (or designee) or the Assistant Secretary of Defense for Health Affairs will review the recommended decision and issue a final decision.

Provider Sanction Determinations

Provider sanctions occur when providers are expelled from TRICARE. Providers may be sanctioned by TRICARE because of provider fraud or abuse, conflict of interest, failure to maintain credentials or other reasons. Only the provider or his or her representative can appeal a sanction. If the sanction is appealed, an independent hearing officer conducts a hearing administered by the DHA Appeals, Hearings and Claims Collection Division.

Dual-Eligible Beneficiary Determinations

If you are eligible for Medicare and TRICARE benefits, you are considered a dual-eligible beneficiary and must file for coverage with Medicare first.

If Medicare approves a claim, the services and supplies will automatically be considered for coverage under TRICARE. If Medicare denies a claim because it is for services or supplies that aren't a covered Medicare benefit, the claim is submitted to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and TRICARE won't consider the claim.

To appeal a denial, you must first exhaust your rights under the Medicare appeals process and get a final Medicare decision which leaves a question of fact and $50 or more in dispute. Only then can you exercise your appeal rights under TRICARE. For more information about the Medicare appeals process, go to the Centers for Medicare & Medicaid Services website at www.medicare.gov. For the TRICARE appeals process follow the instructions on the TRICARE coverage denial you receive.

Filing an Appeal Overseas

Appeals for care you got when traveling overseas must be postmarked within 90 days of the date on your EOB or denial notification letter. If you aren't satisfied with the outcome of your appeal, you may be able to appeal again. For more information about filing an appeal in your area, contact the TRICARE Overseas Program Regional Call Center where you got care during your overseas travel.

Section V

CHANGES IN COVERAGE

You may have several changes in your coverage throughout your military career. These changes could be the result of program availability based on your assigned location, having or adopting children or changing duty status. Despite these changes, rest assured that TRICARE will provide you the information you need to make the best decisions for your health care.

Life Changes

With every life event listed in this section, the first step is to update your information in the Defense Enrollment Eligibility Reporting System (DEERS). See *Contact Information* for options for updating your DEERS record. For more information about how TRICARE coverage may change when you become entitled to Medicare, go to www.tricare.mil/medicare.

Note: Your Social Security number (SSN) and the SSNs of each of your covered family members must be included in DEERS for TRICARE coverage to be shown accurately.

Key Concepts

- When you have a life change, your TRICARE options may change.
- Keep your DEERS record up to date to ensure coverage for you and your family.

Key Terms

- **Survivors:** Eligible family members of service members who have died, including spouses, former spouses, children (stepchildren, adopted children, adult aged children).
- **Terminal leave:** Also known as transitional leave; type of leave service members accrue before transitioning out of the military.
- **Permissive temporary duty (PTDY):** Permission for military members involuntarily separating under honorable conditions or retiring from active duty to transition into civilian life.

Moving

With TRICARE Prime, you can easily transfer your enrollment when moving.

	ACTIVE DUTY	NON-ACTIVE DUTY
How many times can you transfer my enrollment each year?	As often as needed.	Two times each enrollment year.
Moving within your current region?	Your regional contractor will help you transfer to a new primary care manager (PCM).	If the new area is a TRICARE Prime Service Area (PSA), change your PCM when you get to your new location.[1]
Moving to a new region?	Call your new regional contractor to make sure your transfer was processed. Your new regional contractor will work with you to assign a PCM.	If the new area is a PSA, transfer your TRICARE Prime enrollment if you want to keep TRICARE Prime. Don't disenroll from TRICARE Prime before you move to your new location.[1]
Moving overseas?	Before you move, call the appropriate TRICARE Overseas Program (TOP) Regional Call Center (choose option 4) for the area where you are moving. Active duty family members must be command-sponsored for TOP Prime or TOP Prime Remote coverage.	Retirees and their family members aren't eligible for TOP Prime options, but may be eligible for TOP Standard.
How do you transfer my TRICARE Prime enrollment?	**Online:** Use the Beneficiary Web Enrollment website (U.S. only) at www.dmdc.osd.mil/appj/bwe. **Phone:** Call your new regional contractor.[2] **Mail:** Complete a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) and mail it to your new regional contractor using the address listed on the form. Overseas, you may also drop it off at a TRICARE Service Center. To download *DD Form 2876*, go to www.tricare.mil/forms.	

1. *If you are moving to an area where TRICARE Prime isn't available you should disenroll from TRICARE Prime. You will automatically be covered by TRICARE Standard and TRICARE Extra as long as your DEERS information is current. If you don't disenroll, you will be using the point-of-service option, resulting in higher out-of-pocket costs.*
2. *Your new regional contractor will tell you if the US Family Health Plan (USFHP) is available in your new area. USFHP is a TRICARE Prime option. Care is provided through networks of community-based, not-for-profit health care systems in six areas of the U.S. For more information, go to www.usfhp.org.*

Moving with TRICARE Standard and TRICARE Extra

Whether you are moving to another area in the same TRICARE region or to a different TRICARE region, moving with TRICARE Standard and TRICARE Extra is easy. Just update your personal information in DEERS and find a new TRICARE-authorized network or non-network provider. If you move to a new region, be sure to learn who your new regional contractor is and where to file your *Medical Claims*.

Changes in Marital Status

Getting Married

If you get married, register your new spouse in the Defense Enrollment Eligibility Reporting System (DEERS) to ensure he or she shows as TRICARE-eligible. Your spouse's TRICARE options will vary depending on your beneficiary status and where you live.

Getting Divorced

Sponsors must update DEERS when there is a divorce. The sponsor will need to provide a copy of the divorce decree, dissolution or annulment. Former spouses who aren't eligible for TRICARE may not continue to get health care services under TRICARE.

Eligible Former Spouses

To keep TRICARE, former spouses:

- Must not be remarried (if you remarry, benefits can't be regained even if the remarriage ends in death or divorce, unless the new spouse is a sponsor)
- Must not be covered by an employer-sponsored health plan
- Must not be the former spouse of a North Atlantic Treaty Organization or Partners for Peace nation member
- Must meet the requirements listed in either Situation 1 or Situation 2 as follows:
  - **Situation 1:** The former spouse must have been married to the same service member or former member for at least 20 years and at least 20 of those years must have been counted toward the sponsor's eligibility for retirement pay. If this is the case, the former spouse is eligible for TRICARE coverage after the date of the divorce, dissolution or annulment, as long as they don't remarry.
  - **Situation 2:** The former spouse must have been married to the same service member or former member for at least 20 years and at least 15–20 of those married years must have been counted toward the sponsor's eligibility for retirement pay. If this is the case, the former spouse is eligible for TRICARE coverage for only one year from the date of the divorce, dissolution or annulment.

If you are a former spouse who has not remarried, DEERS shows your TRICARE eligibility using your own Social Security number (SSN) or Department of Defense Benefits Number (DBN), not your former sponsor's. Health care information is filed under your name and SSN or DBN and you will use this information to schedule medical appointments and file TRICARE claims.

Note: Former spouses who remarry after age 55 and who were enrolled in the Continued Health Care Benefit Program (CHCBP) for the 18 months before the end of the marriage may still be eligible to continue coverage under CHCBP.

Having a Baby

Getting Maternity Care

Your guidelines for getting care vary based on your TRICARE program option and beneficiary category. You may need a referral and/or prior authorization for some maternity care.

BENEFICIARY TYPE	GUIDELINES
TRICARE Prime	If your primary care manager (PCM) is at a military hospital or clinic, you should get maternity care at the military hospital or clinic. If maternity care is unavailable at your military hospital or clinic, your PCM will refer you to a civilian network provider. If you have a civilian PCM, your PCM will direct your maternity care or give you a referral to an obstetrician.
TRICARE Prime Remote (TPR)	If you have TPR with an assigned PCM, your PCM will direct your care. Otherwise, you may visit a TRICARE-authorized civilian provider with prior authorization from your regional contractor.
TRICARE Standard and TRICARE Extra, TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR) and Continued Health Care Benefit Program (CHCBP)	You may get care from any TRICARE-authorized provider without a referral. Visits to a network provider will cost you less out of pocket and the provider will file claims for you. With a non-network provider, you may pay more out of pocket and have to file your own claims. Non-network providers may charge up to 15 percent above the TRICARE-allowable charge, and you are responsible for that amount in addition to any deductible or cost-shares.
TRICARE Young Adult (TYA)	Young adults who have purchased coverage under TYA follow the rules (including costs and provider choices) of the plan they have—either TYA Prime or TYA Standard.
TRICARE Dental Program	During pregnancy, a third cleaning is covered in a 12-month period.

"Pregnancy and birth coverage is top-notch with TRICARE! We saw several specialists and had very minimal out of pocket costs."

– R.B., TRICARE beneficiary

Maternity Care Costs

ACTIVE DUTY SERVICE MEMBERS AND ACTIVE DUTY FAMILY MEMBERS	ALL OTHER TRICARE BENEFICIARIES
• You pay nothing for maternity care under: ▪ TRICARE Prime ▪ TPR	• You pay copayments and/or cost-shares and a yearly deductible. This includes retired beneficiaries and their families and non-active duty beneficiaries enrolled in: ▪ TRICARE Standard and TRICARE Extra ▪ TRS ▪ TRR ▪ TYA ▪ CHCBP

Note: Except for ADSMs, beneficiaries with a TRICARE Prime option may use the point-of-service (POS) option to self-refer to an obstetrician, but will pay higher out-of-pocket costs. Go to www.tricare.mil/pointofservice for more information about the POS option. For detailed cost information, go to www.tricare.mil/costs.

Losing TRICARE Eligibility during Your Pregnancy

You may lose TRICARE eligibility, including maternity coverage, for various reasons related to life events and sponsor status changes. Depending on the reason for losing eligibility, you may qualify for continued coverage under one of the following programs:

- Transitional Assistance Management Program
- TYA
- CHCBP

TYA and CHCBP require premium payments.

If you are an ADSM who is pregnant at the time of release from active duty, you may also work with your service (unit personnel and military hospital or clinic administrative channels) to determine if you are eligible for ongoing care at a military hospital or clinic. For more information, go to www.tricare.mil/maternitycare.

Getting TRICARE Coverage for Your Child

If you have a baby or adopt a child, register your child in the Defense Enrollment Eligibility Reporting System (DEERS) to ensure he or she has TRICARE.

- For TRICARE Prime options, register your child within 60 days.
- For TRICARE Standard and TRICARE Extra, register your child within 365 days.
- For all other options, there is no grace period and your child must be registered in DEERS for you to buy coverage for him or her.

A birth certificate, certificate of live birth from the hospital, record of adoption or letter of placement of your child into your home by a recognized placement or adoption agency or the court is required. While you don't need a Social Security number to register a newborn in DEERS, you will need to update the DEERS record as soon as you have it. Go to www.dmdc.osd.mil/rsl to find a uniformed services ID card office in your area.

TRICARE Prime Options

Children of active duty service members (ADSMs) are automatically covered as TRICARE Prime or TRICARE Prime Remote beneficiaries for 60 days after birth or adoption. For retirees, children are covered under TRICARE Prime for 60 days after birth or adoption as long as one other family member is enrolled in TRICARE Prime.

Before day 61, enroll your child in a TRICARE Prime option by:

- Using the Beneficiary Web Enrollment website at www.dmdc.osd.mil/appj/bwe
- Calling your TRICARE regional contractor
- Completing and mailing a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) to your regional contractor

If your child isn't enrolled in a TRICARE Prime option by day 61, he or she will be covered under TRICARE Standard and TRICARE Extra.

If your child is not registered in DEERS within one year after the date of birth or adoption, your child will lose all TRICARE coverage until registered in DEERS.

Note: You must complete DEERS registration before enrollment in a TRICARE Prime option.

TRICARE Standard and TRICARE Extra

Children are automatically covered by TRICARE Standard and TRICARE Extra at the time of birth or adoption. Coverage is continuous as long as you register your child in DEERS within 365 days of birth or adoption.

TRICARE Reserve Select and TRICARE Retired Reserve

Your child is covered by TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) if you first register your child in DEERS and then qualify for and purchase TRS or TRR. To purchase TRS or TRR, submit a *Reserve Component Health Coverage Request* form (DD Form 2896-1) to your regional contractor, postmarked within 60 days of birth or adoption. To access *DD Form 2896-1*, log in to the Defense Manpower Data Center Reserve Component Purchased TRICARE Application at www.dmdc.osd.mil/appj/reservetricare.

TRICARE Young Adult

If you are an expectant mother who has purchased TRICARE Young Adult (TYA), your maternity care is covered for the duration of your pregnancy as long as you remain in TYA. However, newborn care is not covered unless your newborn's other parent is a sponsor or the newborn is adopted by an eligible sponsor.

Adult Children

Children of TRICARE-eligible sponsors remain TRICARE-eligible up to age 21 (or age 23 if certain criteria are met) as long as their DEERS information is current. Your child's program options depend on where he or she lives.

To extend coverage after your child's 21st birthday, you need a letter from the school's registrar or documentation from the National Student Clearinghouse that certifies his or her full-time study and expected graduation date. Once you have this information, you can update your DEERS record at a uniformed services ID card office (your child doesn't need to be present).

If your child isn't yet in DEERS, you need to register him or her in DEERS first. Go to www.dmdc.osd.mil/rsl to find the closest uniformed services ID card office and to learn what documents are required for adding a family member to DEERS. Only ADSMs can add a family member to DEERS.

Your dependent child's TRICARE coverage ends if his or her DEERS record isn't updated before he or she turns age 21. Children with disabilities may remain TRICARE-eligible beyond the normal age limits. Check with your sponsor's service for eligibility criteria.

Dependent children who have aged out of TRICARE coverage, but have not yet turned age 26, may qualify to buy TYA. See *TRICARE Young Adult*, for more information.

After aging out of TYA upon turning age 26, dependent children may qualify to purchase Continued Health Care Benefit Program coverage. For more information see *Continued Health Care Benefit Program Coverage*.

Note: Children with disabilities may remain TRICARE eligible beyond the normal age limits. Check with your sponsor's service for eligibility criteria.

Changes in Duty Status

Separating from the Service

If you're separating from active duty or the uniformed services, depending on your situation, you have many TRICARE and civilian health care options depending on your situation:

- *Transitional Assistance Management Program* (TAMP)
- *Continued Health Care Benefit Program* (CHCBP)
- Health care plans for National Guard and Reserve members
- Health care plans for purchase on the Health Insurance Marketplace at www.healthcare.gov

Contact your TRICARE regional contractor or a Beneficiary Counseling and Assistance Coordinator (BCAC) for more information on available Department of Defense plans. To find a BCAC, go to www.tricare.mil/bcacdcao. Or, to learn about commercial plans through the Health Insurance Marketplace, go to www.healthcare.gov.

Terminal Leave

During terminal leave, authorized excess leave or permissive temporary duty (PTDY), you are still considered an active duty service member and must get or coordinate your care with your last duty station. During this time, you can't change your primary care manager (PCM), even if you move. Your family can switch PCMs if you move, but your TRICARE Prime option may not be available in your new location.

If you and your family stay in the same place during leave or PTDY, you and your family can keep using your TRICARE Prime option. If you were stationed overseas and you move back to the U.S., coordinate referrals and prior authorizations with International SOS Government Services, Inc., the TRICARE Overseas Program contractor.

Transitional Assistance Management Program

TAMP offers 180 days of health care benefits to help service members and their families transition to civilian life. The services determine TAMP eligibility and the Defense Enrollment Eligibility Reporting System (DEERS) shows your status. If you have questions, call your personnel office and/or command unit representative. For more information, see *Transitional Assistance Management Program*.

Transitional Care for Service-Related Conditions

If you have TAMP and are newly diagnosed with a medical condition related to your active duty service, you may qualify for the Transitional Care for Service-Related Conditions program. The program gives you up to 180 days of care for your condition with no out-of-pocket costs. If you believe you qualify, go to www.tricare.mil/tcsrc for instructions on how to apply.

Continued Health Care Benefit Program

If you aren't TAMP-eligible or if TAMP has ended and you're not continuing service or you're retiring from the National Guard or Reserve, you may qualify to buy temporary health care coverage under CHCBP for you and your family. This program, administered by Humana Military, offers an extra 18–36 months of coverage. CHCBP is not a TRICARE benefit, but it is considered minimum essential coverage under the Affordable Care Act. For more information, go to www.tricare.mil/chcbp or call Humana Military at **1-800-444-5445**.

TRICARE Reserve Select and TRICARE Retired Reserve

If you transition to or retire from the National Guard or Reserve, you may qualify to buy health care coverage under TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) after your TAMP period ends. These programs include:

- Health care coverage
- Pharmacy coverage
- Monthly premiums
- Cost-shares and deductibles like TRICARE Standard and TRICARE Extra

For more information, go to www.tricare.mil/trs or www.tricare.mil/trr.

If the sponsor purchases TRS or TRR coverage, former dependent children up to age 21 (or age 23 if certain criteria are met) may qualify to purchase TRICARE Young Adult (TYA) coverage. For more information, go to www.tricare.mil/tya.

Civilian Health Care Coverage Options

While you may qualify to buy premium-based TRICARE programs, as well as CHCBP coverage, these aren't your only health care options. You should evaluate all of your options before deciding which coverage is best for you and your family. Many Americans get coverage through their employer or their spouse's employer. If you don't, you may be able to get financial help to buy a commercial plan through the Health Insurance Marketplace, or qualify for Medicaid depending on your situation and the state you live in. To find other health care coverage options, go to www.healthcare.gov.

Retiring

Retiring from Active Duty

When you retire from active service, you and your eligible family members experience a "change in status," and, after you update your DEERS record, you will need to get a new uniformed services ID card that reflects your status as a retiree.

Once you've transitioned to retiree status, you may automatically use TRICARE Standard and TRICARE Extra, or enroll in TRICARE Prime.

TRICARE Standard and TRICARE Extra Changes upon Sponsor Retirement from Active Duty

Outpatient cost-shares and copayments	• Increases to retired service member rates (5% increase)
Catastrophic cap	• Increases to retired service member rate
Health care services	• Eye exams no longer covered except for family up to age 6. • Hearing aids no longer covered
Entitlement to premium-free Medicare Part A	• Must also have Medicare Part B to remain eligible for TRICARE coverage with TRICARE Prime (not yet age 65) or TRICARE For Life (any age).

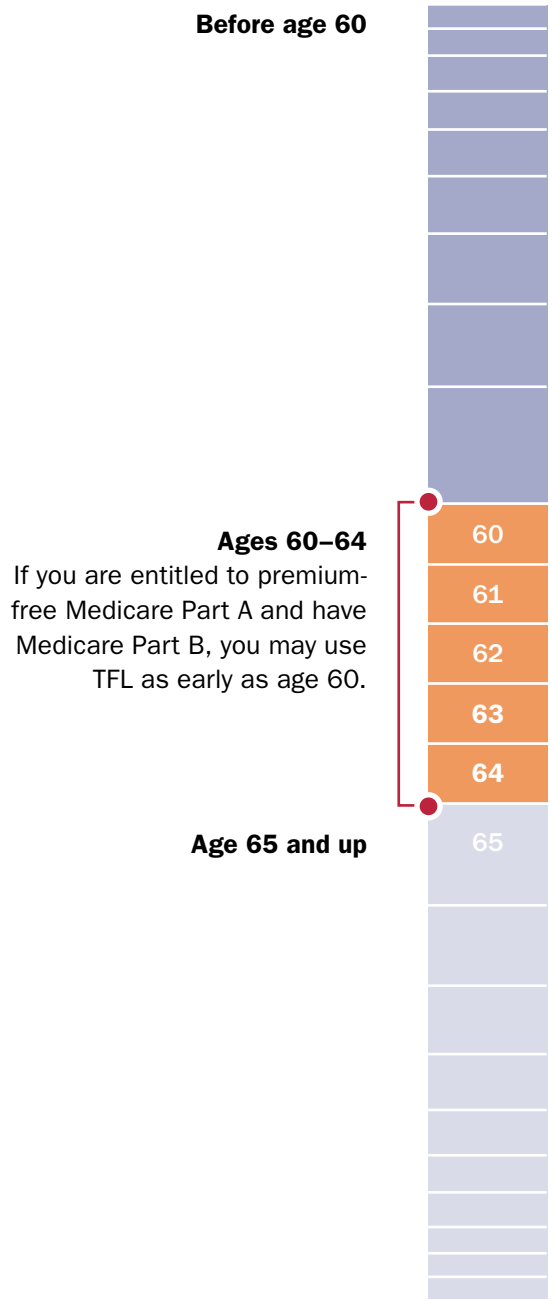
If you enroll in TRICARE Prime after you retire, the following changes apply:

- You will pay a yearly enrollment fee (network copayments apply).
- You will be responsible for copayments for certain medical services.
- There will be an increase in your catastrophic cap (the maximum out-of-pocket amount a beneficiary pays each fiscal year [Oct. 1–Sept. 30] for TRICARE-covered services).
- There will be minor differences in covered services (for example, eye exams are only covered every two years and hearing aids are no longer covered).
- There will be a change in dental coverage. For more information, see *Dental Care Programs*.

You and your family members should look at your health care options together and determine which option best meets your needs after you retire. If you decide to reenroll in TRICARE Prime or enroll your adult child in TYA Prime, you may enroll 30 days before or 30 days after your retirement date; otherwise, the 20th-of-the-month rule may apply.

Note: TRICARE Prime Remote (TPR) isn't available to retirees and their families. If you are in TPR and remain at your same address, you may be able to enroll in TRICARE Prime if you waive your access standards. Call your regional contractor for details.

Go to www.tricare.mil/costs for additional information regarding program costs.



Retiring from the National Guard or Reserve

National Guard and Reserve members who have served 20 years or more, but who aren't yet able to collect retirement pay, may qualify to buy TRR. The period between retiring from National Guard or Reserve and collecting retirement pay is often referred to as the gray area. Qualification as a Retired Reserve member begins the day after retirement, as long as you are:

- Qualified for non-regular retirement
- Under age 60
- Not enrolled (or eligible to enroll in) the Federal Employees Health Benefits Program.

Retired Reserve members ages 60–64 and their family members are eligible for premium-free TRICARE Standard and TRICARE Extra, or may enroll in TRICARE Prime (if in a Prime Service Area), which requires a yearly TRICARE Prime enrollment fee. Beneficiaries who are entitled to premium-free Medicare Part A and also have Medicare Part B become eligible for TRICARE For Life (TFL). In general, if you become entitled to Medicare Part A, you must also have Medicare Part B to remain eligible for TRICARE.

Note: If you become eligible for retirement pay before age 60, you still aren't eligible for premium-free TRICARE program options (for example, TRICARE Prime or TRICARE Standard) until you turn age 60.

At age 65, or if you become Medicare-entitled before age 65, you will transition to TFL.

Becoming Entitled to Medicare

Active Duty Status

Active duty service members (ADSMs) and active duty family members (ADFMs) who are entitled to premium-free Medicare Part A, regardless of the reason, remain eligible for TRICARE Prime or TRICARE Standard and TRICARE Extra program options without signing up for Medicare Part B. However, when the sponsor retires, you must have Medicare Part B to remain TRICARE-eligible. You may sign up for Medicare Part B during the special enrollment period, which is available anytime while the sponsor is still on active duty and you are covered by TRICARE, or within the first eight months following either (1) the month your sponsor's active duty status ends or (2) the month TRICARE coverage ends, whichever comes first.

To avoid a break in TRICARE coverage, ADSMs and ADFMs who are entitled to premium-free Medicare Part A must sign up for Medicare Part B before the sponsor's active duty status ends. If you miss the special enrollment period, you may sign up for Part B during the general enrollment period, which is Jan. 1–March 31. Medicare Part B and TRICARE are effective July 1 of the year you sign up. If you enroll during the general enrollment period, you may have to pay a late-enrollment premium surcharge (10 percent for each 12-month period that you were eligible to enroll in Medicare Part B but did not).

Note: ADSMs and ADFMs with end-stage renal disease don't have a special enrollment period and should enroll in Medicare Part A and Part B when first eligible.

Retired Status

Retirees and their dependents who are entitled to premium-free Medicare Part A must also have Medicare Part B to remain TRICARE-eligible, regardless of their age or place of residence. TFL coverage automatically begins the first month both Medicare Part A and Part B are effective. TRICARE eligibility is terminated for any period of time in which a retiree or retiree family member is entitled to Medicare Part A and doesn't have Medicare Part B. To avoid a break in TRICARE coverage, ADSMs and ADFMs must sign up for Medicare Part B before the sponsor's active duty status ends.

For more details about who is eligible and how to sign up for TFL, see *TRICARE For Life*.

Note: Retirees and their family members aren't eligible for TPR.

Survivor Coverage

TRICARE continues to provide benefits to eligible family members following the death of their sponsor. The type of coverage and costs depend on your sponsor's military status at the time of his or her death.

Upon the death of a sponsor, you will receive a letter from the Defense Manpower Data Center describing your program options and how your benefits will eventually change. Call your regional contractor if you have any questions.

Survivors of Active Duty Service Members

Surviving spouse: You remain eligible as a transitional survivor for three years following your sponsor's death and will have active duty family member (ADFM) benefits and costs, including TRICARE Prime and TRICARE Prime Remote (TPR) eligibility. After three years, you remain eligible as a survivor, and are eligible for benefits as a retiree family member. You pay retiree rates* under TRICARE Prime (if available) or TRICARE Standard and TRICARE Extra. As a survivor, you aren't eligible for TPR, but you may enroll in TRICARE Prime if it is available where you live and you meet enrollment criteria. If you don't enroll in TRICARE Prime, coverage automatically continues under TRICARE Standard and TRICARE Extra.

* *You will need to reenroll at that time and pay retiree enrollment fees.*

Surviving children: Surviving children whose sponsor died on or after October 7, 2001, remain eligible for TRICARE benefits as ADFMs. Unlike spouses, eligibility for children won't change after three years, and children remain covered as ADFMs until eligibility ends at age 21 (or age 23 if certain criteria are met) or for another reason, such as marriage.

Transitional survivors enrolled in TRICARE Prime at the time of their sponsor's death won't be disenrolled. Coverage continues as long as DEERS information is up to date or until eligibility ends.

If you aren't enrolled in TRICARE Prime or TPR and are eligible, you may enroll at any time after your sponsor's death. Normal enrollment rules apply; there is no retroactive enrollment. Transitional survivors not enrolled in TRICARE Prime or TPR will be covered as ADFMs under TRICARE Standard and TRICARE Extra.

Note: Surviving beneficiaries in the U.S. will have their TRICARE Prime enrollment fees frozen at the rate in effect at the time they become survivors and are enrolled in a TRICARE Prime option. Beneficiaries in this category won't be charged a fee increase as long as at least one family member remains enrolled.

Survivors of National Guard and Reserve Members

Non-Activated Sponsor

If you are a survivor of a non-activated National Guard or Reserve member who had TRICARE Reserve Select (TRS) or Transitional Assistance Management Program (TAMP) coverage at the time of his or her death, you may qualify for TRICARE survivor coverage. Former spouses and remarried surviving spouses don't qualify to purchase coverage.

If TRS coverage was in effect, qualified survivors may purchase or continue coverage under TRS for up to six months from the date of their sponsor's death. Children remain eligible for up to six months or until turning age 21, whichever happens first. In some cases, a child may remain eligible for six months or until turning age 23 if certain criteria are met. Surviving family members who are eligible for or enrolled in the Federal Employees Health Benefits (FEHB) Program may purchase TRS coverage.

If TAMP coverage was in effect, eligible survivors remain covered until the end of the 180-day TAMP period.

Sponsor Active 30 Days or Less

If a National Guard or Reserve member dies while serving on active duty for a period of 30 days or less, family members remain eligible as survivors. Survivors have the same benefits, program options, and costs as retiree family members and are eligible for the TDP Survivor Benefit.

Spouses have the TDP Survivor Benefit for three years beginning on the date of the sponsor's death. Children remain eligible until they age out, marry, or otherwise lose their TRICARE eligibility.

Note: Surviving spouses remain eligible for survivor benefits unless they remarry. Surviving children remain eligible up to age 21 (or age 23 if certain criteria are met), but not yet age 26.

Sponsor Active More Than 30 Days

If your sponsor dies while serving on active duty for more than 30 days, family members remain eligible as transitional survivors and have ADFM benefits and costs. After three years, surviving spouses remain eligible as survivors and have retiree family member benefits and costs. Surviving children don't have a status change after three years; they remain eligible for ADFM benefits and costs until they lose TRICARE eligibility due to age limits or for another reason, such as marriage.

TRICARE Reserve Select Coverage Guidelines

Survivors in TRS at the time of their sponsor's death automatically transition to TRS survivor coverage. Coverage continues as long as your information in DEERS is up to date or until your qualification ends (six months from the sponsor's death or earlier if a spouse remarries). If you aren't in TRS at the time of your sponsor's death, you can purchase TRS survivor coverage after your sponsor's death if he or she had member-only or member-and-family coverage at the time of his or her death.

Survivors wishing to enroll in TRS survivor coverage must submit a completed *Reserve Component Health Coverage Request* form (DD Form 2896-1) to their regional contractor. To access *DD Form 2896-1*, log in to the Defense Manpower Data Center Reserve Component Purchased TRICARE Application at www.dmdc.osd.mil/appj/trs. This form must be postmarked or received by the regional contractor no later than 60 days after the date of the sponsor's death.

Survivors wishing to disenroll from TRS survivor coverage must submit a written letter or completed *DD Form 2896-1* to their regional contractor. This form must be postmarked or received by the regional contractor no later than 60 days after the date of the sponsor's death. Premiums will be refunded if no claims were submitted during this 60-day period. For more information, go to www.tricare.mil/trs.

Surviving children may continue their existing benefit up to the six-month expiration or age 21 (or age 23 if certain criteria are met), but not yet age 26. Surviving children who age out of TRICARE may qualify to purchase TRICARE Young Adult (TYA) coverage for up to six months after the date of the sponsor's death or until the child turns age 26; whichever comes first. For more information, go to www.tricare.mil/tya.

Survivors of Retired Reserve Members

If you are a survivor of a Retired Reserve member who had TRICARE Retired Reserve (TRR) coverage at the time of his or her death, you may qualify for TRICARE survivor coverage. To qualify, your sponsor must have had member-only or member-and-family coverage at time of his or her death. Surviving spouses and children remain qualified for TRR survivor coverage until the day the sponsor would have turned age 60, at which point they may become eligible for premium-free TRICARE Standard and TRICARE Extra, or may enroll in TRICARE Prime (if available). Surviving family members who are eligible for or enrolled in the FEHB Program may purchase TRR. For more information, go to www.tricare.mil/trr.

TRICARE Retired Reserve Coverage Guidelines

Survivors in TRR at the time of their sponsor's death automatically transition to TRR survivor coverage. Coverage continues as long as DEERS information is up to date or until eligibility ends (at the time your sponsor would have turned age 60 or earlier if a spouse remarries). If you aren't in TRR at the time of your sponsor's death and you qualify, you may purchase TRR survivor coverage after your sponsor's death. To qualify, your sponsor must have had member-only or member-and-family coverage at time of his or her death.

Coverage may be purchased at any time after the sponsor's death, provided the sponsor would not have turned age 60 at the time of purchase. Survivors who want to enroll in TRR survivor coverage must submit a *DD Form 2896-1* to their regional contractor. To access the *DD Form 2896-1*, log in to the Defense Manpower Data Center Reserve Component Purchased TRICARE Application at www.dmdc.osd.mil/appj/reservetricare. This form must be postmarked or received by the regional contractor no later than 60 days after the date of the sponsor's death. Survivors wishing to disenroll from TRR survivor coverage must submit a written letter or *DD Form 2896-1* to their regional contractor and it must be postmarked or received no later than 60 days after the date of the sponsor's death. Premiums will be refunded if no claims were submitted during this 60-day period.

Surviving children are eligible for TRR up to age 21, or age 23 if certain criteria are met. If the sponsor was enrolled in TRR at the time of death, surviving children who age out of TRICARE may qualify to purchase TYA coverage up to age 26. Go to www.tricare.mil/tya, for more information.

Survivors Who Are Entitled to Medicare

Surviving family members who are already entitled to premium-free Medicare Part A at the time of the sponsor's death should sign up for Medicare Part B within eight months of the date of the sponsor's death to avoid the Medicare Part B late-enrollment monthly premium surcharge (10 percent for each 12-month period you could have had Medicare Part B, but did not). To sign up for Medicare Part B during this special enrollment period (if it applies to you) and waive the Medicare Part B late-enrollment premium surcharge, you will need proof of your eligibility for the special enrollment period. You can call the Defense Manpower Data Center and ask for a Verification of Military Health Care Benefits letter, which you should present to the Social Security Administration to prove your eligibility for the special enrollment period. To call DMDC dial **1-800-538-9552** (**TDD/TTY: 1-866-363-2883**).

Surviving family members who become entitled to premium-free Medicare Part A after the date of the sponsor's death should sign up for Medicare Part B immediately upon becoming entitled to Medicare Part A to avoid the Part B late-enrollment premium surcharge.

If you don't sign up for Medicare Part B when you first become eligible, you may sign up during the general enrollment period (GEP), which occurs each year, January 1–March 31. If you sign up during the GEP, your Medicare Part B will begin July 1 of the year in which you sign up. The Medicare Part B late-enrollment premium surcharge will apply for each 12-month period you could have had Part B, but did not.

It is important to note that in general, TRICARE beneficiaries who are entitled to premium-free Medicare Part A must have Medicare Part B to remain TRICARE-eligible. If you are a surviving family member who is entitled to premium-free Medicare Part A and you don't have Medicare Part B, you will be ineligible for TRICARE after your three-year transitional survivor period ends. Surviving family members of Retired Reserve members become eligible for premium-free TRICARE Standard and TRICARE Extra or may enroll in TRICARE Prime (if available) beginning on the date their sponsor would have turned age 60. To be eligible for TRICARE at that point, beneficiaries entitled to Medicare Part A must also have Medicare Part B.

TRICARE Young Adult Coverage for Survivors

SPONSOR DIES WHILE:	YOU CAN:
On active duty	You may qualify to purchase TYA coverage up to the age of 26, with survivor (retiree) cost-shares.
In the Selected Reserve and enrolled in TRS	You may qualify to purchase TYA coverage for up to six months or age 26, whichever comes first. You will pay survivor (retiree) cost-shares.
In the Retired Reserve and not yet age 60	You may qualify to purchase new or continue existing TYA coverage up to age 26.
In the Retired Reserve and not enrolled in TRR	You aren't eligible to purchase TYA coverage until your sponsor would have turned age 60, at which time, you may qualify to purchase TYA coverage up to you reach age 26. You will pay survivor (retiree) cost-shares.
Covered under TAMP	You may qualify to purchase TYA coverage to the end of the TAMP coverage period or up to age 26, whichever comes first. You will pay ADFM premiums.

Survivor Pharmacy Coverage

As a survivor, your pharmacy benefit remains the same regardless of your TRICARE program option. In the U.S., you may fill prescriptions through military pharmacies, TRICARE Pharmacy Home Delivery, TRICARE retail network pharmacies or non-network pharmacies. Using a non-network pharmacy is your most costly option. Express Scripts, Inc. administers the TRICARE pharmacy benefit in the U.S. and U.S. territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands. For more information, go to www.tricare.mil/pharmacy or www.express-scripts.com/TRICARE.

Survivor Dental Options

TRICARE Dental Program Survivor Benefit

When a sponsor dies while on active duty, surviving family members are eligible for the TRICARE Dental Program (TDP) Survivor Benefit whether or not the family members were enrolled in the TDP before the sponsor's death. Eligible surviving family members don't pay TDP premiums; these costs are covered 100 percent (family members are still responsible for any applicable cost-shares). The TDP Survivor Benefit also applies to family members of the Selected Reserve and the Individual Ready Reserve (special mobilization category), regardless of whether the sponsor was on active duty orders or enrolled in the TDP at the time of his or her death. Former spouses and remarried surviving spouses aren't eligible for TDP benefits.

The surviving spouse is eligible to receive survivor benefits for up to three years from the sponsor's date of death, regardless of the TDP Survivor Benefit enrollment coverage start date.

Surviving children are eligible for the TDP Survivor Benefit up to age 21, or age 23 if certain criteria are met.

Eligible surviving family members enrolled in the TDP at the time of their sponsor's death will be automatically enrolled in the TDP Survivor Benefit. Survivors will be notified of this enrollment change and the terms of the TDP Survivor Benefit. Eligible surviving family members not enrolled in the TDP at the time of the sponsor's death will be notified of their TDP eligibility. If eligible, surviving spouses, parents or legal guardians may elect to enroll in the TDP Survivor Benefit. If eligible, surviving spouses, parents or legal guardians must take action to enroll the eligible surviving family member in the TDP Survivor Benefit.

For more information, go to www.tricare.mil/tdp.

TRICARE Retiree Dental Program

Surviving spouses whose sponsor died while on active duty (including National Guard and Reserve sponsors who were on active duty for more than 30 days) may be eligible for the TRICARE Retiree Dental Program once their TDP Survivor Benefit ends. For more information, go to www.trdp.org.

Disenrollment from TRICARE Prime

Enrollment in TRICARE Prime is continuous—you don't have to reenroll every year to maintain coverage. However, certain events will cause you to be disenrolled.

Voluntary Disenrollment from TRICARE Prime

Active duty family members (ADFMs) who choose to change their enrollment status (for example, from enrolled to disenrolled or vice versa) more than twice in an enrollment year (Oct. 1–Sept. 30) for any reason are subject to a 12-month lockout (doesn't apply to ADFMs with sponsors in pay grades E-1 through E-4), during which they won't be permitted to reenroll in TRICARE Prime or TRICARE Prime Remote (TPR). Retirees and their family members who choose to disenroll from TRICARE Prime before their yearly enrollment renewal date are subject to a 12-month lockout. You must contact your regional contractor to initiate a voluntary disenrollment. If you are disenrolled from TRICARE Prime, you may be covered under TRICARE Standard and TRICARE Extra if all eligibility requirements are met.

Voluntary disenrollment is not an option for active duty service members; active duty personnel must enroll in either TRICARE Prime or TPR.

Involuntary Disenrollment from TRICARE Prime

You may be disenrolled from TRICARE because of change in sponsor status, nonpayment, age or other ineligibility reason.

Sponsor Status Change

A change in your sponsor's status (for example, retirement or National Guard and Reserve member deactivation) will cause you to be disenrolled automatically from TRICARE Prime. To avoid a lapse in coverage, you must submit a new enrollment request to your regional contractor before the date of the status change for you and your family members to remain enrolled in TRICARE Prime if you are still eligible after the status change. In some cases, such as during the Transitional Assistance Management Program period, you may not be able to reenroll in TPR. For example, if you were enrolled in TPR and you retire from active duty, the TPR option is no longer available. To continue TRICARE Prime coverage, you will need to move to an area where TRICARE Prime is offered and enroll or waive access standards. Otherwise, coverage will continue under TRICARE Standard and TRICARE Extra.

Nonpayment of TRICARE Prime Fees

If you are required to pay premiums or enrollment fees and you don't pay them when due, you will be disenrolled from TRICARE Prime. When disenrolled for nonpayment, you are subject to a 12-month lockout, during which you won't be permitted to reenroll in TRICARE Prime.

To avoid missing a payment, learn about automated payment options at www.tricare.mil or contact your regional contractor. If you are disenrolled from TRICARE Prime, you may be covered under TRICARE Standard and TRICARE Extra if all eligibility requirements are met.

Loss of Eligibility

If your Defense Enrollment Eligibility Reporting System (DEERS) record indicates loss of TRICARE eligibility, your TRICARE Prime or TRICARE Standard and TRICARE Extra coverage will automatically end. You will receive electronic or written notification of this loss of eligibility.

Loss of TRICARE eligibility in DEERS also terminates any premium-based TRICARE coverage (TRICARE Reserve Select, TRICARE Retired Reserve or TRICARE Young Adult) you may have purchased.

If you believe you are still eligible for TRICARE, you will need to update your DEERS record to reestablish your eligibility. Call the Defense Manpower Data Center at **1-800-538-9552**.

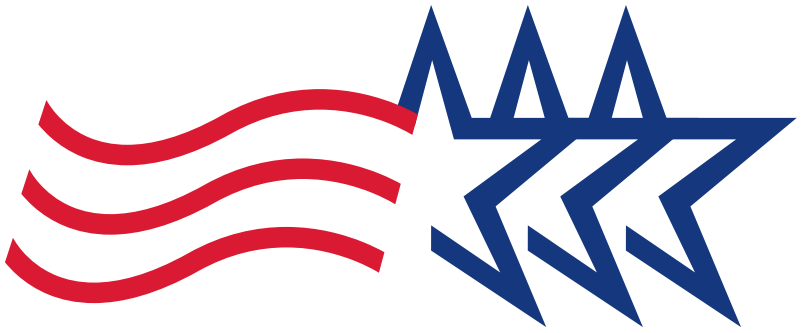
Once DEERS is updated, you must reenroll in TRICARE Prime or, if you are a family member, you will be covered under TRICARE Standard and TRICARE Extra.

Those who previously purchased TRICARE premium-based coverage should contact their regional or overseas contractor for help in re-establishing their coverage.

If your DEERS record is correct and you have lost eligibility, you may qualify for transitional health care. See *Separating from the Service* for details about transitional health care options.

Health Care You Can Count On

Need help after consulting this guide?
If you have questions or concerns, contact your *regional contractor*.



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