Welcome To
The TRICARE® Fundamentals Course
April–June 2014

This course takes three days to complete. On the last day of the course, instructors administer a 50-question final exam. **You must score at least 80% to pass and complete an online course evaluation to receive a training certificate.** We send certificates via e-mail within seven business days of receiving your evaluation.

This TFC Participant Guide is your training tool and a valuable point of reference once the course is over. It's important to remember that the Participant Guide is updated quarterly with new information. To download the most recent version, visit www.tricare.mil/tricareu/participant-guide.aspx.

Once you return to work, visit www.tricare.mil for information on the TRICARE benefit. To get TRICARE updates, visit https://mhs.health.mil/customerservicecommunity/default.aspx. You can also sign up to receive our TRICARE benefit updates via e-mail by visiting www.tricare.mil/bcacdcao_user.

At the time of printing, the information in this Participant Guide is current, but must be read in light of governing statutes and regulations and is not a substitute for legal advice from qualified counsel, as appropriate. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact the managed care support contractor for your region or a local TRICARE Service Center.

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Table of Contents

Module 1: Key TRICARE Concepts and Terms 1
1.0 The Military Health System (MHS) and TRICARE 3
2.0 TRICARE Eligibility 5
3.0 TRICARE and Veterans Affairs Benefits 6
4.0 TRICARE Providers 7
5.0 Terms Associated with TRICARE 9
Appendix A: Special Eligibility and DEERS Registration Categories 11

Module 2: TRICARE Options 15
1.0 TRICARE Standard and Extra and TRICARE Overseas Program (TOP) Standard 18
2.0 TRICARE Prime/TRICARE Overseas Program (TOP) Prime 23
3.0 Prime Costs 26
4.0 Prime Access Standards and Types of Care 28
5.0 TRICARE Prime Portability 30
6.0 Traveling with Prime 32
7.0 TRICARE Coverage for Newborns, Pre-Adoptive, and Adopted Children 33
8.0 US Family Health Plan (USFHP) 33
9.0 TRICARE Options Overview 35
Appendix A: Receiving Care in Canada 38

Module 3: Prime Remote Options 39
1.0 TRICARE Options in Remote Locations 42
2.0 Prime Remote Eligibility 42
3.0 Enrollment 44
4.0 Moving and Traveling with Prime Remote Options 45
5.0 Primary Care Management 45
6.0 Role of Reserve and Service Member Support Office,
Great Lakes (R&SMSO-GL) (Stateside) 46
7.0 Seeking Care, Referrals, and Authorization 46
8.0 The TOP Point of Contact (POC) Program (Overseas) 48
9.0 Medical Travel for Active Duty Service Members (ADSMs) Overseas 49
10.0 TOP Prime Remote Physical Exams (Overseas) 50
11.0 Overseas Maternity Care 51
12.0 TRICARE and Non-Combatant Evacuation Operations (NEO) 51
13.0 TPR Application Exercises 52
Appendix A: Medical Matrix Homework 54
Appendix B: Active Duty Care Guidelines 56
Appendix C: TOP Prime Remote Resources 57

Module 4: Transitional Benefits 59
1.0 TRICARE Transitional Health Care Coverage 62
2.0 Transitional Assistance Management Program (TAMP) 62
3.0 Transitional Care for Service-Related Conditions (TCSRC) 65
4.0 Continued Health Care Benefit Program (CHCBP) 66
5.0 Certificate of Creditable Coverage 68
Appendix A: Sample Certificate of Creditable Coverage 71

Module 5: Pharmacy 73
1.0 Pharmacy Benefits. 76
2.0 TRICARE Uniform Formulary 76
3.0 Eligibility. 77
4.0 Military Treatment Facility (MTF) Pharmacy 78
5.0 TRICARE Pharmacy Home Delivery. 78
6.0 Network Retail Pharmacy 79
7.0 Non-Network Retail Pharmacy 80
8.0 Pharmacy Program Cost Overview. 80
9.0 TRICARE and Medicare Part D 81
10.0 Pharmacy Benefits with Other Health Insurance (OHI) 82
11.0 Pharmacy Claims. 82
Appendix A: Home Delivery and the Overseas Deployment Prescription Program. 85
Appendix B: Pharmacy Contact Information 86

Module 6: Dental. 89
1.0 Introduction 92
2.0 Active Duty Dental Care 92
3.0 TRICARE Dental Program (TDP) and TRICARE Retiree Dental Program (TRDP). 97
4.0 General Anesthesia for Dental Treatment. 101
5.0 Resources 101
Appendix A: Additional TRICARE Dental Program (TDP) Information. 104
Appendix B: Additional TRICARE Retiree Dental Program (TRDP) Information 109

Module 7: National Guard and Reserve 111
1.0 Introduction 114
2.0 Coverage While on Active Service for 30 Days or Less. 114
3.0 Coverage for Guard/Reserve Members With Early Eligibility. 116
4.0 Coverage Available While on Active Service for More Than 30 Days 116
5.0 Coverage Available After Separating from Active Service 117
6.0 Coverage Available When Retired 118
7.0 TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR). 118

Module 8: Other Benefits. 127
1.0 TRICARE Young Adult Program (TYA). 130
2.0 TRICARE Plus. 132
3.0 Extended Care Health Option (ECHO) Program. 133
4.0 Travel Benefit for Those with a Combat-Related Special Compensation Determination 135
5.0 TRICARE Benefits and the Affordable Care Act (ACA) 135
6.0 Computer/Electronic Accommodations Program (CAP) 135
Appendix A: Additional ECHO Information 137
Appendix B: Computer/Electronic Accommodations Program 139

Module 9: TRICARE and Medicare 141
1.0 Introduction 144
2.0 Eligibility. 144
3.0 Basics of Medicare 144
4.0 TRICARE For Life 145
5.0 How TFL Works with Medicare 148
6.0 How TFL Works with Other Health Insurance (OHI) and Veteran's Affairs (VA) Care 149

7.0 Working Beneficiaries Age 65 and Older . . . 149
8.0 Using TFL While Overseas . . . 149
9.0 TFL Claims Processing . . . 150
10.0 Pharmacy and TFL . . . 150
11.0 Application Exercises . . . 150
Appendix A: Medicare Overview . . . 152
Appendix B: What If I'm Not Eligible for Premium-Free Medicare Part A? . . . 154

Module 10: Claims . . . 155
1.0 Introduction to Claims . . . 158
2.0 Claims Filing . . . 158
3.0 Submitting Claims . . . 158
4.0 Claim Forms . . . 159
5.0 Claims Processing Procedures . . . 160
6.0 TRICARE Overseas Program (TOP) Prime Remote Claims . . . 161
7.0 TRICARE and Other Health Insurance (OHI) . . . 162
8.0 Explanation of Benefits (EOB) . . . 162
9.0 Resolving Claims Issues . . . 166
10.0 Program Integrity . . . 167
Appendix A: Claims Resources . . . 170
Appendix B: Sample Explanation of Benefits Statements . . . 172

Module 11: Appeals . . . 179
1.0 Introduction to Appeals . . . 181
2.0 Appeals Process . . . 182
3.0 Appeals of Dual Medicare-TRICARE Claims . . . 184
4.0 TRICARE Prime Remote (TPR) Appeals . . . 185
5.0 Summary . . . 185

Module 12: Resources and Tools . . . 187
1.0 Important TRICARE Resources . . . 188
2.0 The TRICARE Manuals (http://manuals.tricare.osd.mil) . . . 190
3.0 Additional Resources . . . 193

Module 13: Acronyms . . . 201

Module 14: Glossary of Terms . . . 207

TRICARE Fundamentals Course

Key TRICARE Concepts and Terms

1

Participant Guide

Module Objectives

- **Identify the four TRICARE regions**
- **Identify who determines TRICARE eligibility**
- **Explain the purpose of DEERS**
- **Describe the types of TRICARE-authorized providers**
- **List terms commonly associated with TRICARE costs**

Key Terms

- **Military Health System (MHS)**
- **TRICARE**
- **TRICARE Regional Office (TRO)**
- **TRICARE Overseas Program (TOP)**
- **TRICARE Area Office (TAO)**
- **Defense Enrollment Eligibility Reporting System (DEERS)**
- **Military Treatment Facility (MTF)**
- **Authorized Provider**
- **Network Provider**
- **Non-Network Participating Provider**
- **Non-Network Non-Participating Provider**
- **Non-Authorized Provider**
- **Billed Charge**
- **TRICARE-Allowable Charge**
- **Deductible**
- **Cost-Share**
- **Copayment**
- **Premium**
- **Enrollment Fee**
- **Catastrophic Cap**
- **Balance Billing**
- **Explanation of Benefits (EOB)**
- **Foreign Fee Schedule**

?	Throughout this module, you will answer scenario questions on TRICARE beneficiary Alice White, the wife of Captain White, an active duty service member (ADSM) in the United States Army.

1.0 The Military Health System (MHS) and TRICARE

1.1 The Military Health System (MHS)

- The Military Health System (MHS) is the network of organizations that carry out the uniformed services' health care mission.
- The MHS includes those employed or contracted by the Department of Defense (DoD) to deliver care on the battlefield, on ships, in the air, and in uniformed service hospitals and clinics.
- Understanding health care under the MHS requires an understanding of the two distinct types of care:
  - Direct care—health care provided within a uniformed service clinic or hospital, typically referred to as a military treatment facility (MTF).
  - Purchased care—health care received from a civilian TRICARE-authorized or overseas host nation provider.

1.2 TRICARE

- TRICARE is the worldwide purchased health care program serving active duty service members (ADSMs), Guard/Reserve members, retirees, family members, survivors, certain former spouses, and others entitled to TRICARE benefits.
- As a major piece of the MHS, TRICARE increases the availability of health care resources with networks of civilian health care professionals, facilities, pharmacies, and suppliers. This allows the DoD to provide access to high-quality health care services, while supporting uniformed service operations.
- TRICARE is managed through four geographic health service regions: three in the United States and one for overseas locations. Each region has a managed care support contractor who administers and coordinates health care services between uniformed service hospitals and clinics and its network of civilian hospitals and providers. (Regional managed care support contractors are referred to as a regional contractors).

1.2.1 Stateside

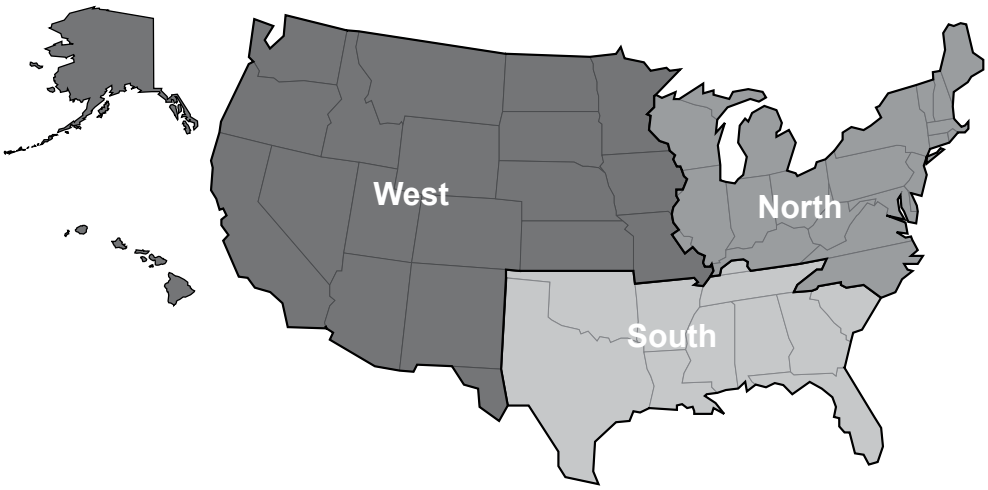
Each of the three stateside TRICARE regions is overseen by a government office known as a TRICARE Regional Office (TRO): TRO-North, TRO-South, and TRO-West. The TROs oversee health care delivery in their region by making sure regional contractors carry out their contractual responsibilities.

- **The North Region** includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (Rock Island Arsenal area), Kentucky (except Fort Campbell area), Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, and Wisconsin.
- **The South Region** includes Alabama, Arkansas, Florida, Georgia, Kentucky (Fort Campbell area) Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (excluding the El Paso area).
- **The West Region** includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner, including El Paso), Utah, Washington, and Wyoming.

Customer service staff should first contact a regional contractor when they need help. If the contractor can't help, staff should then contact the TRO.

?	The White's just moved from Topeka, Kansas to St. Louis, Missouri. Did their TRICARE region change? If so, what region did they live in before their move? What region do they live in now?

TRICARE Stateside Regions



1.2.2 Overseas

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

TRICARE Overseas Region

2.0 TRICARE Eligibility

- **Only the seven uniformed services determine TRICARE eligibility:**
  - Army
  - Marine Corps
  - Navy
  - Air Force
  - Coast Guard
  - Public Health Service
  - National Oceanic and Atmospheric Administration (NOAA)
- The Defense Enrollment Eligibility Reporting System (DEERS) is the central, online eligibility and enrollment data repository that contains personnel and health care benefit information for the DoD.
- DEERS is the established source to verify benefit and entitlement eligibility information for:
  - Uniformed service members
  - Uniformed service retirees
  - U.S. sponsored foreign military members
  - DoD civilian service personnel
  - Eligible family members
  - Others as directed by the DoD
- DEERS maintains information about TRICARE eligibility, TRICARE option coverage, primary care manager (PCM) assignment, catastrophic caps, deductibles, enrollment fee totals, and other health insurance (OHI).
- **Remember, DEERS doesn't determine eligibility, it only reports it**. Beneficiaries may contact the Defense Manpower Data Center Support Office (DSO), or nearest identification (ID) card-issuing facility for help with eligibility questions.

2.1 When to Update DEERS Records

Note: Though DEERS updates some records automatically, the beneficiary is ultimately responsible for making sure information is current at any given time.

Sponsor Status Changes That Require a DEERS Update	Qualifying Life Events That Require a DEERS Update
● Activation or reenlistment ● Deactivation ● Separation or retirement ● Medicare eligibility ● Relocation or change of address ● Death	● Marriage or divorce ● Birth or adoption ● Death ● Relocation or change of address ● Medicare eligibility or loss of eligibility ● Dependent child's enlistment in a uniformed service ● Student status*

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

2.2 Making Status Updates After a Qualifying Life Event

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

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

2.3 Updating Contact Information in DEERS (Address, Phone Number, E-mail)

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

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

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

2.4 DMDC Support for TRICARE Eligibility Issues

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

Note: Recently-issued ID cards list the DoD Benefits Number (DBN) on the back of the card. This may be used in place of a Social Security Number (SSN) when seeking healthcare services .

?	Following the White's recent move to St. Louis, do they need to change any information in DEERS? If so, how can they make sure these changes are made?

3.0 TRICARE and Veterans Affairs Benefits

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

4.0 TRICARE Providers

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

4.1 Military Treatment Facilities (MTFs)

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

4.2 Authorized Providers (Civilian)

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

4.2.1 Subsets of Authorized Provider Types

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

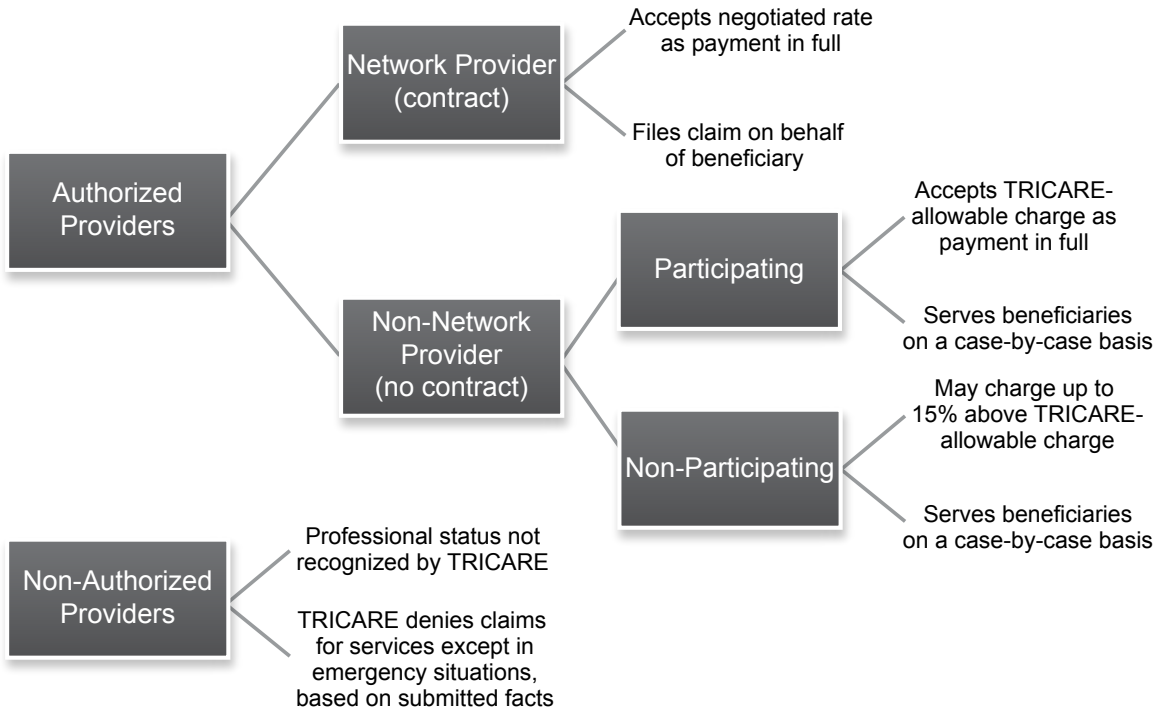
* *"Cashless, claimless" means the overseas contractor authorized a visit and payment to a certified host nation provider. The provider files the claim and doesn't require the enrollee to pay up front.*

4.2.2 Non-Authorized Providers

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

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

4.2.3 Illustration of Provider Types



?	Mrs. White needs to see a dermatologist, but first she must choose one. If she chooses a non-network, non-participating provider, what charges can she expect to pay?

4.3 Finding a Provider

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

Note: Provider directories are always subject to change. A listing in a directory doesn't guarantee the provider's information is current or that a provider is accepting new patients; beneficiaries should call the provider's office to confirm his or her TRICARE status.

5.0 Terms Associated with TRICARE

Billed Charge	The provider's proposed total cost with no discounts or reduced fees. **Note:** Overseas cost-shares are based on the purchased care/host nation provider's billed charges (with some exceptions—e.g., Philippines, Panama).
TRICARE-Allowable Charge	The maximum amount TRICARE pays for a procedure or service. By law, it's tied to Medicare's reimbursement rates when practical. The TRICARE-allowable charge varies depending on location, place of service, date of service, and provider type.
Deductible	The fixed amount a beneficiary pays under a TRICARE Standard/Extra option for covered outpatient services before TRICARE begins to share costs. Prime enrollees also pay a deductible when using the Point-of-Service option or when using a non-network retail pharmacy.
Cost-Share	The percentage (or portion) of the TRICARE-allowable charge the beneficiary and the government are each responsible for paying under the Standard/Extra option.
Copayment	The fixed amount TRICARE Prime option enrollees pay for care in the civilian provider network.
Premium	The pre-determined charge an individual pays for medical or dental benefits for a defined period of time.
Enrollment Fee	The amount some categories of beneficiaries pay to enroll in and receive the benefits of TRICARE Prime (including the US Family Health Plan).
Catastrophic Cap	The maximum amount an individual/family pays out-of-pocket for TRICARE-covered services or supplies per fiscal year (October 1–September 30). Payments that count toward a catastrophic cap include: ● Deductibles ● Cost-shares ● Prescription copayments ● Prime enrollment fees ● Prime copayments
Balance Billing	Occurs when a non-network non-participating provider bills the beneficiary the difference between the billed charges and the TRICARE-allowable charge (stateside only).
Explanation of Benefits (EOB)	A statement, prepared by insurance carriers, health care organizations, and TRICARE, informing beneficiaries and providers of actions taken on a claim for health care services.
Foreign Fee Schedule (Overseas Specific)	A country-specific payment determination for provider services (currently only used in the Philippines and Panama) that is used to calculate deductibles and cost-shares.
Transitional Survivor	The initial eligibility status of a spouse and unmarried dependent child(ren) of a sponsor who died while on active service. Spouses keep their transitional survivor status for up to three years from the date of the sponsor's death. Unmarried dependent children are transitional survivors until they lose TRICARE eligibility. Benefits are the same as ADSMs. See Appendix A of this module for more information on transitional survivors.
Survivor	The eligibility status of surviving spouses and incapacitated children (if applicable) after the three-year anniversary of the active duty sponsor's death. Survivor benefits are the same as retired family members. See Appendix A of this module for more information on survivors.

Module Objectives

- **Identify the four TRICARE regions**
- **Identify who determines TRICARE eligibility**
- **Explain the purpose of DEERS**
- **Describe the types of TRICARE-authorized providers**
- **List terms commonly associated with TRICARE costs**

Key Terms

- **Military Health System (MHS)**
- **TRICARE**
- **TRICARE Regional Office (TRO)**
- **TRICARE Overseas Program (TOP)**
- **TRICARE Area Office (TAO)**
- **Defense Enrollment Eligibility Reporting System (DEERS)**
- **Military Treatment Facility (MTF)**
- **Authorized Provider**
- **Network Provider**
- **Non-Network Participating Provider**
- **Non-Network Non-Participating Provider**
- **Non-Authorized Provider**
- **Billed Charge**
- **TRICARE-Allowable Charge**
- **Deductible**
- **Cost-Share**
- **Copayment**
- **Premium**
- **Enrollment Fee**
- **Catastrophic Cap**
- **Balance Billing**
- **Explanation of Benefits (EOB)**
- **Foreign Fee Schedule**

Appendix A: Special Eligibility and DEERS Registration Categories

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

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

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

Dependent Parents and Parents-In-Law

Although dependent parents and parents-in-law aren't TRICARE eligible (except for pharmacy benefits if qualified at age 65 or older), they may be eligible to receive direct care (care from a uniformed service clinic or hospital/ military treatment facility [MTF]).

- Eligible dependent parents and parents-in-law must be registered in DEERS to get care at the MTF. The sponsor's service determines if they qualify as dependent parents/parents-in-law.
- Sponsors should verify with their service the documentation needed to establish eligibility and access to MTF care, which may include:
  - *DD Form 1172-2*, signed by the sponsor
  - *Dependency Statement—Parent* form (DD Form 137-3)
  - Dependency determination letter from the Defense Financial and Accounting Service
- Eligible dependent parents and parents-in-law may have prescriptions filled at an MTF pharmacy. When they become Medicare-eligible they can get prescriptions filled through TRICARE at network pharmacies or via home delivery, as long as they're enrolled in Medicare Part B.

Transitional Survivors and Survivors

Surviving family members of sponsors who died while on active service may be entitled to TRICARE benefits as transitional survivors or survivors. Eligibility is determined by the sponsor's service and is reflected in DEERS.

Transitional Survivors

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

Survivors

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

Unremarried Former Spouses

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

Unremarried Former Spouse Loss of Eligibility

TRICARE-eligible unremarried former spouses lose TRICARE eligibility if:

- He or she remarries, even if the remarriage ends in divorce or death of the spouse, unless they gain TRICARE eligibility under a new spouse
- He or she purchases or is covered by an employer-sponsored health plan

Note: TRICARE-eligible unremarried former spouses who are offered group health coverage through their employer may choose to decline it and keep their TRICARE coverage.

Additional Special Eligibility Categories

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

- Certain family members of active duty family members (ADSMs) who were discharged as a result of a court-martial conviction or separated for child or spousal abuse.
- Certain spouses, former spouses, and dependent children of uniformed service members who were eligible for retirement, but had their retirement revoked as a result of spousal or child abuse.
- Foreign Force members and their family members when they're in the United States by official invitation or on official military business.
  - This includes all countries that participate in a Reciprocal Health Care Agreement, the North Atlantic Treaty Organization (NATO), a Status of Forces Agreement, or a Partnership for Peace Agreement.
  - Foreign Force members and their dependents seeking routine care may also contact their home country embassy for assistance with health care coverage.
  - For information about MTF or TRICARE coverage for foreign force members and their families register for an account at https://rhca.dhhq.health.mil.

TRICARE Fundamentals Course

TRICARE Options

2

Participant Guide

References

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

Brainteasers

Each of the 8 items below is a separate puzzle.

How many can you figure out?

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

1.Go long_____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

Stateside Objectives:

- **Explain the differences between TRICARE Standard®, TRICARE Extra, TRICARE Prime®, and the US Family Health Plan (USFHP)**
- **Explain the costs associated with the basic TRICARE options**
- **Describe the Point-of-Service (POS) option**
- **Describe the TRICARE Prime Travel Benefit**

Overseas Objectives:

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

Key Terms

- **TRICARE Standard**
- **TRICARE Overseas Program (TOP) Standard**
- **TRICARE Extra**
- **TRICARE Prime**
- **TOP Prime**
- **US Family Health Plan (USFHP)**
- **Primary Care Manager (PCM)**
- **Point-of-Service Option (POS)**
- **Access to Care**
- **Emergency Care**
- **Urgent Care**
- **Routine Care**
- **Specialty Care**

TRICARE offers distinct options for its beneficiaries. Understanding the differences between them is important, as it allows service members, retirees, and their families to make the best choice based on their eligibility and personal situation.

?	Throughout this module, you will answer scenario questions on Senior Airman Matthews, who is being transferred to a new assignment with his family.

1.0 TRICARE Standard and Extra and TRICARE Overseas Program (TOP) Standard

- TRICARE Standard and TOP Standard are available to TRICARE-eligible beneficiaries (except active duty service members [ADSMs]).
- TRICARE Standard is the stateside program; TOP Standard is the overseas program.
- This fee-for-service-like option gives beneficiaries a larger number of authorized providers to choose from without having to get prior authorization for most TRICARE-covered services.
- Standard beneficiaries may get health care from a Military Treatment Facility (MTF) on a space-available basis.

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

1.1 Standard Eligibility and Enrollment

- As long as a beneficiary (other than ADSMs) shows as eligible in the Defense Enrollment Eligibility Reporting System (DEERS), he or she automatically gains Standard coverage. Beneficiaries must show a valid Uniformed Services ID card as proof of eligibility when receiving care.
- Standard has no enrollment fee or forms.

1.2 Standard Benefit

- Standard covers most inpatient and outpatient care that is medically necessary and considered proven.
- Certain services are only available as long as a facility is Medicare-certified and/or TRICARE participating (e.g., skilled nursing care).

1.2.1 TRICARE Standard Prior Authorizations

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

1.2.2 Receiving Care Using Standard

- Emergency care never requires an authorization. In an emergency, Standard beneficiaries should go to the nearest emergency room or call the local emergency number for the country where they’re located.
  - Emergency conditions exist when life, limb, or eyesight are at risk, to include severe psychiatric conditions.
- Beneficiaries may seek routine and urgent care from any TRICARE-authorized or purchased care/host nation provider, or from an MTF if space is available. This includes certain preventive services, which don’t require authorization or copayment.

1.3 TRICARE Extra

- When a TRICARE Standard beneficiary receives care from a network provider, the beneficiary uses the TRICARE Extra option and gets a 5% cost-share discount.
- TRICARE Extra **isn't** available overseas or in U.S. territories.
- All rules that apply to TRICARE Standard also apply to TRICARE Extra.

?	SrA Matthews' son, Bill, has severe asthma. Having a wide-range of providers to choose from is important to SrA Matthews and his wife. Should they consider the TRICARE Standard benefit? What happens to their cost-share if they use a network provider?

1.4 TRICARE Standard and TRICARE Extra Costs

Note: Overseas providers may require that TOP Standard beneficiaries pay the full cost of care at the time of service; beneficiaries then file claims for reimbursement.

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

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

Note: Costs may change each fiscal year (October 1–September 30). Standard beneficiaries pay an annual outpatient deductible; the government and the beneficiary share costs after the beneficiary pays the deductible. Deductibles and cost-shares count towards the catastrophic cap.

1.4.1 Balance Billing Limit (Stateside Only)

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

1.4.2 Standard Billing Example

A TRICARE Standard E-5 active duty family member visits a non-network provider for an outpatient cardiology appointment. The cardiologist "doesn't participate" on the claim. The provider usually charges $1,000 for this type of appointment. TRICARE's allowable charge is $850. Remember, the provider may bill the beneficiary 15% above the TRICARE-allowable charge. How much does the family member owe?

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

Note: Although the total amount charged is $1,000.00, the provider can't legally hold the beneficiary responsible for the total amount. The beneficiary pays his/her deductible, cost-shares, and the 15% above the TRICARE-allowable charge.

1.5 TRICARE Standard Exercise

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

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

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

	What is the charge per visit?	How much of each charge applies to the annual outpatient deductible?	What is the cost-share percentage?	How much does the family pay per visit?
Mrs. Teal's First Visit				
Child #1's Visit				
Child #2's Visit				
Child #3's Visit				
Mrs. Teal's Follow-Up Visit				

1.6 TRICARE Extra Exercise

Mrs. Jade, an E-5 ADFM, and her three children are TRICARE Standard.

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

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

	How much was charged per visit?	How much of each charge applies to the annual outpatient deductible?	What is the cost-share percentage?	What does the family pay per visit?
Mrs. Jade's First Visit				
Child #1's Visit				
Child #2's Visit				
Child #3's Visit				
Mrs. Jade's Follow-Up Visit				

2.0 TRICARE Prime/TRICARE Overseas Program (TOP) Prime

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

- TRICARE Prime/TOP Prime is a managed care option similar to a civilian health maintenance organization (HMO).
- Prime is available in established geographic locations, referred to as Prime Service Areas (PSAs).
  - PSAs typically include those zip-codes located within a 40-mile radius of an MTF or a former Base Realignment and Closure (BRAC) site.
  - To determine if they live in a PSA, beneficiaries can use the PSA Look-up Tool, available at www.tricare.mil/PSAZIP

Note: There are no PSAs in overseas locations.

2.1 The Role of the Primary Care Manager (PCM)

- Each Prime enrollee is assigned a primary care manager (PCM) who is responsible for:
  - Providing all routine, nonemergency health care, including urgent care
  - Submitting referrals for specialty care and establishing medical necessity when needed
- PCMs are:
  - MTF providers (stateside and overseas)
  - Civilian network providers
  - A team organized to take care of the patient if the individual's PCM isn't available
- PCMs may be:
  - Internists, family practitioners, pediatricians, general practitioners
  - Obstetricians/gynecologists, physician assistants, nurse practitioners
- Beneficiaries can note the type of PCM they would like on their enrollment form. PCM assignment is based on the sponsor's status, beneficiary's address, and PCM availability.
  - Within an MTF, PCMs are assigned based on MTF commander guidelines.

2.2 Prime Eligibility

Stateside	● ADSMs ● ADFMs ● Transitional survivors and survivors ● Certain unremarried former spouses ● Retirees and retiree family members ● Certain National Guard/Reserve members and their eligible family members (This only applies when the sponsor is on active service for more than 30 consecutive days or when the sponsor is issued delayed-effective date orders for active service for more than 30 consecutive days in support of a contingency operation; in either instance, the sponsor must show as eligible in DEERS. See the *National Guard and Reserve* module for more information.) ● Medal of Honor recipients and their eligible family members
Overseas	● ADSMs permanently assigned and residing near an MTF ● ADFMs or family members of activated Guard/Reserve members on permanent change of station orders and command sponsored to accompany the sponsor to the overseas location* ● ADFMs on service-funded orders to relocate to an overseas location without the sponsor ● National Guard or Reserve members on active service for more than 30 consecutive days and showing as eligible in DEERS, with final assignment to a TOP Prime location ● Family members of activated Guard/Reserve members, as long as the family members lived with the Guard/Reserve member in a TOP Prime location at the time of activation

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

2.3 Prime Enrollment

Enrollment is required for Prime coverage.

- ADSMs are required to enroll; they are to follow service specific guidance based on their assignment and location. Prime coverage starts on the date the contractor receives the enrollment form.
- The fiscal year (FY) 2013 National Defense Authorization Act (NDAA) states that ADFMs of sponsors who are E-1–E-4 and live within a PSA are to be granted Prime enrollment upon request.
- Enrollment is voluntary for non-ADSMs; beneficiaries may choose to enroll on an individual or family basis.
- Eligible beneficiaries (including ADSMs) must be registered in DEERS and submit a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876).
  - Beneficiaries may get enrollment forms from the TRICARE website at www.tricare.mil/forms or the regional contractor's website.
  - Beneficiaries submit enrollment forms, along with their initial enrollment fee (if applicable), to their regional contractor.
- Stateside Prime-eligible beneficiaries (except ADSMs) are encouraged to enroll online using the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe. To login to BWE, beneficiaries must use a Common Access Card (CAC), Defense Finance and Accounting Services (DFAS) myPay Account, or Department of Defense Self Service (DS) Logon.
  - For more details visit http://milconnect.dmdc.mil for DS Logon information.

- **Stateside**, the regional contractor must receive the enrollment form and fee (not postmarked) by the 20th of the month for coverage to start on the first day of the following month. If received after the 20th of the month, Prime coverage begins on the first day of the second month (20th-of-the month rule).
- **Overseas**, TOP Prime coverage begins on the date a complete enrollment form is signed. To be complete, an enrollment form must include required command sponsorship orders.
  - The 20th-of-the-month rule doesn't apply to ADSMs or to TOP Prime enrollees.
- Eligible beneficiaries (who aren't ADSMs) are covered under TRICARE Standard until TRICARE Prime coverage begins.
- Each enrollment period is one fiscal year (October 1–September 30); enrollment renews automatically each year, unless one of the following occur:
  - Enrollee voluntarily disenrolls (ADSMs can't disenroll)
  - Enrollee isn't eligible for Prime or TRICARE benefits (i.e., member retires, the Guard or Reserve member is deactivated, family members age out or are not command sponsored)

Note: ADSMs stationed in Canada and their command-sponsored ADFMs receive care from Canadian Forces Health Care Facilities. (See Appendix A of this module for more information.)

2.3.1 Prime Enrollment Fees

- ADSMs and ADFMs don't pay enrollment fees.
- All other enrollees pay an annual enrollment fee, per individual or family, per fiscal year. Enrollment fees are likely to change each fiscal year.
  - Prime enrollment fees for survivors of active duty deceased sponsors and medically retired uniformed service members and their dependents freeze at the rate in effect when classified in DEERS and first enrolling in Prime. (This doesn't include TRICARE Young Adult Prime, which is discussed in the *Other Benefits* module.)
    - The fees remain frozen as long as at least one family member remains enrolled in Prime.
  - Enrollees may pay fees on an annual or quarterly basis or by monthly allotment.
  - Enrollees choosing to pay monthly must send in an initial three-month payment by check with their completed enrollment form. All future payments must be electronic.
    - Electronic forms of payment include credit card, electronic fund transfers (EFTs) through an enrollee's financial institution, or allotment from retirement pay set up through the regional contractor or directly through uniformed service finance centers.
- It's recommended that beneficiaries turning 65 make quarterly payments, monthly allotments, or EFT payments so that they can stop paying fees when they become Medicare entitled.
- For current Prime enrollment fees and exceptions visit www.tricare.mil/primecosts.

2.3.2 Prime Lockout and Disenrollment

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

3.0 Prime Costs

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

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

3.1 Point-of-Service Option

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

3.1.1 POS Costs

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

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

3.1.2 POS Doesn't Apply in the Following Circumstances:

- Emergency department services for emergency care
- Certain preventive care services from a network provider
- The initial eight behavioral health outpatient visits from a network provider
- TOP Prime-enrolled ADFMs who seek TRICARE-authorized care within 60 days of permanent transfer to the United States
- Newborn care during the initial 60 days stateside/120 days overseas when they're deemed Prime or if adopted, registered in DEERS (See Section 7.0 of this module for more information.)
- Other health insurance (OHI) is primary, including host nation insurance

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

3.1.3 POS Example

- A TRICARE-authorized provider treats a Prime-enrolled ADFM for medically necessary, TRICARE-covered specialty care.
- The family member didn't get a referral from his/her PCM.
- TRICARE's allowable charge is $850.00. Remember, under point of service, the enrollee pays the POS deductible and a 50% cost-share.

TRICARE-allowable charge	$850
Beneficiary pays POS deductible (individual rate)	$300
TRICARE-allowable charge after the deductible	$550
Beneficiary pays 50% cost-share of TRICARE-allowable charge after the deductible	$275
Balance	**$275**
TRICARE pays remaining 50%	$275
Beneficiary's total out-of-pocket cost ($300 deductible + $275 cost-share)	**$575**

?	The Matthews' are moving to a Prime Service Area. What are the biggest difference(s) between their TRICARE Prime and Standard benefits? What actions do the Matthews' have to take to show as Prime in DEERS?

4.0 Prime Access Standards and Types of Care

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

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

- **Emergency care** refers to medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition exists; that the absence of medical attention would result in a threat to life, limb, or eyesight and requires immediate medical treatment; or when a condition is so painful that sedative treatment is required to relieve suffering.
- **Urgent care** is generally defined as nonemergency acute illness or injury that requires medically necessary treatment, but won't result in disability or death if not treated immediately. This kind of illness or injury requires professional attention and should be treated within 24 hours to avoid further complications.
  - Enrollees should first visit their PCM for urgent care needs.
  - If unable to schedule an appointment, the PCM must issue a referral.
  - If enrollees cannot contact their PCM, they should contact the regional contractor or the country specific Call Center before seeking urgent care.
- **Routine care**, also known as primary care, includes general office visits for the treatment of symptoms, chronic or acute illnesses and diseases, and follow-up care for an ongoing medical condition. A PCM should be the primary source of all routine care.
- **Specialty care** is generally defined as care the PCM can't provide.
- **Preventive care** includes services, such as health screenings and examinations, often conducted at regular intervals, which are meant to keep beneficiaries healthy or detect health problems in a timely manner (e.g., mammograms, pap smears, cholesterol testing).

4.1 Getting Emergency Care

- Prime enrollees should go to the nearest source of emergency care.
- **Stateside**: Prime enrollees must notify their PCM or regional contractor within 24 hours of receiving emergency care and/or being admitted to an inpatient facility.
- **Overseas**: TOP Prime enrollees should contact the TOP Regional Call Center or country-specific Call Center within 24 hours of receiving emergency care or being admitted to an inpatient facility, stateside or overseas.
- Emergency treatment records may be required when the diagnosis on the emergency room claim doesn't meet the definition of emergency care.
- See Appendix A of this module for information on ADSMs and ADFMs getting emergency care when assigned to Canada.

4.2 Referrals for Specialty Care

- When Prime enrollees need specialty care, their PCM writes a referral. The enrollee must make sure the regional or overseas contractor authorizes the care before scheduling any appointments to avoid POS charges.
- Getting the referral authorized is a multi-step process:

Stateside	● The PCM submits the referral electronically or by fax. ○ The local MTF gets one business day to review the referral, sending it back to the contractor with directions to either schedule or not schedule an appointment with the MTF. ○ Regional contractor staff conduct a benefit review and issue the appropriate care determination (approval or denial). ● The regional contractor sends a letter to the enrollee with the name of the MTF or network specialty care provider and the referral authorization, including the length of time the referral is good for, along with the number and types of visits authorized. ○ Before making an appointment, enrollees may call the regional contractor's toll-free number three to five days after the PCM enters the referral to check on the authorization's status. ● The Prime enrollee must contact the specialty provider(s) listed on the authorization letter to set up an appointment(s) or call the regional contractor to change the identified specialist. ● Before the appointment, the enrollee should try to get copies of information the specialty provider may need (e.g., x-rays, lab results). ○ MTF Prime enrollees must find out what the MTF's policy is for transferring medical records (e.g., x-rays) to specialty care providers. ● Prime enrollees should take their PCM's or regional contractor's phone number (listed on their enrollment card) to their specialty appointment in case there are questions.
Overseas	● TOP Prime enrollees referred to a purchased care/host nation network provider can expect a "cashless, claimless" episode of care, as long as the care is properly coordinated and authorized through the TOP contractor. Before scheduling an appointment, the enrollee must confirm the authorization through his or her Regional or Country-specific Call Center. ● All referred care, whether written by an MTF or host nation provider, must be authorized. ○ The TOP contractor conducts a benefit review and issues the appropriate care determination (i.e., approved or denied). ● If approved, the TOP contractor arranges for care to be provided by a certified host nation provider, gives the TOP Prime enrollee information on the specialty care provider, and may assist in coordinating the specialty appointment. ● See Appendix A of this module for information on obtaining specialty care in Canada.

Note: The contractor may authorize the enrollee to see a non-network specialist if there is no network specialist within access standards.

- Care authorizations don't carry over from one region to another.
- Enrollees need to get referrals and authorizations from their new PCM/regional contractor for specialty care in the new location.

?	Unfortunately for the Matthews', Bill's current medication stops being an effective treatment for his asthma, so his PCM writes a referral to a specialist. What are the access standards in this situation? What impacts him getting a referral for a *civilian* specialist?

4.2.1 Stateside TRICARE Prime Travel Benefits for Specialty Care

- When stateside-enrolled **non-active duty** TRICARE Prime enrollees are referred for and authorized to receive medically necessary, nonemergency specialty care more than 100 miles from their assigned primary care manager's location, they may be eligible for the TRICARE Prime Travel Benefit, meaning they may be reimbursed for reasonable travel expenses. (This benefit isn't available overseas.)
- The "greater than 100 mile rule" is statutory and is not negotiable when determining if the Prime travel benefit applies. (An exception applies for Coast Guard ADSMs. For more information, see the 2008 TRICARE Reimbursement Manual, Chapter 1, Section 30.)
- Active duty travel for medical care is handled through service personnel and medical assets, and must follow Joint Federal Travel Regulations.
- MTF enrollees should contact the MTF Prime travel benefit point of contact for information on the benefit and payment process as soon as they are referred and before they travel. Civilian PCM-assigned enrollees must contact the travel benefit point of contact at the TRICARE Regional Office.
- For more information on the Prime travel benefit, visit www.tricare.mil/travelreimbursement

5.0 TRICARE Prime Portability

TRICARE Prime coverage is portable, meaning Prime enrollment can move with an enrollee to a new location—with no break in Prime coverage—as long as Prime is available in the new location.

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

5.1 Transferring Prime Within the Same Region

- Enrollees should update their address in DEERS and notify the regional contractor of their address change.
- Enrollees then request a PCM change for the new location by submitting a new *DD Form 2876*, contacting the regional contractor, or using the BWE website.

5.2 Transferring Prime to a Different Region

- When relocating to a new region, Prime enrollees **shouldn't** disenroll from their current region before they move. Remaining enrolled ensures they have no break in TRICARE Prime coverage.
- While traveling to the new location, enrollees must get referrals from their PCM and authorization from their current regional contractor before getting nonemergency, specialty, or inpatient care to avoid POS charges. Enrollment transfers are effective the date the gaining regional contractor processes a new, signed enrollment form or confirms transfer via phone call (if coordinated before leaving the old location). The gaining regional contractor then assigns a new PCM to the enrollee, provides region- or site-specific TRICARE educational materials, and key telephone numbers.

5.3 Transfer Frequency and Enrollment Fees

- The number of moves within the same region per enrollment year is unlimited; enrollees must ensure they update their address in DEERS.
- Prime-enrolled retirees and their family members who move from one region to another and back to the original region are allowed two enrollment transfers per enrollment year.
- After transferring to a new region, enrollment fees are billed by and paid to the gaining regional contractor.
  - When enrollees anticipate moving to a non-PSA they should consider paying their enrollment fees quarterly or by monthly allotment since TRICARE won't refund the unused portions of their enrollment fees.

5.4 Transferring to a Location Outside of a Prime Service Area

- Enrollees can be covered by TRICARE Prime while en route to a location that isn't a PSA.
- Upon arrival at the new location, enrollees should update their address in DEERS and call the regional contractor or go to the BWE website to:
  - Transfer their enrollment to TRICARE Prime Remote/TRICARE Prime Remote for ADFMs, or TOP Prime Remote (ADSMs and ADFMs only)
  - Disenroll and use Standard/Extra (other than ADSMs)
- If beneficiaries move to a location outside of a PSA and want to remain in TRICARE Prime, they must indicate on their enrollment form that they are willing to waive TRICARE Prime access standards. They then may or may not be enrolled in Prime depending on where they live and if there are Prime network providers available within 100 miles.
  - If approved, enrollees then travel a longer distance to see their assigned PCM and network specialty providers. Enrollees must still follow TRICARE Prime rules (e.g., using a PCM for routine care, obtaining specialty referrals and authorizations).

5.5 Split Prime Enrollment Between Different TRICARE Regions

- TRICARE Prime split enrollment offers families the option to enroll one or some members in Prime in one region while the rest of the family is enrolled in Prime in another region. The sponsor or legal guardian must complete and sign an enrollment form for the affected family member(s) and submit it to the regional contractor where the other family member(s) lives.
- For those who pay enrollment fees:
  - The family may pay one enrollment fee to the regional contractor the family chooses to serve as the home regional contractor. The regional contractor can help with this process.
  - Enrollment fees apply to the family and payment is recorded in DEERS.

?	Six months after the family's first move, SrA Matthews receives notice that he being transferred to another PSA in a different region. What should the Matthews' do to ensure a smooth transfer to the new region without a break in Prime coverage?

6.0 Traveling with Prime

6.1 Stateside Prime Enrollees Seeking Care When Traveling Overseas

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

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

6.2 TOP Prime Enrollees Seeking Care When Traveling Stateside

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

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

6.2.1 TOP Prime: Referrals and Authorizations When Traveling Stateside

- Routine care stateside is generally not authorized for TOP Prime enrollees. Exceptions are made in unique circumstances on a case-by-case basis.
  - Routine care stateside requires a referral from the TOP Prime enrollee's PCM, with appropriate justification of the unique circumstances, and an authorization from the TOP contractor.
- TOP Prime enrollees traveling or between duty stations should try to seek all nonemergency care at MTFs whenever possible.
  - Nonemergency and urgent care outside of an MTF requires authorization from the TOP contractor. Visit the TOP contractor's website at www.tricare-overseas.com/contactus for call center contact information.

Note: A TOP authorization for care overseas doesn't carry over to a stateside provider. Likewise, a stateside care authorization doesn't carry over to an overseas provider. Enrollees need new authorizations if changing locations.

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

7.1 Newborn Coverage

- Beneficiaries are encouraged to formally enroll their newborn or adoptee in Prime as soon as possible following birth so the child will be assigned a PCM and appropriate well-child care may be provided.
- By policy, a newborn is covered under TRICARE Prime for 60 days after birth, as long as another family member is already enrolled in a Prime option.
- After the initial 60 days, any newborn claim processes as TRICARE Standard until the newborn is registered in DEERS and formally enrolled in TRICARE Prime.
  - The TRICARE Regional Director or TRICARE Area Office Director may extend the enrollment period up to 120 days on a case-by-case or regional basis. Currently, a regional waiver for 120 days is in effect in all overseas locations.
- TRICARE eligibility ends on day 366 for any newborn not registered in DEERS.

7.2 Pre-Adoptive and Adopted Children Coverage

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

8.0 US Family Health Plan (USFHP)

The US Family Health Plan (USFHP) is a TRICARE Prime-like option available at community-based, not-for-profit health care systems in six service areas of the United States. These areas are determined by ZIP code.

8.1 USFHP Designated Providers

There are six systems that sponsor the USFHP:

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

8.2 USFHP Eligibility

Eligible beneficiaries must be registered in DEERS and live within one of the designated USFHP service areas.

Eligible	Not Eligible
● ADFMs and unmarried dependent children until they lose eligibility (See Appendix A of the *Key TRICARE Concept and Terms* module for more information.) ● Retired service members, their spouses, and unmarried dependent children (until they lose eligibility) ● Medicare-TRICARE eligible beneficiaries under 65 (and those over 65 who enrolled in USFHP before September 30, 2012) ○ Medicare-TRICARE eligible beneficiaries under age 65 who enroll in USFHP after September 30, 2012 aren't eligible for USFHP when they turn 65. They become TRICARE For Life (TFL) as long as they have Medicare Part B. ○ Retirees and their eligible family members who are 65 and older can't enroll in USFHP after September 30, 2012. ● Eligible unremarried former spouses of active duty or retired service members ● Certain former ADSMs, including Guard/Reserve members and eligible family members during their Transitional Assistance Management Period (TAMP).	ADSMs

8.3 USFHP Enrollment

- Enrollment is open all year.
- There currently are no enrollment fees for ADFMs or Medicare-eligible beneficiaries who purchase Medicare Part B. All others pay an annual enrollment fee that mirrors the TRICARE Prime enrollment fee. For current USFHP enrollment fees visit www.tricare.mil/costs.
- To enroll, eligible beneficiaries must complete *DD Form 2876*. They must include an initial three-month payment, payable by check or electronic funds transfer. Ongoing payments must be made by electronic funds transfer, recurring credit/debit charges, or monthly allotment.
- Re-enrollment is automatic at the beginning of each fiscal year.

8.4 USFHP Coverage

- USFHP relies on PCMs to make arrangements for all of an enrollee's health care needs.
- Covered benefits are available only from USFHP-approved providers, except during a medical emergency.
  - USFHP enrollees must get specialty referrals from their PCM and use USFHP network providers and facilities for specialty services.
  - USFHP offers the point-of-service option where enrollees may self-refer for specialty care.

8.5 USFHP Costs

- USFHP handles payment for covered services. USFHP-approved providers file claims for enrollees. Enrollees are only responsible for the applicable copayment.
- USFHP costs mirror TRICARE Prime.

8.6 USFHP Prescription Coverage

- Although USFHP prescription coverage is unique, costs mirror those of the TRICARE Pharmacy Program.
- USFHP also offers beneficiaries various ways to obtain medications, including a home delivery program (see www.usfhp.com for more information).

8.7 Benefit Limitations

When they sign up, USFHP enrollees agree **not** to use the following health care options:

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

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

8.8 USFHP Portability

- When enrollees move within their current USFHP's zip code-defined service area, they must notify USFHP of their new address and select a new PCM (if desired).
  - USFHP sends a new membership card with the new PCM's name and phone number.
- If enrollees move to an area where USFHP is offered through a different health care system, they may transfer their enrollment.
- If enrollees move to an area where USFHP isn't available and they qualify for TRICARE Prime or Prime Remote enrollment, they can transfer their enrollment to those plans. Otherwise, they are disenrolled and covered under TRICARE Standard or TFL, depending on their Medicare status.

8.9 Accessing Medical Care While on Vacation

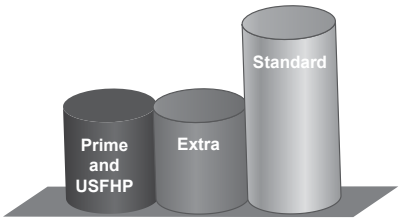
For medical emergencies, USFHP enrollees should go to the nearest civilian medical facility or MTF. Enrollees or an authorized representative should call the USFHP provider's toll-free number (located on the back of the USFHP enrollment card) or their PCM within 24 hours, even when traveling overseas.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

9.0 TRICARE Options Overview

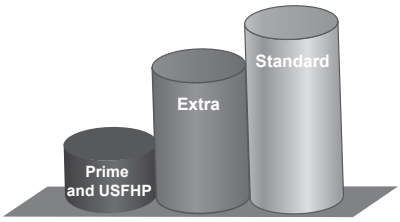
- **TRICARE Standard** is a fee-for-service option that offers the freedom to seek care from any TRICARE-authorized provider.
  - No enrollment forms or fees required
  - Available overseas (including U.S. territories) as TOP Standard
  - Has a deductible and cost-shares (based on sponsor's rank and status)
  - Beneficiary may have to file a claim.
- **TRICARE Extra** is a preferred-provider option where a Standard beneficiary receives a cost-share discount for using a TRICARE network provider.
  - No enrollment forms or fees required
  - Not available overseas
  - Five percent cost-share discount
  - No claims to file (network provider files for beneficiary)

- **TRICARE Prime** is a managed care option similar to a civilian HMO.
  - Enrollment is required
  - Care is coordinated through a PCM; specialty care requires a PCM/Regional Call Center referral and contractor authorization.
  - Available overseas as TOP Prime
  - Fixed copayment for most services
  - No claims to file (network provider files for beneficiary)
- **USFHP** is a Prime-like option available at community-based, not-for-profit health care systems in six areas of the United States.
  - Beneficiaries must live within one of the designated USFHP service areas, as determined by ZIP code
  - Enrollment is required
  - Care is coordinated through a PCM; specialty care requires a PCM/Regional Call Center referral and contractor authorization
  - Not available overseas
  - Costs mirror TRICARE Prime
  - No claims to file (provider files for beneficiary)

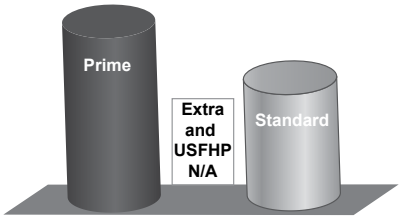
9.1 Comparing TRICARE Options



Freedom of Choice



Out-of-Pocket Costs



Access to MTF

- If freedom of choice is the most important factor to a beneficiary (other than an ADSM), TRICARE Standard is the preferred choice for health care.
- If cost savings is the most important factor, TRICARE Prime or USFHP (if available) are the best health care choices. TRICARE Extra is the next best choice due to the cost-share discount.
- If access to an MTF is the most important factor, TRICARE Prime is the best option, if available in the local area. Prime gives enrollees higher priority for accessing care within the MTF.

Module Objectives

Stateside Objectives:

- **Explain the differences between TRICARE Standard®, TRICARE Extra, TRICARE Prime®, and the US Family Health Plan (USFHP)**
- **Explain the costs associated with the basic TRICARE options**
- **Describe the Point-of-Service (POS) option**
- **Describe the TRICARE Prime Travel Benefit**

Overseas Objectives:

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

Key Terms

- **TRICARE Standard**
- **TRICARE Overseas Program (TOP) Standard**
- **TRICARE Extra**
- **TRICARE Prime**
- **US Family Health Plan (USFHP)**
- **TOP Prime**
- **Primary Care Manager (PCM)**
- **Point-of-Service Option (POS)**
- **Access to Care**
- **Emergency Care**
- **Urgent Care**
- **Routine Care**
- **Specialty Care**

Appendix A: Receiving Care in Canada

Routine Care in Canada

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

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

Emergency Care in Canada

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

Specialty Care in Canada

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

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

TRICARE Fundamentals Course

Prime Remote Options

3

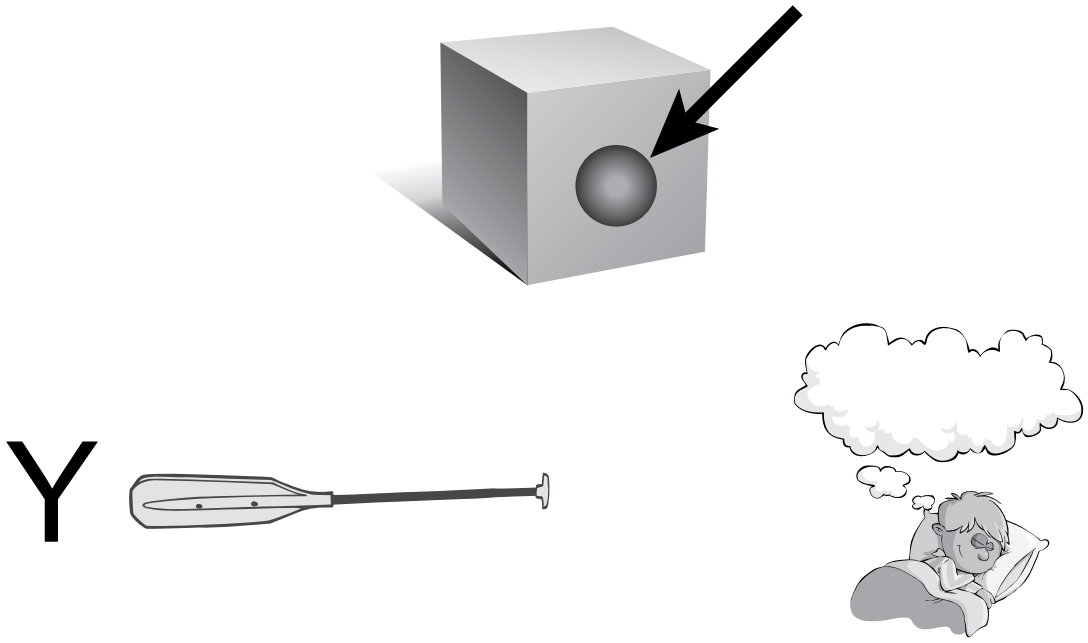
Participant Guide

References

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

Brainteaser

What phrase is represented below?



Riddle

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

Module Objectives

- **Define the TRICARE Prime Remote Options**
- **Identify who is eligible for Prime Remote**
- **Explain how Prime Remote enrollees access health care**
- **Describe the role of the Reserve and Service Member Support Office, Great Lakes (R&SMSO-GL) or TRICARE Overseas Program (TOP) Points of Contact (POCs)**

Key Terms

- **TRICARE Prime Remote (TPR)**
- **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)**
- **TRICARE Overseas Program (TOP) Prime Remote**
- **Reserve and Service Member Support Office, Great Lakes (R&SMSO-GL)**
- **TOP Point of Contact (POC) Program**

?	Throughout this module, you will answer scenario questions on active duty service member Corporal Williams and his wife.

1.0 TRICARE Options in Remote Locations

All Prime Remote options offer:

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

Sponsors must make sure their address, unit, and family member information is current and accurate in the Defense Eligibility Enrollment Reporting System (DEERS) so members and families enroll in the correct Prime Remote/Prime option. Remember, the services determine TRICARE eligibility and regional contractors process enrollments.

1.1 TRICARE Prime Remote (TPR)

TRICARE Prime Remote (TPR) is a stateside option for active duty service members (ADSMs) who live and work in TPR-designated ZIP codes (greater than 50 miles or one-hour drive time from a military treatment facility [MTF]). Like Prime, it covers health care from civilian network or TRICARE-authorized providers. All TRICARE-covered specialty services require referrals and authorizations.

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

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

1.3 TRICARE Overseas Program (TOP) Prime Remote

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

Note: Throughout this module, TPR, TPRADFM, and TOP Prime Remote are referred to as "Prime Remote" unless a particular option is named.

2.0 Prime Remote Eligibility

- ADSMs, Guard/Reserve members on active service for more than 30 consecutive days and showing as eligible in DEERS, eligible family members, and transitional survivors are eligible for Prime Remote options.
- The following aren't eligible for a Prime Remote option:
  - Retirees and their eligible family members, survivors, unremarried former spouses, and ADSMs and ADFMs during their Transitional Assistance Management Program (TAMP) period
  - ADFMs who live in Prime Remote locations, but don't live with the sponsor or aren't command sponsored
- Newborns and adoptees are eligible for TPRADFM/TOP Prime Remote as long as they meet Prime eligibility criteria. (See the *TRICARE Options* module for more information.)

Stateside (TPR/TPRADFM) Eligibility

TPR

- To qualify for TPR, ADSMs and eligible Guard/Reserve members must be permanently assigned to **and** reside at a location greater than 50 miles (based on ZIP code), or approximately a one-hour or more drive, from an MTF.
  - To see if they qualify for TPR, direct ADSMs to the *TPR ZIP Code Look-up Tool* at www.tricare.mil/tpr.
- If the active duty member lives within 50 miles of an MTF, but geographic conditions create more than a one-hour drive time, the ADSM may ask to enroll to a civilian network provider since his or her residency doesn't meet TPR requirements.
  - These ADSMs should review regional requirements and complete a *TRICARE Prime Remote (TPR) Determination of Eligibility Enrollment Request Form* and submit it through their unit commander for consideration by the TRICARE Regional Office (TRO). For information and the form, direct service members to the following websites:
    - North Region: www.tricare.mil/tronorth/eligibilityenrollmentform
    - South Region: www.tricare.mil/trosouth/eligibilityenrollmentform
    - West Region: www.tricare.mil/trowest/tprwaiverrequest

TPRADFM

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

    Note: In this case, the sponsor doesn't need to be enrolled in TPR for his/her family to enroll in TPRADFM.

Overseas (TOP Prime Remote) Eligibility

The following beneficiaries may qualify for TOP Prime Remote:

- ADSMs with a permanent duty assignment at a designated remote overseas location
- Guard/Reserve members who are on active service for more than 30 consecutive days and have a permanent duty assignment at a designated remote overseas location
- ADFMs or family members of activated Guard/Reserve members on permanent change of station orders and command sponsored to accompany the sponsor to the overseas location*
- ADFMs who are command sponsored or on service-funded orders to relocate to a remote overseas location without the sponsor
- Transitional survivors who live in TOP Prime Remote-designated locations
- Family members of activated Guard/Reserve members, as long as the family members lived with the Guard/Reserve member in a TOP Prime Remote location at the time of activation

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

?	Corporal Williams just transferred to a new duty station in a mountainous, rural area where caution must be used when driving. The nearest MTF is 45 miles away, but due to the terrain, it would take about an hour and a half to drive there. Are Corporal Williams and his wife eligible for TRICARE Prime Remote?

3.0 Enrollment

- When an ADSM or an activated Guard/Reserve member is eligible for TPR or TOP Prime Remote, enrollment is mandatory unless there are service-specific directions or if the ADSM waives access standards and asks to enroll in Prime at the closest MTF (subject to commander/TRO approval).
- Enrollment (Prime or Prime Remote) depends on the sponsor's work unit location, not where he/she lives (the residential address in DEERS).
- Enrollment is voluntary for ADFMs; they may enroll on an individual or family basis.
  - Eligible family members who live in designated Prime Remote locations but don't enroll are covered under TRICARE Standard/Extra.

3.0.1 Ongoing Stateside Enrollment

- If a TPR-enrolled sponsor receives unaccompanied assignment orders (where family members aren't authorized to go with the sponsor), the family members may remain enrolled in TPRADFM as long as they continue to live at the same TPR address they lived at before the sponsor's departure (as recorded in DEERS).
- Guard/Reserve family members may remain enrolled in TPRADFM at the same address as when the member was activated, no matter where the sponsor is assigned, enrolled, or temporarily living, as long as the sponsor remains on active duty.

3.0.2 Ongoing Overseas Enrollment

- When a TOP Prime Remote ADSM sponsor is assigned to a new location that doesn't permit command-sponsored family members, TOP Prime Remote enrolled family member(s) may remain enrolled as long as they don't move and they remain command sponsored.
  - **Note:** These family members may remain in TOP Prime Remote based on the length of the sponsor's unaccompanied orders, but for no more than two years. (The normal unaccompanied tour is less than 24 months.)

?	Corporal Williams' wife, Allison, is undecided about the options that TPR provides. Does she have other options?

3.1 Enrollment Processing

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

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

3.2 Lockouts and Disenrollment

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

4.0 Moving and Traveling with Prime Remote Options

- Prime Remote coverage may transfer upon change of assignment or duty location within or between regions, and between Prime Remote and Prime. Enrollees must meet required enrollment criteria (e.g., live and work more than 50 miles from an MTF, reside with their sponsor, command sponsorship).
- With permanent change of station assignments, ADSMs must transfer their enrollment to another Prime option and location (stateside or overseas), or follow Service guidance when they get to their new duty station.
- Enrollment transfers are effective the date the enrollment is completed and command-sponsored orders are received (overseas).
- When moving or traveling, Prime Remote enrollees follow the same rules and processes as TRICARE Prime and TOP Prime enrollees. (See the *TRICARE Options* module for more information on transferring TRICARE coverage when moving and receiving care while traveling.)

5.0 Primary Care Management

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

6.0 Role of Reserve and Service Member Support Office, Great Lakes (R&SMSO-GL) (Stateside)

- The R&SMSO-GL provides oversight of ADSM TPR enrollees with the Army, Navy, Marines, and Air Force. The Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration (NOAA) oversee their respective TPR enrollees.
- R&SMSO-GL authorizes ADSM TPR enrollee specialty care and assists as a liaison between remote ADSMs, service branches, and regional contractors.
- R&SMSO-GL reviews:
  - Referrals and medical claims to determine the impact on the ADSMs fitness-for-duty and whether the member needs to go to an MTF
  - Deferred medical claims from regional contractors and approves or denies payment
  - R&SMSO-GL questions may be directed to:
    - The Reserve and Service Member Support Office, Great Lakes, IL (1-888-647-6676)
    - www.tricare.mil/MMSO
    - Reserve and Service Member Support Office
      P.O. Box 886999
      Great Lakes, IL 60088-6999
    - United States Coast Guard: (757) 628-4379
    - United States Public Health Service (USPHS): 1-800-368-2777, option #2
    - National Oceanic and Atmospheric Administration (NOAA): 1-800-224-6622 (NOAA Commissioned Personnel Center)
- **Note:** BCACs/DCAOs, providers, and health care finders are encouraged to contact R&SMSO-GL for help with complex cases dealing with TPR-enrolled service members. (A partial listing in Appendix B of this module provides basic guidelines on the types of health care services that require fitness-for-duty review by R&SMSO-GL.)

7.0 Seeking Care, Referrals, and Authorization

Under the Prime Remote options, enrollees access routine, urgent, emergency, and specialty care services similar to Prime.

7.1 Routine Care

Routine care includes general office visits for preventive care, as well as for the treatment of symptoms, chronic or acute illnesses and diseases, and follow-up care for an ongoing medical condition.

Stateside Routine Care (TPR/TPRADFM)
● TPR/TPRADFM enrollees receive routine care from their assigned or chosen PCMs (if there are no network PCMs in the local area.)
Overseas Routine Care (TOP Prime Remote)
● Routine care is usually provided by a U.S. Embassy provider or clinic. If they can't provide the needed service, then care is coordinated through the overseas contractor's Regional or Country-specific Call Center. ● Enrollees should expect to receive a routine care appointment within seven days.

7.2 Urgent Care

Urgent care is generally defined as medically necessary treatment required for an illness or injury that wouldn't result in disability or death if not treated immediately. This kind of illness or injury requires professional attention and should be treated within 24 hours to avoid further complications.

Stateside Urgent Care (TPR/TPRADFM)
● TPR enrollees should contact their PCM, civilian primary care provider, or regional contractor for urgent care. ● If the PCM or primary care provider can't meet the urgent care need, the enrollee must get a referral from his or her provider, otherwise claims may be denied (ADSMs) or processed as a POS charge (ADFMs). The regional contractor issues the care authorization determination letter based on medical necessity and benefit review.   ○ The contractor forwards TPR-enrolled ADSMs' referrals to R&SMSO-GL for fitness-for-duty review and authorization determination. R&SMSO-GL may require TPR ADSMs to seek services from an MTF or may authorize the enrolled ADSM to seek services from a network or authorized provider.
Overseas Urgent Care (TOP Prime Remote)
● Urgent care is coordinated through the overseas contractor's Regional or Country-specific Call Centers. Enrollees should expect to receive an urgent care appointment within 24 hours.

7.3 Specialty Care

Specialty care is generally defined as care that a PCM isn't able to provide.

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

Stateside Specialty Care (TPR/TPRADFM)
TPR ● The regional contractor directs specialty care and inpatient referrals for TPR-enrolled **ADSMs** to R&SMSO-GL for fitness-for-duty and care authorizations. **TPRADFM** ● TPRADFM enrollees should only seek specialty care after getting an authorization to avoid POS charges.
Overseas Specialty Care (TOP Prime Remote)

● Enrollees coordinate specialty care through the overseas contractor's Regional or Country-specific Call Centers. Specialty care overseas includes diagnostic tests.
● Appointments are "cashless and claimless" if coordinated through the overseas contractor's call centers.
  ○ The TOP contractor forwards the authorization to the purchased care/host nation provider.
● Enrollees should expect to receive a specialty care appointment within 28 days.
  ○ For non-urgent specialty care appointments, enrollees may set up appointments for themselves, but should allow the overseas contractor at least 48 hours advanced notice to prepare the authorization.
● TOP Prime Remote enrollees who seek care without prior authorization may have to pay up front and file their own claims. POS charges apply to enrolled ADFMs; enrolled ADSMs' claims may be denied.

?	Corporal Williams enrolls in TPR. Not long after, his PCM discovers an irregular heartbeat and refers him to a specialist. Who should his PCM send the referral to? What do they do with it? Who provides care authorization details?

7.4 Emergency Care

Refers to medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition exists, the absence of medical attention would result in a threat to life, limb, or eyesight and requires immediate medical treatment, or the condition is so painful that sedative treatment is required to relieve suffering.

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

Stateside Emergency Care (TPR/TPRADFM)
● TPR-enrolled ADSMs should contact their PCM/primary care provider or the regional contractor as soon as possible after receiving emergency services. The member's provider or the member needs to get a referral to the regional contractor as soon as possible. R&SMSO-GL will do a referral review and make an authorization determination. Follow-up care needs to be managed through the usual referral and authorization process. ● TPRADFM enrollees must notify their PCM or primary care provider within 24 hours, or the next business day, to get a referral and authorization for emergency care and to coordinate ongoing care and services.
Overseas Emergency Care (TOP Prime Remote)
● Enrollees may contact the overseas contractor's Regional or Country-specific Call Center to find a purchased care/host nation emergency medical facility, if time permits. ○ Enrollees must notify the contractor of an emergency care visit within 24 hours, or the next business day, so that ongoing care can be coordinated and authorized. ○ Enrollees should provide the emergency medical facility's contact information to the contractor and/or a copy of the emergency room bill. ● For emergency care, ADSMs should also contact their parent service unit as soon as possible before, during, or after receiving care. ● If enrollees follow the process above, they likely won't pay out-of-pocket for TRICARE-covered services.

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

- The TOP Point of Contact (POC) Program is a liaison service for TOP Prime Remote enrollees that helps with enrollment, medical travel, and TRICARE claims processing.
  - TOP POCs are designated by various government agencies.
  - TOP POCs:
    - Assist with timely completion and filing of TOP claims forms
    - Secure and safeguard Protected Health Information (PHI), Personally Identifiable Information (PII), and Sensitive Information
    - Help ADSMs and TOP Prime Remote enrollees coordinate their return travel after medical evacuation or hospital discharge.
  - TRICARE Area Offices (TAOs) develop and distribute a region-specific POC Program booklet outlining specific POC duties and responsibilities. Each TAO office also develops and conducts area-specific POC training.
    - Questions about specific POC duties and responsibilities should be asked of TAO staff.

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

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

- When necessary medical care (including diagnostic services) isn't available in an overseas remote location, the overseas contractor contacts the TAO to begin coordination of medical care (travel and appointments) to the nearest MTF or purchased care/host nation medical facility. Part of the coordination involves determining medical necessity for the out-of-country appointment. When appropriate, the TAO may set up the appointment with a designated medical facility based on the availability of care and travel, as well as per diem costs.
  - ADSMs are required to have medical Temporary Additional Duty/Temporary Duty (TAD/TDY) orders and contact their respective POC for assistance with coordinating and receiving funding through their respective command or service. The ADSM's command or service funds his/her travel, per diem, and other associated costs.
- If TOP Prime Remote enrollees need specialty or diagnostic services (e.g., follow-up appointments, MRIs, CT scans) the enrollee or provider must contact the overseas contractor to set up a new referral/authorization. In some instances, multiple visits may be authorized in advance based on a proposed treatment plan.

9.2 Aeromedical Evacuation

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

9.2.1 Role of the TOP Contractor in Aeromedical Evacuation

- The TOP contractor's Regional Call Center arranges medically necessary aeromedical evacuations for the following beneficiaries:
  - TOP Prime Remote enrollees
  - ADSMs who are deployed, TAD/TDY, or in an authorized leave status overseas
  - Stateside Prime-enrolled ADSMs and ADFMs while traveling outside of the United States.
- The TOP contractor:
  - Determines medical necessity
  - Identifies the most appropriate method of evacuation
  - Schedules the evacuation
  - Authorizes the services needed
  - Arranges transfer of medical records
  - Coordinates patient transfers with the receiving health care provider or institution
  - Makes sure the ADSM's unit is aware of the medical evacuation

9.2.2 Role of POCs in Aeromedical Evacuations

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

9.2.3 Aeromedical Evacuations and Fund Sites

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

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

9.3 Care Onboard Commercial Seagoing Vessels

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

10.0 TOP Prime Remote Physical Exams (Overseas)

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

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

10.1 Fitness for Duty

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

10.2 Routine Physicals for ADSMs

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

10.3 Retirement Physicals

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

10.4 School Physicals for ADFMs

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

10.5 Sports and Other Physical Exclusions

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

11.0 Overseas Maternity Care

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

11.1 Getting Care

- If the enrollee's PCM is located at an MTF, the enrollee should receive maternity care from the MTF if it is available there.
- If the enrollee isn't near an MTF or care is unavailable, the enrollee's PCM will refer her to a host nation provider.
- TOP Prime Remote ADFMs may contact the TOP Regional Call Center for help finding a host nation provider.
- TOP Prime Remore ADFMs may also use the point-of-service option to self-refer to obstetricians; however, higher out-of-pocket costs apply.

11.2 Stork's Nest Program

- The Stork's Nest Program provides temporary housing to ADSM and ADFM maternity patients and those with high-risk conditions, allowing them to reside on or near a military hospital or clinic that offers obstetric services.
- Stork's Nest facilities are located at Landstuhl Regional Medical Center in Landstuhl, Germany, and the U.S. Naval Hospital in Okinawa, Japan.
- For more information about the Stork's Nest Program, enrollees should contact their Regional or Country-specific Call Center.

12.0 TRICARE and Non-Combatant Evacuation Operations (NEO)

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

13.0 TPR Application Exercises

First Lieutenant John Smith, an Army National Guard member, lives with his wife and two children in Brookline Station, Missouri, a TPR-designated location. He was called to active service for 365 consecutive days. Effective tomorrow, he reports to Fort Smith, Arkansas, for 15 days with a follow-on deployment to Afghanistan.

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

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

Q1. Is the Smith family eligible for TPRADFM during Lieutenant Smith's deployment?

Q2. Can Lieutenant Smith's family enroll in TPRADFM even if he is not enrolled in TPR?

Q3. How do you know whether they're eligible?

Module Objectives

- **Define the TRICARE Prime Remote Options**
- **Identify who is eligible for Prime Remote**
- **Explain how Prime Remote enrollees access health care**
- **Describe the role of the Reserve and Service Member Support Office, Great Lakes (R&SMSO-GL) or TRICARE Overseas Program (TOP) Points of Contact (POCs)**

Key Terms

- **TRICARE Prime Remote (TPR)**
- **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)**
- **TRICARE Overseas Program (TOP) Prime Remote**
- **Reserve and Service Member Support Office, Great Lakes (R&SMSO-GL)**
- **TOP Point of Contact (POC) Program**

Appendix A: Medical Matrix Homework

Medical Benefit Program Matrix Homework Instructions

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

	Prime			Prime Remote			Standard/Extra		
	ADSM	ADFM	Retired	ADSM	ADFM	Retired	ADSM	ADFM	Retired
Available to Beneficiary Type									
Enrollment Required									
Enrollment fee									
PCM assigned									
Deductible									
Copays									
Civilian Outpatient Cost-Shares									
Civilian Inpatient Cost-Shares									
Civilian Inpatient Mental Health Costs									
Catastrophic Cap									
Who Files Claims (Beneficiary or Provider)									
MTF Access									
Portable									
Available Overseas									
Command Sponsorship Req'd Overseas									
Advantages									

Appendix B: Active Duty Care Guidelines

The following is a partial list of guidelines for providers and the contractors as to the types of health care services that require a fitness-for-duty review by the R&SMSO-GL.

For a sampling of additional treatment situations that require R&SMSO-GL review, please see the *2008 TRICARE Operations Manual*, Chapter 16, Addendum B.

For additional information on the R&SMSO-GL review process, visit the R&SMSO website at www.tricare.mil/mmso.

Health Care Service	R&SMSO-GL Review Required?	Who Provides Care?
Primary care medical services	No	PCM (TRICARE-authorized civilian provider or MTF)
Emergency/urgent consults and tests required within 48 hours	Yes, but care won't be delayed while waiting for R&SMSO-GL response	TRICARE-authorized civilian provider
	Follow-up specialty care requires R&SMSO-GL review	
Periodic health assessments	No	PCM (TRICARE-authorized civilian provider) or MTF
Periodic eye and hearing exams	No	TRICARE-authorized civilian provider or MTF
Eyeglasses/contacts	Yes	MTF or service labs; R&SMSO-GL provides information to ADSM
Service specific physical exams (for DoD/Service forms)	Yes	TRICARE-authorized civilian provider or MTF as designated by R&SMSO-GL
Mental health counseling, psychiatric care and testing	Yes	TRICARE-authorized civilian provider or MTF
Drug, alcohol, and follow-on care for substance abuse	Yes	TRICARE-authorized civilian provider or MTF
Inpatient care	Yes	TRICARE-authorized civilian provider

Appendix C: TOP Prime Remote Resources

Eurasia-Africa	Latin America and Canada	Pacific
Africa, Europe, and the Middle East	Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands	Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries
TOP Regional Call Center 1-877-678-1207 (stateside) +44-20-8762-8384 (overseas) tricarelon@internationalsos.com Medical Assistance: +44-20-8762-8133	**TOP Regional Call Center** 1-877-451-8659 (stateside) 1-215-942-8393 (overseas) tricarephl@internationalsos.com Medical Assistance: 1-215-942-8320	**TOP Regional Call Centers** Singapore: 1-877-678-1208 (stateside) +65-6339-2676 (overseas) sin.tricare@internationalsos.com Sydney: 1-877-678-1209 (stateside) +61-2-9273-2710 (overseas) sydtricare@internationalsos.com Medical Assistance: Singapore: +65-6338-9277 Sydney:+61-2-9273-2760
TRICARE Area Office Toll Free Phone (Stateside): 1-888-777-8343, opt. #1 Commercial Phone: 0049-6371-9464-2999 DSN: 1-314-590-2999 Commercial Fax: +49-(0)6302-67-6378 DSN Fax: 1- 314-496-6378 E-mail: tma.sembach.medcom-ermc.mbx.teoweb-tao-ea@mail.mil Web: www.tricare.mil/eurasiaafrica Address: TAO-Eurasia-Africa Unit 10310 APO AE 09136-0130	**TRICARE Area Office** Toll Free Phone (Stateside): 1-888-777-8343, opt. #3 Commercial Phone: +1-210-292-8520 DSN: 94-554-8520 Commercial Fax: +1-210-292-3224 E-mail: taolac@tma.osd.mil Web: www.tricare.mil/tlac Address: TAO-Latin America & Canada 7800 IH-10 West, Suite 400 San Antonio, TX 78230	**TRICARE Area Office** Toll Free Phone (Stateside): 1-877-678-1208, opt #4 1-877-678-1209, opt #4 Commercial Phone: + 81-98-970-9155 DSN: 315-643-2036 Commercial Fax: +81-6117-43-2037 DSN Fax: 315-643-2037 E-mail: tpao.csc@med.navy.mil Web: www.tricare.mil/pacific Address: TAO-Pacific NH Okinawa PSC 482, Box 2749 FPO AP 96362
Overseas Claims Information		
All Overseas Active Duty Claims TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 1-608-301-2311, opt 2		
All Other Claims (Separated by Region)		
TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 1-608-301-2310, opt. #2	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-608-301-2311, opt. #2	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-608-301-2311, opt #2
Website: www.tricare-overseas.com		

TRICARE Fundamentals Course

Transitional Benefits

4

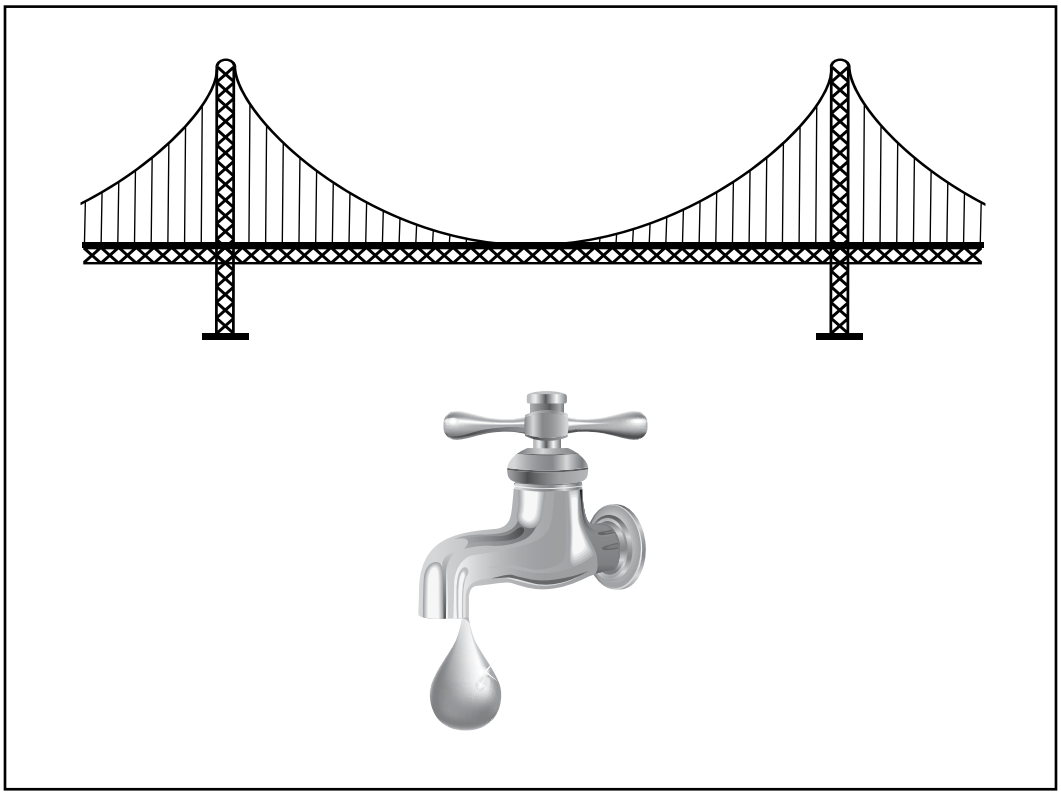
Participant Guide

References

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

Brainteaser

What phrase is represented below?



Riddle

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

Module Objectives

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

Key Terms

- **Transitional Assistance Management Program (TAMP)**
- **Transitional Care for Service-Related Conditions (TCSRC)**
- **Continued Health Care Benefit Program (CHCBP)**
- **Certificate of Creditable Coverage**

?	Throughout this module, you will answer scenario questions on former active duty service member Sergeant McDonald and his family.

1.0 TRICARE Transitional Health Care Coverage

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

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

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

2.0 Transitional Assistance Management Program (TAMP)

The Transitional Assistance Management Program (TAMP) provides 180 days of transitional health care coverage for certain members of the uniformed services and their families, based on the sponsor's eligibility.

2.1 TAMP Eligibility

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

2.1.1 Eligibility for Service Members

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

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

Note: Those who are involuntarily separated or any service members who believe they may be eligible for TAMP should check with their service personnel community to see if they qualify for TAMP benefits.

2.2 Health Care Coverage During TAMP

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

?	Sergeant McDonald recently separated from active duty after volunteering to stay on active duty for six months in support of Operation Enduring Freedom. Is he TAMP eligible? If so, for how many days does he have coverage? Will he be Prime since he was an ADSM?

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

- The following guidelines apply to TAMP eligibles who enroll in TRICARE Prime, TOP Prime, or USFHP after the sponsor separates.

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

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

?	Before Sergeant McDonald's separation from active duty, he and his family were enrolled in TRICARE Prime and would like to continue their enrollment. Are they still eligible for Prime under TAMP? If so, what do they have to do to avoid a break in coverage?

2.3 Dental Coverage During TAMP

- During TAMP, former ADSMs may receive dental care at dental treatment facilities on a space-available basis.
  - Once a member separates from active service, his or her family members are no longer eligible for the TRICARE Dental Program (TDP) and should receive a disenrollment letter, effective the date of the sponsor's separation.
- Guard/Reserve members who were on active service for more than 30 consecutive days in support of a contingency operation and show as TAMP eligible in DEERS continue active duty dental benefits.
  - They may receive care at a uniformed services dental treatment facility (DTF) or from civilian dental providers (no matter how close they live to a DTF) through the Active Duty Dental Program (ADDP).
  - All orthodontics, implants, and certain complex treatments received through the ADDP must have prior authorization and be able to be completed within the TAMP period.
  - This coverage is limited to the sponsor only and doesn't apply to family members.
- See the *Dental* module for more information.

2.4 Claims

During TAMP, the sponsor's status is neither active duty nor retiree, so claims for those covered under TAMP, including the former active duty member, process as active duty family member claims; active duty family member deductibles, copays, and cost-shares apply. When TAMP beneficiaries have other health insurance (OHI), TRICARE pays after the OHI.

2.5 TAMP Application Exercises

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

Q2. Lieutenant Karen Anderson is an active duty navy officer, and is pregnant. She separates from active duty this month. Is she eligible for TAMP upon separation? Explain.

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

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

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

3.0 Transitional Care for Service-Related Conditions (TCSRC)

The Transitional Care for Service-Related Conditions (TCSRC) benefit provides extended transitional health care coverage to certain former active service members with certain service-related conditions.

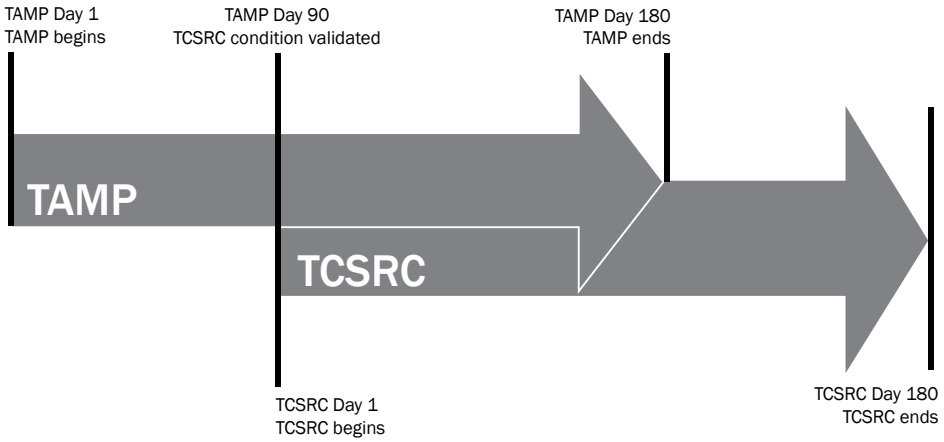
3.1 Eligibility

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

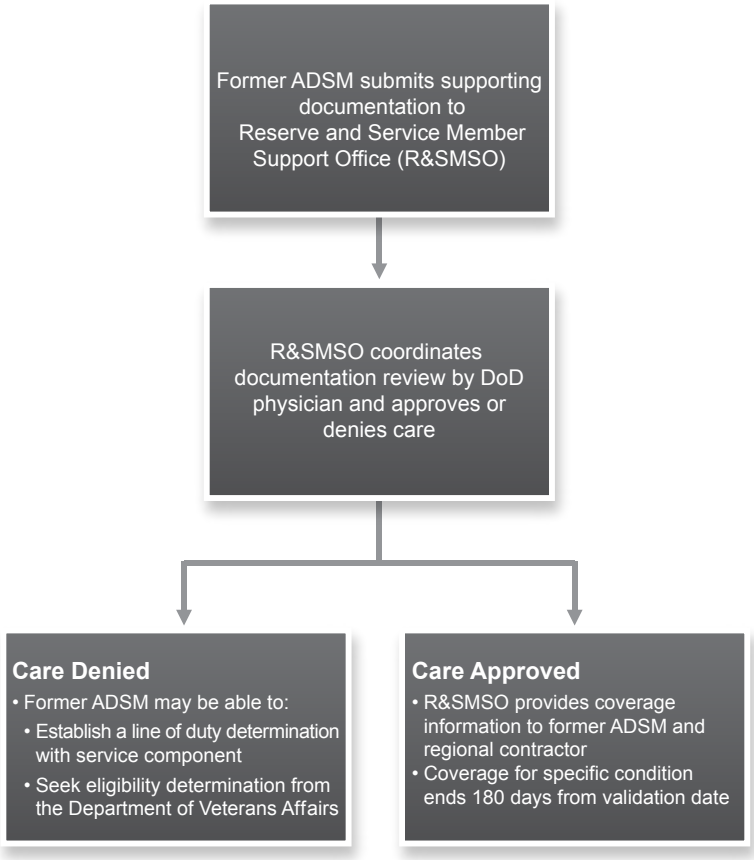
Note: If a former ADSM has a service-related condition that can't be resolved within the 180-day TCSRC period and can't be approved for the TCSRC benefit, he or she may be eligible to receive medical care for this condition through the Department of Veteran's Affairs (VA). The VA determines eligibility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

3.2 TCSRC Example

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



3.3 TCSRC Process



?	A month into Sergeant McDonald's TAMP coverage, he begins experiencing extreme soreness in his right shoulder, which is diagnosed as ligament damage. Aware of the Sergeant's active duty history, his family physician suspects the condition is related to his service. Is Sergeant McDonald eligible for the TCSRC benefit? If so, what does Sergeant McDonald need to do to be covered under the TCSRC benefit?

4.0 Continued Health Care Benefit Program (CHCBP)

The Continued Health Care Benefit Program (CHCBP) is a premium-based program that offers temporary transitional health coverage after uniformed service health care benefits end.

- CHCBP uses existing TRICARE-authorized providers and follows TRICARE Standard rules and procedures. CHCBP enrollees aren't eligible for Prime.
  - When using TRICARE network providers, CHCBP enrollees' cost-shares are reduced (similar to TRICARE Extra).
  - Emergency care is the only service that CHCBP enrollees may receive from an MTF, and also aren't eligible to use MTF pharmacies.
- Health care is limited to TRICARE-covered services.
- All CHCBP questions, regardless of region, should be addressed to the CHCBP contractor at 1-800-403-3950. (See the *Resources and Tools* Section for more information).

4.1 CHCBP Eligibility

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

- Former ADSMs and their family members
- Certain former active duty Guard/Reserve members and their family members
- Certain unremarried former spouses
- Children who lose eligibility due to age
- Certain unmarried children by adoption or legal custody (i.e., non-biological children)

4.2 CHCBP Coverage

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

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

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

4.3 CHCBP Enrollment Requirements

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

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

?	Following the expiration of Sergeant McDonald's TAMP coverage, he and his wife enroll in CHCBP. How is the coverage different than when they were enrolled in Prime during TAMP? How long does their CHCBP coverage last?

4.4 CHCBP Premiums

- The enrollment application must include a premium payment for the first quarter.
- Quarterly premiums are subject to change on an annual basis. The CHCBP contractor bills beneficiaries quarterly until their CHCBP coverage period ends.
- Visit www.tricare.mil/chcbp for the most recent premium rates.

4.5 CHCBP Claims Processing

- TRICARE-authorized providers may file for enrollees, but aren't required to. CHCBP enrollees are responsible for making sure all claims, including provider and pharmacy claims, are filed within one year from the date of service stateside (including U.S. territories) or within three years from the date of service overseas.
- To file a claim, the enrollee must submit:
  - A *TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment* (DD Form 2642)
  - The provider's bill
  - A copy of their CHCBP enrollment card
- Mail all CHCBP claims to:

TRICARE South Region
Claims Department
PGBA, LLC
P.O. Box 7031
Camden, SC 29020-7031

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

5.0 Certificate of Creditable Coverage

- A <u>certificate of creditable coverage</u> is a document that reflects proof of prior health care coverage.
- It's used to reduce the time a civilian health care plan may keep an individual from getting coverage for a pre-existing condition.
  - Pre-existing conditions are medical conditions that exist at the time an individual applies for health insurance coverage..
- See *Appendix A* of this module for a sample certificate of creditable coverage.

5.1 Eligibility

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

5.2 Additional Details

- The certificate reflects each period of continuous TRICARE coverage for 24 months before the individual lost eligibility.
- Each certificate identifies the name of the sponsor or family member it is issued to, the dates TRICARE coverage began and ended, and the certificate issue date.

5.3 Requests for Certificate of Creditable Coverage

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

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

- For more information on certificates of creditable coverage, visit www.tricare.mil/certificate.

Module Objectives

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

Key Terms

- **Transitional Assistance Management Program (TAMP)**
- **Transitional Care for Service-Related Conditions (TCSRC)**
- **Continued Health Care Benefit Program (CHCBP)**
- **Certificate of Creditable Coverage**

Appendix A: Sample Certificate of Creditable Coverage

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

COCC

Case Number: xxxxxxxx

NAME
ADDRESS
ADDRESS

Certificate of Creditable Coverage

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

1. Date of this certificate: Date

2. Participant (Sponsor) name: Name

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

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

   Name

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

6. Date coverage began: Date

7. Date coverage ended: Date

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

TRICARE Fundamentals Course

Pharmacy

5

Participant Guide

References

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

Brainteaser

Each of the eight items below is a separate puzzle.

How many can you figure out?

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

1.Toolbox_____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

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

Key Terms

- **Uniform Formulary**
- **Basic Core Formulary**
- **Pharmacy Home Delivery**
- **Network Retail Pharmacy**
- **Non-Network Retail Pharmacy**

1.0 Pharmacy Benefits

- The TRICARE Pharmacy Benefits Program cost-shares on prescription medications that:
  - Are approved for marketing by the U.S. Food and Drug Administration (FDA)
  - By U.S. law, require a prescription that must be signed by a U.S.-licensed provider, acting within the scope of his or her authorization
  - Are ordered and prescribed in accordance with state and federal law

Note: Benefit doesn't include non-traditional medications

- The TRICARE Pharmacy Benefits Program offers services through:
  - Military Treatment Facility (MTF) pharmacies
  - TRICARE Pharmacy Home Delivery (including specialty services)
    - Restrictions apply for home delivery outside of the United States and U.S. territories (See Section 5.1 of this module for details.)
  - TRICARE network retail pharmacies (stateside and U.S. territories)
  - Non-network retail pharmacies
    - Overseas: host nation pharmacies are considered non-network pharmacies. Beneficiaries are responsible for the total cost of pharmacy services up front and must file a claim for reimbursement.

?	Throughout this module, you will answer scenario questions on Tech Sergeant Michelle Clarkson.

2.0 TRICARE Uniform Formulary

2.1 Uniform Formulary

- The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee's Uniform Formulary process determines and lists which medications are covered, when they're covered, and if there are specific rules for certain medications.
- The DoD P&T Committee can also make recommendations for the Basic Core Formulary.
  - The Basic Core Formulary is a list of medications from the TRICARE Uniform Formulary that all full-service MTFs must carry.
- The Uniform Formulary process studies the clinical and cost aspects of drugs within established drug classes, then places medications in one of three cost tiers:
  - Tier 1: Generic Formulary
  - Tier 2: Brand-Name Formulary
  - Tier 3: Non-Formulary
- The DoD directs prescriptions be filled with a generic medication if one is available. Active duty service members (ADSMs) can't fill prescriptions for non-formulary medications unless their provider establishes medical necessity.
  - If a brand-name medication has a generic version, the brand-name medication may only be dispensed if a provider establishes medical necessity (brand-name copays apply). If medical necessity isn't established, the beneficiary pays the full cost for the brand-name medication.

2.1.1 Uniform Formulary Limits and Prior Authorization

- TRICARE has quantity limits on certain medications, meaning TRICARE only issues and pays for a specific amount of medication.
- Certain medications require prior authorization, meaning the provider has to justify its use before TRICARE can give a beneficiary the medication.
- TRICARE won't pay for medications used to treat conditions that aren't covered by TRICARE or aren't in the formulary due to federal regulations (e.g., food supplements, drugs for cosmetic purposes).

?	TSgt Clarkson is an active duty service member who was recently placed on a medication that is FDA approved to treat high cholesterol. Her physician wrote the prescription for a brand-name medication. Does this mean TSgt Clarkson will receive the brand-name medication? What determines if she gets a brand-name or generic medication?

2.2 TRICARE Formulary Search Tool

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

3.0 Eligibility

The TRICARE Pharmacy Benefits Program is available to:

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

Note: Beneficiaries don't have to enroll to use the pharmacy benefit. Eligibility is verified through DEERS.

?	After being on the medication for six months, TSgt Clarkson gets married, and her spouse becomes eligible for TRICARE as an active duty family member. He also needs a monthly maintenance medication. When is he eligible for TRICARE pharmacy benefits?

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

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

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

4.0 Military Treatment Facility (MTF) Pharmacy

- Each MTF has to stock the medications listed on the Basic Core Formulary.
  - Non-formulary drugs generally aren't available at MTFs. Based on the level and type of care the MTF provides and the beneficiary population it serves, an MTF may add certain drugs to its local formulary.
- MTFs fill most prescriptions with a 90-day supply (exceptions may include controlled substances/narcotics).
- MTFs can fill prescriptions written by licensed civilian providers if the MTF carries the medication.
- Prescriptions are filled at no cost to the beneficiary.
- CHCBP beneficiaries **can't** get prescriptions filled at MTFs. They must use TRICARE Pharmacy Home Delivery, network retail pharmacies, and non-network retail pharmacies.

Note: MTFs may identify a beneficiary as showing "drug-seeking behavior" and may choose to limit how and where he/she gets prescriptions filled. This work is done with the provider, nurse case manager, and pharmacy contractor.

?	TSgt Clarkson and her husband live in a Prime Service Area, ten miles from an MTF pharmacy. Recently, TSgt Clarkson's PCM referred her to a civilian provider, who gave her a new prescription. Can the MTF fill this prescription? How much does TSgt Clarkson pay out of pocket to have this prescription filled at the MTF?

5.0 TRICARE Pharmacy Home Delivery

- The TRICARE Pharmacy Home Delivery option is a cost-effective and convenient way for beneficiaries to get refills of prescription medications that they take regularly.
- Beneficiaries may also have specialty medications filled through home delivery if the medication is on the formulary.
  - Specialty medications are usually high-cost, self-administered, injectable, or oral medications that treat serious chronic conditions.

5.1 Pharmacy Home Delivery—Overseas

- There are unique restrictions for home delivery overseas (not including U.S. territories); prescription medications are subject to local customs and policies.
  - Outside of the United States and U.S. territories, home delivery is only available to registered beneficiaries with Army Post Office (APO), Fleet Post Office (FPO), or Diplomatic Post Office (DPO) addresses.
  - Due to German law, which prohibits the shipment of prescription medications through the postal service, home delivery isn't available in Germany (even to APO/FPO/DPO addresses).
  - Refrigerated medications can't be shipped to APO/FPO/DPO addresses.
  - Prescriptions must be written by U.S.-licensed providers.
- Beneficiaries can update their APO/FPO/DPO and e-mail addresses online at www.express-scripts.com/TRICARE or www.dmdc.osd.mil/appj/bwe.

5.2 Opening a Pharmacy Home Delivery Account

- To use home delivery, beneficiaries must register for an online account. Families must create separate accounts for each family member.
- Beneficiaries can register via one of the following options:
  - Online: www.express-scripts.com/TRICARE
  - Phone: Stateside call toll-free: 1-877-363-1303 (for overseas, see Appendix B of this module)
  - Telecommunications Device for the Deaf (TDD): 1-877-540-6261
  - Mail: Download the registration form on www.express-scripts.com/TRICARE and mail it to:

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

5.3 Using Home Delivery

- Beneficiaries can fill or refill home delivery prescriptions by mail, fax, phone, or online.
  - By law, **new** prescriptions can only be submitted by mail or through a provider's fax or e-prescribing system.
    - Faxed prescriptions (new or changes) must be faxed directly from a provider's office to the pharmacy contractor.
  - Prescriptions for controlled substances must be sent by mail.
- A 90-day supply and three refills are available for most medications.
  - Certain medications, such as controlled substances (a prescription medication identified by the Drug Enforcement Agency as having a potential for abuse), may have a 30-day or other limit based on federal law or TRICARE quantity limits.
- Registered users have online access to account and general prescription drug information.
  - Registered users mail their provider's written prescription(s) and pay their copayments (by check or credit card) to the pharmacy contractor. The following must be noted on each new prescription:
    - Patient's full name, date of birth, address, and sponsor's identification (ID) number (sponsor's Social Security number or DoD Benefits Number may be used)
    - Prescriber's name, address, phone number, license, and Drug Enforcement Agency (DEA) number
    - Prescriber's handwritten signature
- Once the prescription processes (usually within 10–14 days), the contractor sends medications directly to the beneficiary.
- The contractor recommends beneficiaries have a 30-day supply on hand while they set up their home delivery account.
- Beneficiaries may then use the auto-refill option or request refills based on the refill date on the medication label.
- Beneficiaries can switch their retail or MTF prescriptions to home delivery by going online or by contacting the pharmacy contractor.
- Deployed service members may get medications mailed overseas through the Overseas Deployment Prescription Program. (See Appendix A of this module for more information.)

6.0 Network Retail Pharmacy

6.1 Network Retail Pharmacy

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

6.2 Using Network Retail Pharmacies

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

7.0 Non-Network Retail Pharmacy

- A non-network retail pharmacy doesn't agree to be part of the TRICARE retail pharmacy network.
- Advise stateside Prime enrollees that using a non-network retail pharmacy results in point-of-service (POS) charges, with higher out-of-pocket costs. (See Section 8.1 of this module for information on pharmacy costs.)
- When using a non-network retail pharmacy, beneficiaries, including ADSMs, pay the total cost up front and file claims for reimbursement (less their cost-shares, deductibles, or copays). (See Section 11.0 of this module for claims filing information.)

7.1 TRICARE Pharmacy Services in the Philippines

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

8.0 Pharmacy Program Cost Overview

8.1 Stateside and U.S. Territories

- By law, annual changes in pharmacy copays are based on retiree cost-of-living adjustments (COLAs), and so are subject to change the beginning of each calendar year. Current costs are as follows:

	Formulary Medication		Non-Formulary Medication
	Generic	Brand Name	
MTF (up to a 90-day supply)	$0	$0	Not Applicable (generally not available at MTFs)
Home Delivery* (up to a 90-day supply)	$0	$13	$43
Network Retail Pharmacy* (up to a 30-day supply)	$5	$17	$44
Non-Network Retail Pharmacy* (up to a 30-day supply)	TRICARE Prime options: 50% cost-share after the POS deductible is met ($300 single/$600 family) All other beneficiaries: $17 or 20% of the total cost, whichever is greater, after the annual outpatient deductible is met		TRICARE Prime options: 50% cost-share after the POS deductible is met ($300 single/$600 family) All other beneficiaries: $44 or 20% of the total cost, whichever is greater, after annual outpatient deductible is met

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

Note: Copayments apply to the beneficiary's deductible and catastrophic cap.

8.2 Overseas

- Overseas beneficiaries receiving prescriptions through home delivery pay the same copays as stateside beneficiaries.
- Beneficiaries filling prescriptions at overseas host nation pharmacies file claims with the overseas contractor.
  - TOP Prime/TOP Prime Remote enrollees are reimbursed 100% of billed charges.
  - TOP Standard ADFMs and TRS members pay a 20% cost-share after meeting their annual deductible.
  - All others using TOP Standard or TRR pay a 25% cost-share after meeting their annual deductible.

?	A year after her marriage, TSgt Clarkson receives orders to a non-Prime Service Area. She now lives too far away from an MTF to get her prescriptions filled there. She knows she has other options though, and is trying to decide if she should sign up for home delivery or use her local network retail pharmacy. TSgt Clarkson is admittedly forgetful when it comes to ordering her refills. Which of these two options would be better for her? How do the costs differ?

9.0 TRICARE and Medicare Part D

- TRICARE for Life (TFL) beneficiaries are covered under the TRICARE Pharmacy Benefits Program. Requirements and costs are based on how and where prescription services are received (i.e., MTF, home delivery, retail, non-network; stateside/U.S. territories or overseas).
- Beginning March 2014 TRICARE is conducting a pilot program for mandatory one-year use of the Home Delivery pharmacy program for TFL beneficiaries
  - This program applies to TFL beneficiaries who refill brand-name, “maintenance” medications at a retail pharmacy.
  - After a mandatory one-year period, affected beneficiaries have the option to leave the program or to continue using the Home Delivery option.
  - Please visit http://www.express-scripts.com/TRICARE/ for more information.
- Medicare has a prescription drug option referred to as Medicare Part D. It is only available in the United States and U.S. territories.
  - **Note:** Medicare eligible beneficiaries don’t have to purchase Medicare Part D to have prescription drug coverage under the TRICARE Pharmacy Benefits Program. TRICARE is considered creditable coverage (i.e., equal to) Medicare Part D coverage for Medicare purposes.
  - If a TFL beneficiary shows in DEERS as having Medicare Part D but says that he or she isn’t enrolled or disenrolled, the beneficiary should contact the DEERS support office to get their record corrected.
    - Phone: 1-800-538-9552 (worldwide) or 1-866-363-2883 (TTY/TDD)
    - In person: To find a DEERS office, visit www.dmdc.osd.mil/rsl
- TFL beneficiaries who live overseas should contact the overseas contractor with pharmacy-related questions. Overseas contact information is available in Appendix B of this module.

10.0 Pharmacy Benefits with Other Health Insurance (OHI)

- For beneficiaries with OHI and TRICARE pharmacy coverage, federal law requires the OHI be the primary payer. TRICARE is second payer.
  - Between the two, most medication costs are covered.
- TRICARE is the primary payer for TRICARE-covered medications when the beneficiary's OHI doesn't cover the medication or the beneficiary reaches the OHI plan's pharmacy benefit cap—meaning the OHI no longer pays prescription medication costs.
- Those with OHI prescription coverage can't use TRICARE's home delivery, unless:
  - The medication isn't covered under the OHI; or
  - The beneficiary reached his/her OHI dollar coverage limit for the current year
- Beneficiaries must show both their OHI and uniformed services ID cards at retail pharmacies.
- Beneficiaries use their OHI's home delivery or retail pharmacy benefit, pay the OHI's copayment, and then submit claims to the TRICARE pharmacy or overseas contractor for reimbursement.
- Stateside beneficiaries with OHI should go to a pharmacy that's in both their OHI's and TRICARE's network. (If they don't, they may have to pay non-network retail pharmacy cost-shares or POS charges if enrolled in TRICARE Prime).
- Many TRICARE network retail pharmacies can coordinate benefits electronically, which allows the pharmacy to process the OHI's and TRICARE's payment before the beneficiary leaves the pharmacy. This is how it works:
  - The beneficiary goes to a pharmacy that accepts their OHI and is also a TRICARE network retail pharmacy.
  - The beneficiary shows proof of OHI and TRICARE (OHI card and uniformed services ID card).
  - The pharmacy submits the claim to the OHI.
  - The pharmacy then submits a second transaction to TRICARE.
  - TRICARE's claims system reviews the unpaid portion of the claim and pays up to the TRICARE-allowable amount.
  - The beneficiary pays any remaining costs after both plans process the claim.

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

11.0 Pharmacy Claims

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

Note: Billing statements showing only total charges, canceled checks, or cash register and similar types of receipts can't be accepted unless the receipt has the detailed information listed above. Beneficiaries with OHI must include a copy of the Explanation of Benefits (EOB) from their OHI.

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

Note: TRICARE will reimburse for prescriptions filled at U.S. Embassy clinics. The beneficiary pays out-of-pocket and then files a claim.

11.1 Appealing a Denied Claim

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

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

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

Module Objectives

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

Key Terms

- **Uniform Formulary**
- **Basic Core Formulary**
- **Pharmacy Home Delivery**
- **Network Retail Pharmacy**
- **Non-Network Retail Pharmacy**

Appendix A: Home Delivery and the Overseas Deployment Prescription Program

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

DHA Pharmacy Operations Center	
Phone	1-866-275-4732 (stateside or overseas) or 1-210-221-8274
DSN:	312-471-8274
E-mail:	pdts.ameddcs@amedd.army.mil

Appendix B: Pharmacy Contact Information

Pharmacy Benefit Contractor Contact Information for Home Delivery and Retail (Stateside and U.S. Territories)	
General Correspondence in the U.S.	**Phone:** 1-877-363-1303 **Online:** www.express-scripts.com/tricare **Mail:** Express Scripts, Inc. PO Box 52150 Phoenix, AZ 85072
Contact information for locations outside of the U.S.	Dial the in-country access code listed below **Germany:** 00+800-3631-3030 **Italy:** 00+800-3631-3030 **Japan—IDC:** 0061+800-3631-3030 **Japan—Japan Telecom:** 0041+800-3631-3030 **Japan—KDD:** 010+800-3631-3030 **Japan—Other:** 0033+800-3631-3030 **South Korea:** 002+800-3631-3030 **Turkey:** 0811-288-0001 (once prompted, input 877-363-1303) **United Kingdom:** 00+800-3631-3030 **Note:** Beneficiaries residing overseas located in areas outside of these six countries should call 1-866-ASK-4PEC/1-866-275-4732
Pharmacy Operations Center	**Phone:** 1-866-ASK-4PEC (1-866-275-4732) **Online:** www.pec.ha.osd.mil
Pharmacy Claim Filing Information	**Phone:** 1-877-363-1303 **Online:** www.tricare.mil/pharmacy/claims
TDD (Toll free)	1-877-540-6261
E-mail	DOD.customer.relations@express-scripts.com

Pharmacy Claims Contact Information	
United States and U.S. Territories	**Overseas Areas, Excluding U.S. Territories**
Express Scripts, Inc. P.O. Box 52132 Phoenix, AZ 85082 1-877-363-1303 www.express-scripts.com/TRICARE	**Active Duty Service Members** TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 Eurasia-Africa: 1-877-678-1207, opt 2 Latin America and Canada: 1-877-451-8659, opt 2 Pacific: 1-877-678-1208, opt 2 (Singapore) 1-877-678-1209, opt 2 (Sydney) www.tricare-overseas.com/beneficiaries.htm
	All Other Beneficiaries—Eurasia-Africa TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 1-877-678-1207, opt 2 www.tricare-overseas.com/beneficiaries.htm
	All Other Beneficiaries—Latin America and Canada TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-877-451-8659, opt 2 www.tricare-overseas.com/beneficiaries.htm
	All Other Beneficiaries—Pacific TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 Singapore: 1-877-678-1208, opt 2 Sydney: 1-877-678-1209, opt 2 www.tricare-overseas.com/beneficiaries.htm

TRICARE Fundamentals Course

Dental

6

Participant Guide

References

10 USC
32 CFR §§ 199.13, 199.22
2008 TRICARE Operations Manual, Chapter 24, Section 10; Chapter 16, Addendum B
TRICARE Dental Program Benefit Booklet
www.trdp.org
www.addp-ucci.com
www.tricare.mil/tdp

Brainteasers

What phrase is represented below?

YGOLOHCYSP

Riddle

What can run, but not walk?

Module Objectives

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

Key Terms

- **Dental Treatment Facility (DTF)**
- **Active Duty Dental Program (ADDP)**
- **TRICARE Dental Program (TDP)**
- **TRICARE Retiree Dental Program (TRDP)**

1.0 Introduction

TRICARE covers dental care provided through three distinct channels:

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

?	Throughout this module, you will answer scenario questions on Chief Petty Officer Gorman and his family.

2.0 Active Duty Dental Care

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

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

2.1 Active Duty Dental Care Eligibility

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

2.1.1 Active Duty Dental Program (ADDP)

ADDP covers all eligible service members living stateside or in U.S. territories, which includes:

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

2.1.2 Overseas Active Duty Dental Care

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

2.2 Dentists

ADDP- Stateside and U.S. Territories	Overseas
● ADSMs are required to use a network dentist ○ If a network dentist isn't available, the ADSM or the DTF must contact the ADDP contractor to receive authorization to use a non-network dentist. Otherwise, the ADSM may pay for all services received. ● A list of network dentists is available: ○ Online: www.addp-ucci.com ○ Phone: 1-866-984-2337/ADDP ○ E-mail: addpdcf@ucci.com	● ADSMs are required to use host nation dental providers; appointments must be coordinated through the overseas regional contractor. ● For assistance and appointment coordination, ADSMs should contact their Regional or Country-specific Call Center. Contact information can be found at www.tricare-overseas.com.

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

DTF-referred care authorizes ADSMs to receive care from a civilian dentist when the DTF can't provide the care.

2.3.1 ADSM Dental Emergencies

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

2.3.2 DTF Referrals to a Civilian Dentist

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

2.3.3 Managing DTF-Referred Care Under the ADDP

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

2.3.4 Cancelled and Missed Appointments Under the ADDP

- ADSMs should cancel civilian dentist appointments as soon as possible or within 24 hours of the appointment.
- ADSMs must notify the ADDP contractor of missed/cancelled appointments and of the need to reschedule. The ADSM should also inform the ADDP contractor if the civilian dentist bills them for the missed appointment.

2.4 Dental Care for Active Duty in Remote Locations

- Remote active duty dental care is handled by:
  - The ADDP contractor through the R-ADDP (stateside and U.S. territories)
  - The overseas contractor (who also works with the ADSM to schedule dental appointments)
- ADSMs in remote locations must have civilian dentists complete and submit an authorization request form listing the treatment(s) that match the following procedure and cost criteria:
  - Dental care greater than $750 per procedure or appointment stateside and in U.S. territories, or $500 per procedure or episode in overseas areas
  - Dental care with a cumulative total of more than $1500 per treatment plan
  - Specialty care (e.g., crowns, bridges, dentures, periodontal treatment)
  - Dental care from a non-network dentist (stateside only)
- **ADSMs must make sure care is authorized before getting services**, otherwise they may be responsible for payment.
  - ADSMs get prior-authorization from either the ADDP contractor (stateside or U.S. territories) or from the overseas contractor's Regional or Country-specific Call Centers (who coordinate care authorization with the appropriate TRICARE Dental Consultant).

2.4.1 Managing Remote Dental Care—Routine and Specialty Care

Stateside Routine and Specialty Care
● Routine care: ○ ADSMs must fill out an appointment request form online at www.addp-ucci.com to set up a civilian dental appointment. The form provides two options for appointment scheduling: (1) ADSMs make their own appointment (preferred) or (2) let the ADDP contractor's Dental Care Finder make the appointment. An ACN is required before seeking services. Information on making appointments can be found at https://secure.addp-ucci.com/ddpddw/adsm/care-remote.xhtml. ● Speciality care: ○ Specialty dental care requires prior authorization from the ADDP contractor. ○ ADDP network dentists download the prior authorization request form from the ADDP contractor's website, complete it, and send it in a single package to the address on the bottom of the form. ○ When approved, the contractor assigns an ACN and notifies the ADSM and the specialty dentist what care is authorized; the ADSM then schedules the appointment. ○ ADSMs seeking dental implant or orthodontic services must have a command memorandum signed by their unit commander or designated representative. **Note:** Coast Guard members should contact 1-800-942-2422 (1-800-9HBA-HBA) for information about their dental benefits.

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

?	Chief Petty Officer Gorman is on active duty when he starts having tooth pain. He lives less than 10 miles from a dental treatment facility. His DTF dentist determines the care he needs isn't available at the DTF. The DTF refers CPO Gorman to a civilian dentist. Who issues the authorization for this care? What steps must be taken to set up an appointment?

2.5 Payment and Claims Filing

ADDP—Stateside
● Network dental providers submit claims to and are paid by the ADDP contractor. ● When ADSMs seek emergency dental services or obtain **authorized** services from a non-network provider, they may have to pay up front and file the claim with the ADDP contractor. ○ If the ADSM files the claim, he or she needs to ask for and submit documentation showing what services were received and billed (when the provider doesn't give the ADSM an American Dental Association claim form). ○ If needed, direct payments to non-network dentists must be approved by the contractor. If not approved, payment goes to the ADSM, who then pays the dentist. ● Claims can be filed on any standard dental claim form from the American Dental Association or on the ADDP claim form. ○ The ADDP claim form can be downloaded from www.addp-ucci.com, printed, completed, and mailed to the contractor's address found on the top of the form. ● Claims are paid at the network rate.

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

- If the contractor doesn't receive the dental claim within the following timelines, the claim will be denied:
  - ADDP: within one year from the date of service
  - Overseas: within three years from the date of service

3.0 TRICARE Dental Program (TDP) and TRICARE Retiree Dental Program (TRDP)

3.1 Purpose

TDP	TRDP
● The TRICARE Dental Program (TDP) offers voluntary, premium-based coverage ● Available stateside and overseas	● The TRICARE Retiree Dental Program (TRDP) offers voluntary, premium-based coverage ● Available stateside and overseas under the following group plans: ○ Stateside: Enhanced TRDP ○ Overseas: Enhanced-Overseas TRDP

3.2 Eligibility

TDP	TRDP
● Those eligible for TDP coverage include: ○ Active duty family members (ADFMs) ○ Family members of activated Guard/Reserve members ○ Inactive Guard/Reserve members and their families ○ Members of the Selected Reserve who are involuntarily separated under other than adverse conditions (These members and their families are eligible to continue purchasing TDP coverage for 180 days after the member's separation date.) ▪ Member must be enrolled on the last day of his or her Selected Reserve service to be eligible and for coverage to automatically take effect. ▪ Family members may be added to an existing family policy, but no new plans can be created. ▪ Members/families automatically disenrolled on the 180th day of coverage. ▪ When coverage ends, so does eligibility. ▪ Those who fail to pay their premiums, become activated, or opt-out of continuing TDP coverage during the 180 days can't request coverage at a later date. ○ Surviving spouses and children ● Sponsor must have at least 12 months remaining on his or her service commitment at the time of enrollment ● Eligibility is verified through DEERS	● Those eligible for TRDP coverage include: ○ Former uniformed services members who are entitled to retired pay, including those 65 years of age or older, and their family members ○ Retired Guard/Reserve members, including those who are not yet 60 years old, and their eligible family members ○ Unremarried surviving spouse or eligible child of a deceased member who died on retired status or died while on active service for more than 30 consecutive days (once their eligibility for the TDP Survivor Benefit ends) ○ Medal of Honor recipients and their eligible family members, including unremarried surviving spouses and eligible family members ○ Current spouses and/or eligible children of certain non-enrolled members ● Eligibility is verified through DEERS

?	Officer Gorman's wife recently went from working full-time to part-time. As a result, she lost her employee-sponsored benefits, and now wants dental coverage though her husband's TRICARE. Is she eligible for coverage? If so, will she and her husband both be covered under the same dental program? Why or why not?

3.3 Enrollment

TDP	TRDP
● Enrollment is required ○ Initial 12-month commitment period ○ After the initial commitment, enrollment continues on a month-to-month basis ● Options: ○ Single Plan (one covered individual) ○ Family plan (two or more covered individuals) ● Coverage follows 20th-of-the-month rule, and begins on the date on the TDP enrollment card ● Guard/Reserve members must enroll on his/her own and enroll family members via a separate enrollment form. ● Beneficiaries can enroll online, by phone, or by mail (See Appendix A of this module for more information on TDP enrollment.)	● Enrollment is required ○ Initial 12-month commitment period ○ After the initial commitment, enrollment continues on a month-to-month basis ● Options: ○ Single-person plan ○ Two-person plan ○ Family plan (three or more persons) ● ADSMs and eligible family members may submit an enrollment form the month before the sponsor's retirement effective date ● Coverage begins the first day of the month after the TRDP contractor processes a complete enrollment package ● Beneficiaries can enroll online or by mail (See Appendix B of this module for more information on TRDP enrollment.)

3.4 Disenrollment

TDP	TRDP
● To disenroll, TDP enrollees must complete a new *TDP Enrollment/Change Authorization* document ○ The 20th-of-the-month rule applies to disenrollments ○ Certain circumstances allow for disenrollment before the 12-month initial commitment is completed (See Appendix B of this module for more information on exceptions to the Early Disenrollment Rule for TDP)	● Beginning on the coverage effective date, enrollees have a 30-day grace period to disenroll ● To disenroll after the initial 12-month commitment, the TRDP contractor must receive the disenrollment request no less than 30 days before the first day of the 13th month ● Enrollees who don't complete the initial 12-month commitment are locked out for 12 months before they can re-enroll

3.5 Premiums

TDP	TRDP
● Premiums are based on type of plan and status of sponsor ● Benefit year is May 1–April 30 ● Premiums change every February; payments increase in January ● A one-month prepayment must be submitted with the enrollment application ● TDP collects premiums through a uniformed services finance center if the sponsor has a military payroll account. See Appendix A of this module for more information.	● Premiums are based on the enrollee's residential ZIP code and the number of family members enrolled (overseas enrollees enter ZIP "00000") ○ Premiums can be viewed at www.trdp.org/pro/premiumSrch.html ● Benefit year is January 1–December 31 ● Premiums change annually on January 1 ● Enrollees must submit a two-month pre-payment with the enrollment application ● TRDP collects premiums through retired pay allotment

3.6 Provider Types

TDP	TRDP
Stateside (The TDP stateside service area includes the United States, Puerto Rico, Guam, and the U.S. Virgin Islands.) ● Enrollees are encouraged to visit a Preferred Dentist Program (PDP) dentist ● Enrollees may visit any licensed civilian dentist within the service area—costs then vary ● PDP dentists agree to accept TDP-established payment	**Stateside** (The TRDP stateside service area includes the United States, all U.S. territories, and Canada.) ● Enrollees are encouraged to visit a TRDP-network dentist ● Enrollees may visit any licensed civilian dentist within the service area—costs then vary ● TRDP-network dentists agree to accept TRDP-negotiated fees
Overseas (The TDP overseas service area includes everywhere outside the TDP stateside service area.) ● Enrollees are encouraged to use a TRICARE OCONUS Preferred Dentist (TOPD) ● Enrollees may visit any licensed, authorized dentist ● TOPDs agree to bill the enrollee only the applicable cost-share, if any ● If a TDP enrollee visits a non-TOPD provider, he or she may have to pay up front for services	**Overseas** (The TRDP overseas service area includes everywhere outside the TRDP stateside service area.) ● Enrollees may use any overseas host nation dentist. ○ There are no TRDP-network dentists overseas

3.7 Costs

TDP	TRDP
Stateside ● TDP enrollees pay cost-shares based on treatment provided and the sponsor's pay grade ● If a TDP enrollee visits a non-PDP dentist, he or she is responsible for paying the difference between the TDP established payment and the amount charged by the non-network dentist, as well as his or her cost-share percentage ● Visit www.tricare.mil/costs for TDP cost-shares	**Stateside** ● There is a $50 annual deductible per person (capped at $150 per family) ● After meeting their annual deductible, TRDP enrollees pay cost-shares based on the treatment provided ● If a TRDP enrollee visits a non-network dentist, the TRDP contractor pays as if the enrollee had gone to a network dentist; the TRDP enrollee must pay the difference between the TRDP-allowed amount and billed charges, as well as any applicable cost-shares ● Visit www.tricare.mil/costs for TRDP cost-shares
Overseas ● Overseas command-sponsored TDP enrollees pay a reduced cost-share ○ These reduced cost-shares don't apply when command-sponsored TDP enrollees receive care stateside ● Visit www.tricare.mil/costs for TDP cost-shares	**Overseas** ● Enrollees have the same deductibles and cost-shares as stateside TRDP enrollees ● Since there are no TRDP-network dentists overseas, enrollees pay the difference between the TRDP-allowed amount and billed charges, as well as any applicable cost-shares ● Visit www.tricare.mil/costs for TRDP cost-shares

3.8 Annual and Lifetime Maximums

TDP	TRDP
● TDP enrollees are entitled to the following annual and lifetime maximums: ○ Annual maximum: $1,300 ○ Accidental annual maximum (additional to annual maximum): $1,200 ○ Orthodontic lifetime maximum: $1,750 ● "Annual" is defined as the length of a benefit year ● "Annual maximum" is the most the government will pay in a benefit year	● TRDP enrollees are entitled to the following annual and lifetime maximums: ○ Annual maximum benefit: $1,300 ○ Accidental annual maximum: $1,200 ○ Orthodontic lifetime maximum: $1,750 ● "Annual" is defined as the length of a benefit year ● "Annual maximum" is the most the government will pay in a benefit year

Note: For TDP enrollees, orthodontic *diagnostic* services are applied to the annual maximum.

?	Officer Gorman's father is soon to be a retired uniformed service member. To continue dental coverage for her and his wife, they submit a TRDP enrollment form a month before his retirement effective date. Will the elder Mrs. Gorman's dental cost shares be the same as her cost shares under TDP? If not, name some of the cost differences between the two programs.

3.9 Claims

- For both TDP and TRDP, the provider type determines who files the claim.
  - When receiving services from a preferred dental provider (PDP), TRICARE Outside the Continental United State (OCONUS) Preferred Dentist (TOPD), or TRDP-network dentist, the dentist submits claims on behalf of the enrollee and is reimbursed directly.
  - When receiving services from a non-PDP, non-TOPD, or non-network dentist, the enrollee is responsible for paying the dentist and submitting the claim.
- Stateside claims must be filed within one year of the date of service, and overseas claims within three years.
- See Appendix A and Appendix B of this module for more information on both TDP and TRDP claims.

4.0 General Anesthesia for Dental Treatment

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

5.0 Resources

5.1 Active Duty Dental Program Resources

United States and U.S. Territories	Overseas
• Website: www.addp-ucci.com • E-mail: addpdcf@ucci.com • Phone: 1-866-984-ADDP (1-866-984-2337) • Mail: United Concordia Companies, Inc. ADDP Unit, P.O. Box 69430 Harrisburg, PA 17106-9430	• Contact the overseas contractor Regional or Country-specific Call Center for assistance. • For contact information, see Section 5.2 of this module.

5.2 TRICARE Overseas Program Contractor Regional Call Centers

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

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

5.3 TRICARE Dental Program Resources

Stateside	Overseas
Customer Service Phone: 1-855-MET-TDP1 (1-855-638-8371) TDD/TTY: 1-855-MET-TDP3 (1-855-638-8373) Sunday 6 PM to Friday 10 PM, Eastern Time Online: http://mybenefits.metlife.com/tricare	**Customer Service** Phone: 1-855-MET-TDP2 (1-855-638-8372) TDD/TTY: 1-855-MET-TDP2 (1-855-638-8372) Sunday 6 PM to Friday 10 PM, Eastern Time Online: http://mybenefits.metlife.com/tricare
Claims MetLife TRICARE Dental Program P.O. Box 14181 Lexington, KY 40512 Phone: 1-855-638-8371 Fax: 1-855-763-1333	**Claims** MetLife TRICARE Dental Program P.O. Box 14182 Lexington, KY 40512 Phone: 1-855-638-8372 Fax: 1-855-763-1334

5.4 TRICARE Retiree Dental Program Resources

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

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

Module Objectives

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

Key Terms

- **Dental Treatment Facility (DTF)**
- **Active Duty Dental Program (ADDP)**
- **TRICARE Dental Program (TDP)**
- **TRICARE Retiree Dental Program (TRDP)**

Appendix A: Additional TRICARE Dental Program (TDP) Information

Enrollment Plans

- A single plan (one covered individual) includes one ADFM, one Guard/Reserve family member, or one inactive Guard/Reserve sponsor.
- A family plan (two or more covered individuals) includes two or more eligible ADFMs or eligible Guard/Reserve family members.

Special Types of Enrollment

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

- **Guard and Reserve Sponsors** must enroll independent of family members.
  - If the sponsor enrolls, he or she must submit a separate, single enrollment form.
  - Sponsors may enroll their family members, but are not required to be enrolled themselves
  - If called to active service for more than 30 consecutive days and showing as eligible in DEERS, the sponsor is automatically disenrolled and re-enrolled upon deactivation. (See the chart on the following page for more information.)
  - **Note:** All members of the Guard and Reserve are required to have an annual dental examination.
    - TDP-participating dentists complete the *DoD Active Duty/Reserve Forces Dental Examination* form (DD Form 2813) at no cost to TDP enrollees (form is available at https://mybenefits.metlife.com/tricare).
    - Guard and Reserve members are responsible for reporting their dental readiness status to their service.
- Special enrollment processes apply to activating/deactivating Guard/Reserve members and their families. See the chart on the following page for more information.
- **Children under age 4** may be voluntarily enrolled at any time, but are automatically enrolled on the first day of the month following the month they turn 4 as long as other family members are enrolled. The premium rate then changes from a single to a family plan.
- **Split Enrollment for Active Duty Family Members Only**: When a family member requires a hospital or special treatment environment (due to medical, physical handicap, or mental condition) for dental care covered by the TDP, he or she doesn't have to be enrolled in TDP to receive care at an MTF.
  - Before seeking services, the sponsor must provide documentation, such as a signed letter or memorandum from the MTF provider or administrator to the TDP contractor, verifying the need for a hospital or special treatment environment.
- **Note:** Two sponsors can't enroll the same family member(s), and the service members must decide which sponsor children will be enrolled under. When both husband and wife are service members, neither one can enroll in TDP as a family member—they each enroll as their own sponsor.

National Guard and Reserve Activation/Deactivation Coverage Status

SPONSOR

ENROLLED in individual TDP plan prior to activation

ACTIVATED
Sponsor disenrolled from TDP. Active duty benefits apply.

DEACTIVATED
Sponsor reenrolled in TDP automatically. **Must** complete the remainder of the 12-month minimum enrollment requirement.

NOT ENROLLED in individual TDP plan prior to activation

ACTIVATED
Sponsor not eligible for TDP enrollment. Active duty benefits apply.

DEACTIVATED
Sponsor eligible for enrollment in TDP. **Must** complete the 12-month minimum enrollment requirement.

FAMILY MEMBERS

ENROLLED in individual or family TDP plan (*separate from sponsor*) prior to sponsor's activation

SPONSOR ACTIVATED
Family members' coverage continues at reduced premium rate.

SPONSOR DEACTIVATED
Family members' coverage continues at applicable National Guard and Reserve premium rate. **Must** complete the remainder of the 12-month minimum enrollment requirement.

NOT ENROLLED in TDP plan prior to sponsor's activation

SPONSOR ACTIVATED
Family members enrolled in individual or family plan **within 30 days** of sponsor activation (*for specific contingency operations*) pay the reduced premium rate.[1]

SPONSOR DEACTIVATED
Family members' coverage automatically canceled upon sponsor's deactivation. Sponsor **must** notify MetLife if family member reenrollment is desired.

SPONSOR ACTIVATED
Family members who enroll in individual or family plan **more than 30 days** after sponsor activation, or whose sponsors are not activated for specific contingency operations, pay the reduced premium rate.[1]

SPONSOR DEACTIVATED
Family members' coverage continues uninterrupted at applicable National Guard and Reserve premium rate. **Must** complete remainder of 12-month minimum enrollment requirement.

1. Timing of enrollment affects minimum lock-in requirement, not premium rates.

Reduced Premium Rate: Government pays 60 percent, enrollee pays 40 percent
National Guard and Reserve Premium Rate: 100 percent non-government shared premium rate

TDP Survivor Coverage

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

Enrollment Methods

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

Exceptions to Early Disenrollment Rule for TDP

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

TDP Premiums

- Credit or debit card payments for initial enrollments may be made online via Beneficiary Web Enrollment (BWE), phone, or mail.
- If necessary, TDP enrollees may mail their initial premium payment by check or money order with their *TDP Enrollment/Change Authorization* document.
- For ongoing payments, the government collects the premium through a uniformed services finance center if the sponsor has a military payroll account
  - If the TDP contractor can't collect the requested premium payment from the payroll account, the premium collection transfers from the finance center payroll allotment or deduction to direct billing by the TDP contractor.
  - Premium payments for non-active duty Guard/Reserve family members are paid directly to the TDP contractor.
    - Ongoing payments for Guard/Reserve members and their eligible family members may be made with a credit card, electronic fund transfer, or through allotment.
- TDP enrollees who fail to pay monthly premiums are disenrolled and not allowed to re-enroll ("locked out") for 12 months from the date of the last premium payment covered.

TDP Claims: Finding and Submitting Forms

Stateside

- The TDP contractor accepts any standard American Dental Association claim form.
- A separate claim form is needed for each TDP enrollee receiving services. For example, if a family of four is treated by the same dentist on the same day, four separate claim forms must be submitted.
- Documents and instructions are located on www.tricare.mil/tdp.

Overseas

- The TDP claim submission document is on the TDP contractor's website at http://mybenefits.metlife.com/tricare.
- Claim documents are also available from TAOs, overseas dental treatment facilities (ODTFs), designated overseas TRICARE point of contacts (POCs), or by calling the TDP contractor.
- Claims documents must include the following if an American Dental Association form isn't used:
  - Date(s) of service
  - Provider name, address, and phone number
  - Specific problem encountered
  - Procedure code(s) (If a procedure code isn't on the claim form, a complete description of the service performed, including applicable tooth number(s), must be noted.)
  - Specific tooth/teeth treated for each service performed
  - Total charges

TDP Appeals

- There are three levels of appeal for denial of TDP claims:
  - Reconsideration
  - Formal review
  - Hearing
- All denials explain how, where, and by when to file for the next level of review.

Appendix B: Additional TRICARE Retiree Dental Program (TRDP) Information

Eligibility

- Current spouses and/or eligible children of certain non-enrolled members are eligible for TRDP if they have documented proof the non-enrolled member is:
  - Eligible to receive ongoing comprehensive dental care from the Department of Veterans Affairs
  - Enrolled in a dental plan through employment but the plan isn't available to family members
  - Unable to obtain benefits through the TRDP due to a current and enduring medical or dental condition

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

Enrollment Methods

- All TRDP enrollments must be authorized by the sponsor or surviving dependent.
  - Sponsors may manage personal and family member enrollment online or by mail.
  - Sponsors or surviving dependents may manage enrollment information via BWE.
  - Spouses may enroll family members via mail as long as they have Power of Attorney.
- To enroll:
  - Online: www.trdp.org
  - By Mail : Download application from www.trdp.org/pro and mail to:

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

TRDP Premiums

- To view the premium rate for a specific region, enrollees may visit the TRDP website at www.trdp.org/pro/premiumSrch.html or call the TRDP customer service toll-free number at 1-888-838-8737.

TRDP Claims

- Claims may be completed using any standard dental claim form (available at www.trdp.org).
- TRDP enrollees mail their claims to:

Delta Dental of California
Federal Government Programs
P.O. Box 537007
Sacramento, CA 95853-7007

- The enrollee who files the claim receives the claim payment; however, the enrollee can authorize payment directly to the dentist by marking that option on the claim form.
- Beneficiaries can review their benefits, verify deductibles, and check on the status of claims by visiting the self-service Customer Toolkit at www.trdp.org.

TRDP Appeals

- There are two levels of appeal for denied claims: Reconsideration and Formal Review
- All denials explain how, where, and by when to file for the next level of review.

TRICARE Fundamentals Course

National Guard and Reserve

7

Participant Guide

References

10 USC
32 CFR § 199.20
2008 TRICARE Policy Manual, Chapter 10
2008 TRICARE Operations Manual, Chapter 22
www.tricare.mil/mmso
www.dol.gov/elaws/userra.htm
DoD Instruction 1241.03

Brainteaser

Each of the eight items below is a separate puzzle.

How many can you figure out?

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

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

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

Key Terms

- **Line of Duty (LOD)/Notice of Eligibility (NOE) Determination**
- **Early Eligibility**
- **TRICARE Reserve Select (TRS)**
- **TRICARE Retired Reserve (TRR)**
- **Purchase Suspension**

1.0 Introduction

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

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

TRICARE options for Guard/Reserve members vary based on the sponsor's status. When on active service for more than 30 consecutive days and showing as eligible in the Defense Enrollment Eligibility Reporting System (DEERS), Guard/Reserve members have the same health care benefits as active duty service members (ADSMs). When serving on active service for 30 days or less, Guard/Reserve members are covered under line of duty care.

?	Throughout this module, you will answer scenario questions on Sergeant Wilson, who is a member of the Selected Reserve of the Ready Reserve.

2.0 Coverage While on Active Service for 30 Days or Less

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

When Guard/Reserve members are on active service for 30 days or less (e.g., drilling on weekends, training during the summer), they're covered for any injury, illness, or disease that occurs or gets worse in the line of duty, this includes traveling directly to or from their place of duty. They don't show as eligible in DEERS, but may receive care based on an LOD/NOE determination.

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

- The Services use an LOD determination to document, establish, manage, and request authorization for civilian health care for Guard/Reserve members if injury or illness occurs in the line of duty. The Coast Guard refers to an LOD as an NOE.
- Guard/Reserve members who live or are stationed within a military treatment facility's (MTF's) Prime Service Area (PSA) should seek LOD/NOE care from that MTF. The Guard/Reserve member's command or medical unit should contact the MTF's patient administration office to arrange care.
- If the Guard/Reserve member lives or is stationed outside the MTF's PSA, the Guard/Reserve member's command or medical unit requests an authorization for civilian medical care by submitting a LOD/NOE determination to the Reserve and Service Member Support Office (R&SMSO).

- R&SMSO authorizes LOD/NOE care with a civilian provider for Guard/Reserve members **not** in a PSA.
  - The unit medical representative submits the LOD/NOE, a copy of orders or drill attendance sheet, along with the R&SMSO *Medical Eligibility Verification* form, which can be found at www.tricare.mil/tma/mmso/pdf/mmsoformmedicaleligibility.pdf.
  - Once R&SMSO receives and reviews the documentation, they issue an authorization determination.
- The member doesn't need prior authorization for an initial emergency room visit. However, if admitted to a hospital/facility, the member must obtain authorization from R&SMSO or the MTF—either before admission or as soon as possible after admission. If the member needs additional care for the LOD/NOE illness or injury, he or she must get prior-authorization before seeking services.
- Overseas Guard/Reserve members must use their respective service component's procedures for LOD/NOE care. R&SMSO isn't involved in LOD/NOE care overseas other than the U.S. Virgin Islands.
  - For information on LOD/NOE care in the U.S. Virgin Islands, unit medical representatives should call R&SMSO at 1-888-647-6676, option #4.

?	Two days after SGT Wilson's arrival, a canister falls on her foot while she's unloading a military transport vehicle. What type of coverage is SGT Wilson's injury covered under? Is she eligible for treatment at a military treatment facility? Can she get civilian care?

2.2 LOD/NOE Coverage after Release from Active Service

Guard/Reserve members are also covered for LOD/NOE care after release from qualified active duty if the condition needs continued treatment and the care is authorized.

Members should make sure they and their command or medical unit receive and retain the official LOD/NOE document before the Guard/Reserve member's release from active service in case they need follow-up care later. For more information, visit the R&SMSO website at www.tricare.mil/tma/mmso.

2.3 Guard or Reserve Members and LOD/NOE Retail Pharmacy Claims

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

	Care Rendered Stateside and in the U.S. Virgin Islands	**Care Rendered in All Other Overseas Locations**
Step 1	Member submits the *DD Form 2642*, claims receipts, and LOD/NOE documents to: Reserve and Service Member Support Office (R&SMSO) Attn: RC Retail Pharmacy Reimbursement P.O. Box 886999 Great Lakes, IL 60088-6999 Fax: 1-847-688-6460	Member submits the *DD Form 2642*, claims receipts, and LOD/NOE documents to: Overseas Active Duty Claims TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968
Step 2	Once R&SMSO reviews and verifies the information, they fax the *DD Form 2642* and the receipt or invoice to the pharmacy contractor for payment.	Once the overseas claims processor receives, reviews, and verifies eligibility, they process the claim.
Step 3	The pharmacy contractor mails the reimbursement check directly to the member.	The overseas contractor's claims processor mails the reimbursement check directly to the member.

3.0 Coverage for Guard/Reserve Members With Early Eligibility

- When Guard/Reserve members receive delayed-effective-date orders to active service for more than 30 consecutive days in support of a contingency operation, they and their eligible family members may become TRICARE eligible on the date the delayed-effective-date order is issued or 180 days before being called to active duty, whichever is later. This benefit is known as "early eligibility."
  - The coding of "early eligibility" in DEERS is a service responsibility and may need to be addressed by the Guard/Reserve member's unit. (The personnel office provides notification of eligibility.)
- Sponsors with early eligibility may either:
  - Remain unenrolled but seek care through an MTF if living within a PSA
  - Seek covered primary care from a TRICARE-authorized provider if living in a remote location (referrals and authorizations are coordinated through R&SMSO or the overseas contractor)
- Family members:
  - Are automatically covered under TRICARE Standard/Extra when shown as eligible in DEERS
  - May be able to enroll in an available TRICARE Prime option, including TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Overseas Program (TOP) Prime, TOP Prime Remote, and the US Family Health Plan (USFHP)
- If a sponsor and family are enrolled in TRS when early eligibility begins, TRS coverage automatically ends.

3.1 Guard/Reserve Early Eligibility Scenarios

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

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

?	On November 1, SGT Wilson receives orders calling her to active service for 90 consecutive days, beginning on May 1. Does SGT Wilson qualify for early eligibility? If so, when does she become eligible? Would she be eligible to enroll in TRICARE Prime?

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

Potential Coverage	Sponsor Coverage	Family Coverage
Medical Coverage (during active service)	• After arriving at their final duty location, members should follow command guidance on TRICARE Prime-option enrollment.	• Family members are automatically covered under TRICARE Standard/ Extra • Family members may enroll in an available TRICARE Prime option.
Dental Coverage	• If enrolled, TDP coverage automatically ends. • Dental care is provided through military dental treatment facilities or through the Active Duty Dental Program (ADDP).	• If already enrolled, TDP coverage continues at a reduced premium rate. • New TDP coverage is available for purchase by eligible family members at the reduced premium rate.

5.0 Coverage Available After Separating from Active Service

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

* *To qualify for TAMP coverage, Guard/Reserve members must have been on active service for more than 30 consecutive days in support of a contingency operation.*

?	SGT Wilson has been serving on active duty for the past eight months, but her orders are about to end. She doesn't want a break in health care coverage. As a National Guard/Reserve member separating from active service for more than 30 consecutive days in support of a contingency operation, what program is available to her? How long will she have coverage?

6.0 Coverage Available When Retired

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

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

- TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) are premium-based health plans available for purchase worldwide. They both deliver the TRICARE Standard/Extra or TRICARE Overseas Program (TOP) Standard benefit.
- TRS and TRR are available overseas.
  - The TOP contractor handles overseas enrollments, premium payments, billing, and customer support services.
  - TRICARE Area Offices (TAOs) provide information on getting health care overseas.

7.1 Eligibility

- TRS is available for purchase by qualified members of the Selected Reserve for themselves and their eligible family members.
  - TRICARE offers 180 days of TRICARE Standard coverage to members of the Selected Reserve who are involuntarily separated under other than adverse conditions. This benefit is carried out through continued purchased of TRS coverage for these members and their families.
    - Member has to be enrolled on the last day of his or her Selected Reserve service for coverage to automatically take effect.
    - Members and families are automatically disenrolled on the 180th day.
    - When coverage ends, so does TRS eligibility since the member is no longer in the Selected Reserve.
    - Those who fail to pay their premiums or opt-out of continuing TRS coverage will not be reinstated at a later date.
- TRR is available for purchase by qualified Retired Reserve members and their eligible family members. This population of Guard/Reserve retirees is commonly referred to as "gray-area retirees."

7.2 Types of Coverage

TRS and TRR offer two types of coverage:

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

7.3 Qualifying for Coverage

7.3.1 Qualifying for TRS and TRR Coverage

- Guard/Reserve components validate a member's qualification to purchase TRS.
- Members must not be enrolled or eligible to enroll in the Federal Employees Health Benefits (FEHB) Program.
  - To qualify to purchase TRS coverage, Guard/Reserve members must be in the Selected Reserve of the Ready Reserve throughout the entire coverage period.
  - To qualify to purchase TRR coverage, retired Guard/Reserve members must be under age 60 and a member of the Retired Reserve of a reserve component who is qualified for non-regular retirement under 10 USC, Chapter 1223.

?	A few years later, SGT Wilson retires and becomes a member of the Retired Reserve. She's 55 and isn't receiving retirement pay. She interviews for and is offered a civilian job with the Defense Health Agency that makes her eligible for the Federal Employees Health Benefits (FEHB) Program. Can she keep her TRS coverage? If not, is she eligible for TRR? Why or why not?

7.3.2 Verifying Qualification for TRS or TRR

- To verify qualification for either TRS or TRR, members must log on to the DMDC *Reserve Component Purchased TRICARE Application* at www.dmdc.osd.mil/appj/reservetricare. Members need a DoD Self-Service Logon (DS Logon), DFAS myPay account, or DoD Common Access Card (CAC) to access the application
  - Members can obtain a DS Logon online by visiting https://myaccess.dmdc.osd.mil/identitymanagement.

7.4 Purchasing TRS and TRR Coverage

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

7.4.1 General Enrollment

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

7.4.2 Loss of Other TRICARE Coverage

- Qualified members who lose coverage under another TRICARE plan may purchase TRS or TRR with no break in TRICARE coverage. This only applies to:
  - A Selected Reserve member or a retired reserve Guard/Reserve member
  - A Guard/Reserve member whose TAMP coverage is ending
- Deadline: The form must be postmarked or received no later than 30 days after the loss of other TRICARE coverage.
- Effective date: TRS or TRR coverage begins the day after the previous TRICARE coverage ends.
- Members who qualify may apply up to 60 days before their other TRICARE coverage ends.

7.4.3 Change in Family Composition

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

Note: If the new application is **not** postmarked or received within the 60 days following the qualifying life event, claims will be denied until the family member is enrolled. Coverage then starts on the actual date of enrollment, not the date of the life event.

7.4.4 Survivor Coverage

- If TRS or TRR coverage (member-and-family or member-only) is in effect when the sponsor dies, qualified survivors may purchase or continue coverage as follows:
  - TRS: For up to six months beyond the sponsor's date of death
  - TRR: Until the day the sponsor would have become eligible for retiree benefits (typically age 60)
- If TRS or TRR member-and-family coverage is in effect at the time of death:
  - DEERS automatically converts coverage to TRS or TRR survivor coverage. (Advise beneficiaries to verify status changes in DEERS.)
  - If survivors don't want TRS or TRR survivor coverage, they must submit a written letter or a *DD Form 2896-1* no later than 60 days after the date of the sponsor's death for coverage to be suspended retroactive to the day after the sponsor's death. Premiums are refunded if there were no claims for health care submitted during the 60 days.
- If TRS or TRR member-only coverage is in effect at the time of death:
  - Eligible survivors may qualify to purchase TRS or TRR survivor coverage.
  - If the survivor wants coverage to start on the date of the sponsor's death (qualifying life event), he or she must submit an application within 60 days of the sponsor's death.
  - Surviving family members who are eligible for or are enrolled in the FEHB program may still purchase TRS or TRR.
- If a sponsor wasn't enrolled in TRS or TRR at the time of death, surviving family members can't purchase coverage under either plan.

7.5 Receiving Care Under TRS and TRR

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

7.6 TRS and TRR Costs

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

7.6.1 TRS and TRR Monthly Premiums

- TRS and TRR premiums are adjusted on an annual basis, effective January 1.
- See Section 7.9 of this module for TRS and TRR costs, or visit www.tricare.mil/costs.
- The initial two-month premium payment (included with the request form) can be made with a personal check, cashier's check, money order, or credit/debit card (Visa or MasterCard).
- After the initial payment, all premiums must be paid by either recurring monthly electronic funds transfer (EFT) or credit/debit card.
  - The contractor processes recurring EFT and credit/debit card payments within the first five business days of the month of coverage.

7.7 Loss of TRS or TRR Coverage

7.7.1 Loss of TRS or TRR Eligibility

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

TRS	TRR
● Failure to pay monthly premiums (See Section 7.7.3 of this module for more information.) ● The sponsor: ○ Separates from the Selected Reserve ○ Is called to active duty ○ Retires from the Selected Reserve ○ Becomes eligible for FEHB coverage	● Failure to pay monthly premiums (See Section 7.7.3 of this module for more information.) ● The sponsor: ○ Turns 60, or becomes eligible for health benefits as a retiree per his or her Service ○ Becomes eligible for FEHB coverage

Note: Typically, when starting a new job that offers FEHB, FEHB coverage doesn't begin until the first day of the second pay period. TRS and TRR members should keep this in mind when selecting their disenrollment date to ensure continuous health care coverage

7.7.2 Voluntary Disenrollment

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

7.7.3 Failure to Make Premium Payments

- Failure to pay monthly premiums results in suspension of coverage.
  - For example, if a member cancels the credit card used for the recurring monthly premium and doesn't give a new credit card number to the regional or overseas contractor, the member's coverage is suspended.
- Coverage ends on the last day of the month for which payment was received.

7.7.4 Purchase Suspension

- TRS/TRR members who voluntarily disenroll without submitting a disenrollment form are subject to a 12-month purchase suspension, effective the date coverage ended.
- If a beneficiary is facing a purchase suspension for the first time, he or she may request reinstatement.
  - Requests must be sent to the regional contractor within the first three months of suspension.
  - If the request meets certain criteria, the regional contractor reinstates coverage.
- TRS members facing a second suspension may have that suspension lifted if they request coverage more than three months after the paid-through date but within a year of that same paid through date.
  - The contractor will then allow the member to purchase coverage, which will be effective the first of the month after the request was made.
  - Two months' worth of premiums must be included, as well as information needed for recurring electronic premium payments.
- Purchase suspensions don't apply to Selected Reserve members and their family members if they:
  - Are losing TRS eligibility (See Section 7.7.1 of this module for more information.)
  - Are ending TRS coverage because they're gaining other TRICARE coverage
- For more information on reinstatement processes, see the 2008 *TRICARE Operations Manual*, Chapter 22.

?	SGT Wilson decided to turn down the civilian job because she and her fiance decide to relocate. Soon after they marry, she voluntarily disenrolls from TRS in favor of being covered by her husband's employer-sponsored health plan. SGT Wilson forgets to submit a disenrollment form when she ends her TRS coverage. One month later, her husband loses his job and benefits. Can SGT Wilson use her TRS coverage? If so, what steps does she need to take?

7.8 Coverage Options After TRS/TRR Ends

- TRS members and TRR family members may be eligible to purchase Continued Health Care Benefit Program (CHCBP) or other health insurance through their employer, another family member, or their state's Health Insurance Marketplace when their TRS/TRR coverage ends. Visit www.healthcare.gov for more information. (See the *Transitional Benefits* module for more information on CHCBP.)

7.9 Distinguishing Between TRS and TRR

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

	TRICARE Reserve Select (TRS)	TRICARE Retired Reserve (TRR)
Qualifying	● Must be a member of the Selected Reserve of the Ready Reserve throughout entire period of coverage ● Must not be eligible for or enrolled in the FEHB program	● Must be a member of the Retired Reserve of a Reserve Component who has not reached age 60 ● Must not be eligible for or enrolled in the FEHB program
Cost-Shares	● ADFM rate	● Retiree rate
Premium Rates (Valid January 1, 2014–December 31, 2014)	● Monthly premium rate: ○ $51.68 for member-only ○ $204.29 for member-and-family ● Minimum two-month initial premium payment required ● Premiums are adjusted every calendar year, effective January 1 ○ Visit www.tricare.mil/costs for the most recent premium rates	● Monthly premium rate: ○ $390.99 for member-only ○ $956.65 for member-and-family ● Minimum two-month initial premium payment required ● Premiums are adjusted every calendar year, effective January 1 ○ Visit www.tricare.mil/costs for the most recent premium rates
Survivor Coverage	Surviving family member(s) may purchase or continue TRS coverage for up to six months beyond the date of the sponsor's death (only if the sponsor has TRS coverage on the date he/she passes away).	Surviving family member(s) may purchase or continue TRR coverage until the date the deceased member would have turned 60 (only if the sponsor has TRR coverage on the date he/she passes away).

7.10 TRS/TRR Application Exercises

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

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

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

7.11 TRS/TRR Resources

Stateside		
North	**South**	**West**
TRS/TRR Enrollment Address: Health Net Federal Services, LLC. TRS/TRR Enrollment P.O. Box 870162 Surfside Beach, SC 29587-9762 **Phone:** 1-800-555-2605 **Website:** www.hnfs.com	**TRS/TRR Enrollment Address:** Humana Military Healthcare Services, Inc. ATTN: PNC Bank P.O. Box 105838 Atlanta, GA 30348-5388 **Phone:** 1-877-298-3408 **Website:** www.humana-military.com	**TRS/TRR Enrollment Address:** UnitedHealthcare Military & Veterans TRICARE West Region Enrollment Department P.O. Box 105492 Atlanta, GA 30348 **Phone:** 1-877-988-9378 **Website:** www.uhcmilitarywest.com
Overseas		
Eurasia-Africa	**Latin America and Canada**	**Pacific**
TRS/TRR Enrollment Address: International SOS Assistance, Inc. TOP TRS/TRR Enrollments P.O. Box 11689 Philadelphia, PA 19116 **Phone:** +44-20-8762-8384 (overseas) 1-877-678-1207 (stateside) **E-mail:** tricarelon@internationalsos.com	**TRS/TRR Enrollment Address:** International SOS Assistance, Inc. TOP TRS/TRR Enrollments P.O. Box 11689 Philadelphia, PA 19116 **Phone:** +1-215-942-8393 (overseas) 1-877-451-8659 (stateside) **E-mail:** tricarephl@internationalsos.com	**TRS/TRR Enrollment Address:** International SOS Assistance, Inc. TOP TRS/TRR Enrollments P.O. Box 11689 Philadelphia, PA 19116 **Singapore** **Phone:** +65-6339-2676 (overseas) 1-877-678-1208 (stateside) **E-mail:** sin.tricare@internationalsos.com **Sydney** **Phone:** +61-2-9273-2710 (overseas) 1-877-678-1209 (stateside) **E-mail:** sydtricare@internationalsos.com
Website: www.tricare-overseas.com		

Module Objectives

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

Key Terms

- **Line of Duty (LOD)/Notice of Eligibility (NOE) Determination**
- **Early Eligibility**
- **TRICARE Reserve Select (TRS)**
- **TRICARE Retired Reserve (TRR)**
- **Purchase Suspension**

TRICARE Fundamentals Course

Other Benefits

8

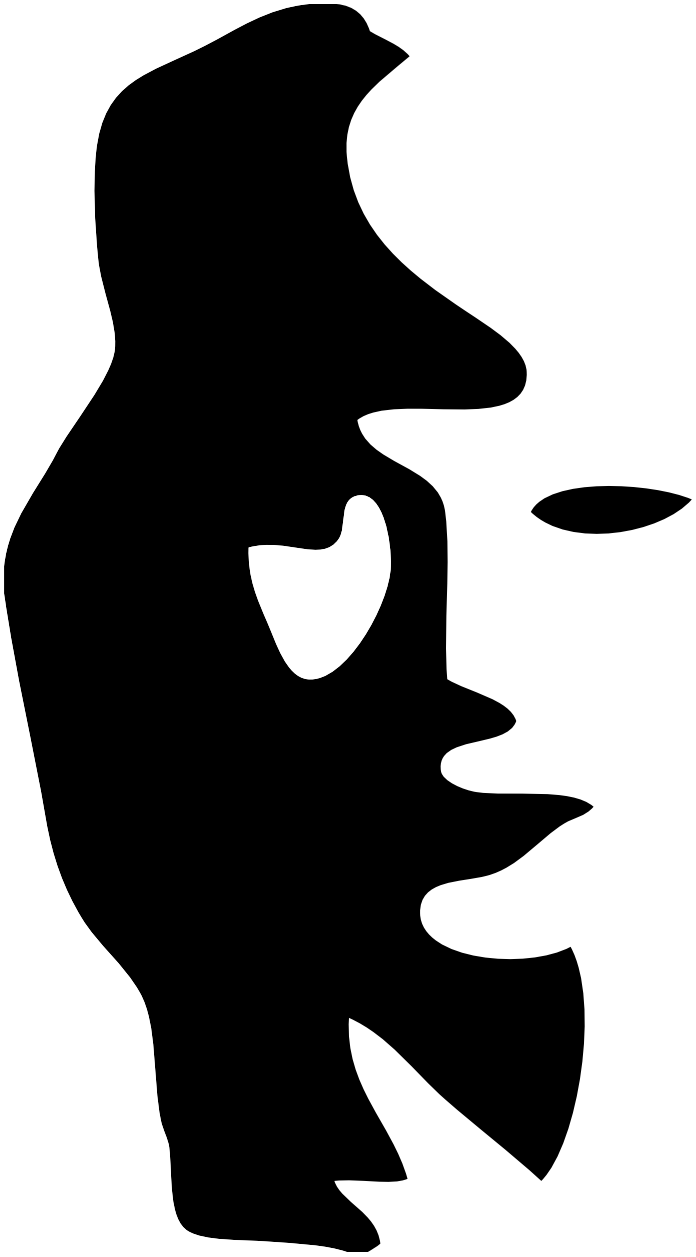
Participant Guide

References

10 USC § 1079 (d)–(f)
32 CFR §§ 199.5, 6, 8
2008 TRICARE Operations Manual, Chapter 6
2008 TRICARE Operations Manual, Chapter 25
2008 TRICARE Policy Manual, Chapter 9
www.militaryhomefront.dod.mil
www.usfhp.com
www.cap.mil/wsm
www.tricare.mil/tmaprivacy
www.tricare.mil/aca

Brainteaser

What do you see in the picture below?



Module Objectives

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

Key Terms

- **TRICARE Young Adult Program (TYA)**
- **Extended Care Health Option (ECHO)**
- **Exceptional Family Member Program (EFMP)**

1.0 TRICARE Young Adult Program (TYA)

The premium-based TRICARE Young Adult Program (TYA) extends TRICARE Standard or Prime option coverage to qualified young adults who lose eligibility due to age.

?	Throughout this module, you will answer scenario questions on Master Sergeant Cooper and his family.

1.1 TYA Eligibility

- Qualified young adults may purchase TYA coverage if they meet all of the following criteria:
  - Are a dependent of a TRICARE-eligible uniformed service sponsor
  - Are at least age 21 but under age 26
  - Aren't married
  - Aren't a member of the uniformed services
  - Aren't eligible to enroll in an employer-sponsored health plan based on their own employment
  - Aren't eligible for other TRICARE coverage
- TYA coverage is based on the sponsor's status (e.g., active duty, retiree, etc.) and where the young adult lives.
  - Overseas: The young adult must meet all TRICARE Overseas Program (TOP) and service approval requirements (i.e., command sponsorship) to purchase TOP Prime/Remote coverage under TYA. (See the *TRICARE Options* and *Prime Remote Options* modules for more information on command sponsorship.)
- Young adult dependents of TRICARE For Life (TFL) sponsors can purchase TYA Standard, or may be eligible to purchase a TYA Prime option (stateside, overseas, or US Family Health Plan [USFHP]) if they meet TYA and TRICARE Prime rules.
- TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) eligible sponsors must be enrolled in TRS or TRR for the young adult dependent to purchase TYA Standard/Extra (Prime isn't available since the sponsor can't be Prime).
  - If the sponsor dies while enrolled in TRS/TRR, the young adult dependent may initially purchase or continue purchasing TYA coverage:
    - TYA coverage ends six months after a TRS sponsor's death, or when the TYA-covered young adult turns 26, whichever comes first.
    - TYA coverage, under a TRR sponsor who dies, continues until the date the sponsor would have become a regular retiree or when the young adult reaches age 26, whichever comes first.

Note: If the young adult is under age 26 on the date the sponsor would have retired, he or she can repurchase TYA as a dependent of a retiree sponsor.

- TYA coverage ends when:
  - The young adult submits a *TRICARE Young Adult Application* (DD Form 2947) asking for coverage to end because he or she no longer qualifies for coverage (e.g., he or she gains health care through an employer)
  - The young adult's sponsor loses TRICARE eligibility
  - The young adult reaches age 26

1.2 TYA Purchase

- Qualified young adult dependents may purchase TYA coverage on a month-to-month basis as long as they're listed in the Defense Enrollment Eligibility Reporting System (DEERS).
- To purchase TYA, qualified young adults must submit a *DD Form 2947* (available at www.tricare.mil/forms or www.tricare.mil/tya) to the regional or overseas contractor, along with an initial two-month premium payment.

- Coverage effective dates are as follows:
  - TRICARE Standard: the first day of the next month after the *DD Form 2947* is received or up to 90 days in the future (as noted on the form)
  - TRICARE Prime options: the "20th-of-the-month rule" applies
- Young adult dependents who lose TRICARE eligibility (e.g., age out of TRICARE at age 21) may avoid a break in coverage by making sure that their *DD Form 2947* is postmarked no later than 30 days after losing coverage; claims are denied until the application is processed.
- Continuous coverage requires an electronic payment from a checking or savings account or an automatic recurring credit/debit charge.
- Once covered, the young adult receives a TYA card and welcome letter. The young adult and sponsor should then either visit the nearest uniformed service ID-card issuing facility or have the young adult present a sponsor-notarized *Application for Identification Card/DEERS Enrollment* (DD Form 1172-2) so the young adult dependent can get a new ID card to present when seeking health care services.
- Qualified young adults may purchase TYA coverage anytime unless locked out after failing to pay TYA premiums or the sponsor fails to pay his or her own TRS or TRR premiums.
  - If locked out, the young adult dependent may submit a new *DD Form 2947* up to 45 days before the lockout period ends for coverage to start as soon as the lockout ends.
  - Young adults may ask to be reinstated if an error was made when processing the application or if there are extraordinary circumstances that justify continued TYA coverage.
    - Requests should be sent to the regional, overseas, or USFHP contractor within 90 days of the last full premium payment.
    - The TRICARE Regional Office (TRO), TRICARE Area Office (TAO), or USFHP system determine if a young adult is able to resume TYA coverage.

?	Master Sergeant Cooper's daughter, Rachel, just graduated from college at age 23. She has yet to find a job, leading her parents to suggest that she purchase TRICARE Young Adult coverage. Because the rest of the Cooper family is enrolled under TRICARE Prime, they feel it would be the best option for Rachel. What must Rachel do to be covered by TYA? How does she make premium payments? Can she keep using her old ID card?

1.3 TYA Portability

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

1.4 TYA Coverage

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

1.5 TYA Costs

1.5.1 Monthly Premiums

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

1.5.2 Out-of-Pocket Expenses

- Costs are determined by the status of the sponsor (active duty, retiree, etc.)
- TRICARE Standard deductibles and cost-shares apply if the young adult is covered by TYA Standard.
- TRICARE Prime copays and cost-shares apply if the young adult is covered by TYA Prime.
- Deductibles, cost-shares, and copays for TRICARE-covered services apply to the individual/family's catastrophic cap.
- TYA premiums aren't credited to the catastrophic cap; they offset health care costs.
- Pharmacy copays and cost-shares apply. (See the *Pharmacy* module for more information.)

2.0 TRICARE Plus

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

2.1 TRICARE Plus Eligibility

Eligible	Not Eligible
● TRICARE Standard beneficiaries ● TFL beneficiaries ● Dependent parents and parents-in-law	● Beneficiaries enrolled in a: ○ Prime option (stateside or overseas) ○ Civilian health maintenance organization (HMO) ○ Medicare HMO ● Active duty service members (ADSMs) ● Activated Guard/Reserve members

2.2 TRICARE Plus Enrollment

- There are no enrollment fees or cards associated with TRICARE Plus. Eligible beneficiaries must complete a *TRICARE Plus Enrollment Application* (DD Form 2853) and submit it to the MTF.
- The MTF validates eligibility in DEERS.
- If approved, the MTF forwards the *DD Form 2853* to the regional contractor.
- Once the regional contractor enters the TRICARE Plus enrollment into the Defense Online Enrollment System (DOES) the beneficiary shows as TRICARE Plus in DEERS.
- Once the TRICARE Plus enrollment indicator appears in the MTF's medical appointment system, enrollees can make appointments with their PCM.

2.3 TRICARE Plus Disenrollment

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

2.4 TRICARE Plus—Not Portable

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

2.5 Specialty Care

- MTFs may see TRICARE Plus enrollees for specialty care on a "space-available basis." If not available at the MTF, TRICARE Plus enrollees must seek specialty care from a civilian TRICARE-authorized provider as long as they are still TRICARE eligible (i.e., Standard/Extra, TFL) or use Medicare or other health insurance (OHI).
- The MTF isn't responsible for any costs associated with care outside the MTF and the MTF can't authorize civilian care.
- TRICARE Standard/Extra, TFL, Medicare, or OHI rules apply, as do cost-shares and deductibles when enrollees are seen outside the MTF.

3.0 Extended Care Health Option (ECHO) Program

- The Extended Care Health Option (ECHO) Program is a supplemental program to the basic TRICARE benefit.
- ECHO provides qualified active duty family members (ADFMs) with an additional financial resource for services and supplies that help reduce the disabling effects of a family member's qualifying condition.
- Services may include medical and rehabilitative services, institutional care, and respite care. (See Appendix A of this module for more information on ECHO-covered services and exclusions.)

3.1 ECHO Eligibility

- If a sponsor or provider believes a family member may qualify for ECHO services, the sponsor should speak with the family member's primary care manager/provider, case manager, regional contractor, overseas TAO, or USFHP provider to get an eligibility determination. (See Appendix A of this module for information on which family members are eligible for the ECHO program.)
- Potential ECHO beneficiaries must be ADFMs, have qualifying conditions, and be enrolled in the Services' Exceptional Family Member Program (EFMP).
  - The EFMP identifies ADFMs with special medical and/or educational needs.
  - Each service branch has its own EFMP and enrollment process.
  - TRICARE may waive the EFMP requirement when either the sponsor's service doesn't provide the EFMP (i.e., Guard/Reserve, Coast Guard, U.S. Public Health Service [USPHS], National Oceanic and Atmospheric Administration [NOAA]), the beneficiary is a transitional survivor, or the beneficiary resides with a custodial parent, not the active duty sponsor.
  - For more information on EFMP, see Appendix A of this module.
- Each regional contractor, TAO, or USFHP system determines eligibility for ECHO. If they determine the beneficiary isn't eligible, the decision is a factual determination and **isn't** appealable.

3.2 ECHO Registration

- The sponsor or other authorized persons acting on behalf of the family member must submit the following documents to the appropriate regional contractor, TAO, or USFHP system.
  - Proof the sponsor is an ADSM in one of the uniformed services
  - Medical records of qualifying conditions (See Appendix A of this module for information on ECHO qualifying conditions.)
  - Proof from the sponsor's branch of service that the family member is enrolled in the EFMP (unless the EFMP requirement is waived)
- To avoid delay of ECHO services due to a delay in the EFMP enrollment process, the regional contractor, TAO, or USFHP system may grant provisional ECHO status for 90 days.

?	The Cooper's son, Samuel, was recently diagnosed with cerebral palsy. The Coopers decide to register Samuel in the ECHO Program to receive some financial assistance for his treatments. Before registering Samuel in ECHO, what must the Coopers do? What documentation must the Cooper's submit to register him? What office is ultimately responsible for accepting or denying their request?

3.3 ECHO Benefit Authorization

- All ECHO benefits must be prior-authorized by the regional contractor, ECHO case manager, TAO, or USFHP before the family member receives any services, supplies, or equipment.
- If the family member changes providers, they must obtain a new referral and authorization.
- Beneficiaries may appeal the denial of ECHO services and supplies.

3.4 ECHO Costs

- ECHO has no deductibles or enrollment fees.
- A monthly cost-share (based on the sponsor's pay grade) must be paid during the months registered family members receive ECHO benefits. ECHO cost-shares don't count towards the family's catastrophic cap. (See Appendix A of this module for specific cost-share amounts.)
- Additionally, families may incur cost-shares for health services that:
  - Establish qualifying conditions
  - Confirm the severity of the disabling effects of a qualifying condition
  - Measure the extent of functional loss
- For example, the sponsor of a beneficiary who uses TRICARE Standard/Extra to receive diagnostic services that result in the diagnosis of an ECHO-qualifying condition must pay cost-shares and deductibles for the diagnostic services. These cost-shares and deductibles can't be paid under ECHO.

3.4.1 Government's ECHO Cost-Share Limit

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

3.5 Claims for Benefits with Prior Authorization

- When family members file claims for ECHO-authorized care, they or their sponsor must submit:
  - A *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request For Medical Payment* (DD Form 2642)
  - A copy of the family member's prior authorization
- Families should send claims to the TRICARE regional/USFHP claims processor based on where the family member lives and where he or she is enrolled if using a Prime option.

3.6 ECHO Resources

Additional information on the ECHO program is available at www.tricare.mil/ECHO.

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

- Certain retirees who aren't enrolled in TRICARE Prime or USFHP and were awarded Combat-Related Special Compensation (CRSC) may be entitled to the CRSC travel benefit if the following conditions are met:
  - Travel must be more than 100 miles from the referring provider's location.
  - Travel must be for medically necessary, nonemergency specialty care for a documented combat-related condition.
  - The primary care provider writes a referral for the needed service(s).
- The CRSC travel benefit is not available overseas.

Note: The TROs manage the CRSC travel benefit. (See the TRO websites for more information.)

5.0 TRICARE Benefits and the Affordable Care Act (ACA)

- The Affordable Care Act (ACA) of 2010 requires individuals to have and keep basic health care coverage, also known as "minimal essential coverage" (MEC).
- The following TRICARE health care plans are considered MEC:
  - TRICARE Prime
  - TRICARE Prime Remote
  - TRICARE Prime Overseas
  - TRICARE Prime Remote Overseas
  - TRICARE Standard and Extra
  - TRICARE Standard Overseas
  - TRICARE For Life
  - TRICARE Reserve Select (if purchased)
  - TRICARE Retired Reserve (if purchased)
  - TRICARE Young Adult (if purchased)
  - US Family Health Plan
- The following transitional health plans are considered MEC:
  - Transitional Assistance Management Program (premium-free, 180 days)
  - Continued Health Care Benefit Program (if purchased, 18-36 months)
- Those not considered to have MEC are those who are **only** direct-care eligible and those with line of duty care.

6.0 Computer/Electronic Accommodations Program (CAP)

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

Module Objectives

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

Key Terms

- **TRICARE Young Adult Program (TYA)**
- **Extended Care Health Option (ECHO)**
- **Exceptional Family Member Program (EFMP)**

Appendix A: Additional ECHO Information

Exceptional Family Member Program (EFMP)

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

ECHO Eligibility

- The following family members are eligible for the ECHO program if they have a qualifying condition(s):
  - A spouse, dependent child, or an unmarried person whose sponsor is an active duty member of a uniformed service, including Guard/Reserve members on active service orders for more than 30 consecutive days
  - A spouse, dependent child, or an unmarried person whose sponsor is a former member of a uniformed service and the spouse, child, or unmarried person is a victim of physical or emotional abuse (Benefits are limited to the amount of time the abused dependent receives transitional compensation.)
  - A transitional survivor (This is the surviving spouse, for up to three years from the sponsor's death, and surviving dependent children until they lose eligibility. See the *Key TRICARE Concepts and Terms* module for more information on transitional survivors.)
  - A family member who is eligible for TRICARE benefits through the Transitional Assistance Management Program (TAMP).

ECHO Qualification Determination

- Qualification is based on the specific mental or physical disabilities and enrollment in EFMP, when applicable.
- The family member may need to see his or her assigned PCM or a TRICARE-authorized/USFHP provider to get the necessary testing, screening, and exams to determine and document the qualifying disability and the need for specialty services.
- ECHO qualifying conditions include:
  - An extraordinary physical or psychological condition, defined as a complex physical or psychological clinical condition of such severity that the beneficiary is home bound
  - Multiple disabilities, which aren't ECHO qualifying conditions on their own, that affect multiple body systems
  - Neuromuscular developmental conditions or other conditions which come before a diagnosis of moderate or severe mental retardation or a serious physical disability in infants or toddlers under age three

ECHO Benefits

Services Covered Under ECHO

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

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

Services Not Available Under ECHO

- Inpatient care for medical or surgical treatment of an acute illness or an acute worsening of the qualifying condition
- Structural changes to living space and permanent fixtures, including changes needed to make room for installation of equipment or to facilitate entrance or exit
- Dental care and orthodontic treatment (covered under adjunctive dental care or purchase of a dental program option)
- Certain durable medical equipment and maintenance of beneficiary-owned equipment
- Homemaker services that help with household chores, except those under the ECHO Home Health Care benefit
- The purchase and maintenance of service animals including and not limited to seeing eye dogs, hearing/handicap assistance dogs, seizure and other detection animals, and service monkeys.

ECHO Cost-Shares

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

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

Appendix B: Computer/Electronic Accommodations Program

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

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

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

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

CAP Eligibility

- Disabled employees who work for the DoD or one of 66 federal agency partners.
- ADSMs with limitations from an injury or illness the occured while on active duty.

CAP Services

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

CAP Websites

For more information on CAP, please visit:

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

TRICARE Fundamentals Course

TRICARE and Medicare

9

Participant Guide

References

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

Brainteasers

Each of the eight items below is a separate puzzle.

How many can you figure out?

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

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

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

Key Terms

- **TRICARE For Life (TFL)**
- **Medicare Part A**
- **Medicare Part B**
- **Other Health Insurance (OHI)**

1.0 Introduction

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

?	Throughout this module, you will answer scenario questions on retired Sergeant Major Gill and his wife, Noelle.

2.0 Eligibility

- TFL is for TRICARE beneficiaries entitled to premium-free Medicare Part A who also purchase Medicare Part B (dual-eligibles), no matter how old they are or where they live.
- TFL benefits start the first day Medicare Part A **and** Part B are in effect.
- Those under age 65 may enroll in TRICARE Prime (if they live in a Prime Service Area).
  - TRICARE doesn't charge Prime enrollment fees for those with Medicare Part B.

2.1 Defense Enrollment Eligibility Reporting System (DEERS)

- TRICARE and Medicare exchange files to verify beneficiaries' Medicare Part A entitlement and Part B status.
  - TFL status shows as pending until verified with Medicare.
- The Defense Enrollment Eligibility Reporting System (DEERS) must reflect a beneficiary's Medicare and TRICARE status for TFL benefits and claims processing.

3.0 Basics of Medicare

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

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

3.1 Medicare Part A and Part B

- Medicare Part A (hospital insurance), which is funded through payroll taxes, helps cover inpatient care and costs in hospitals, skilled nursing facilities, hospice care, and home health care. If a person pays into Medicare for 40 quarters, he or she is entitled to premium-free Medicare Part A at age 65.
  - If eligible for premium-free Medicare Part A at age 65, a person receives a *Notice of Award*, the official letter from the Social Security Administration (SSA) showing his or her entitlement to premium-free Medicare Part A and enrollment in Medicare Part B.
  - If not eligible for premium-free Medicare Part A based on their own work history, a person should contact the SSA to find out if he or she qualifies under their spouse's or divorced spouse's Social Security number (SSN). If a person doesn't qualify, he or she may purchase Medicare Part B on his or her own. (See *Appendix B* of this module for more information.)
- Medicare Part B (medical insurance) helps cover medically-necessary outpatient services, such as physician services, outpatient care, home health services, some preventive health services, durable medical equipment, and other medical services. Medicare bases its Part B premiums on a person's reported income.

4.0 TRICARE For Life

4.1 Medicare Part B Enrollment Is Required

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

- Around three months before their 65th birthday, the Defense Manpower Data Center (DMDC) notifies TRICARE beneficiaries of the need to purchase Part B.

Note: Beneficiaries must enroll in Medicare Part B when first eligible to avoid paying a Medicare premium penalty. This fee is collected by raising the beneficiary's monthly premium by 10% for every full 12-month period he or she was eligible for Medicare Part B, but didn't to sign up.

4.2 Exceptions to Medicare Part B Enrollment Requirement

The following beneficiaries entitled to Medicare Part A don't have to enroll in Medicare Part B to remain TRICARE eligible. They will be covered by TRICARE Standard or may enroll in a Prime option.

- Active duty service members (ADSMs) and active duty family members (ADFMs) whose sponsor is on active duty.
  - Medicare Part B MUST be in effect on or before the sponsor's retirement date (medical or regular) to avoid a break in TRICARE coverage.
  - If these individuals enroll in Medicare Part B after the sponsor's retirement date, there may be a break in TRICARE coverage until Medicare Part B takes effect.
- TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) members.

?	Sergeant Major Gill is turning 65 in two months and will be entitled to Medicare Part A. What happens to SgtMaj Gill's TRICARE eligibility if he fails to enroll in Medicare Part B? What happens to his wife, who is 63, when SgtMaj Gill starts on Medicare? Are there situations in which SgtMaj Gill wouldn't enroll in Medicare Part B, yet still be TRICARE-eligible?

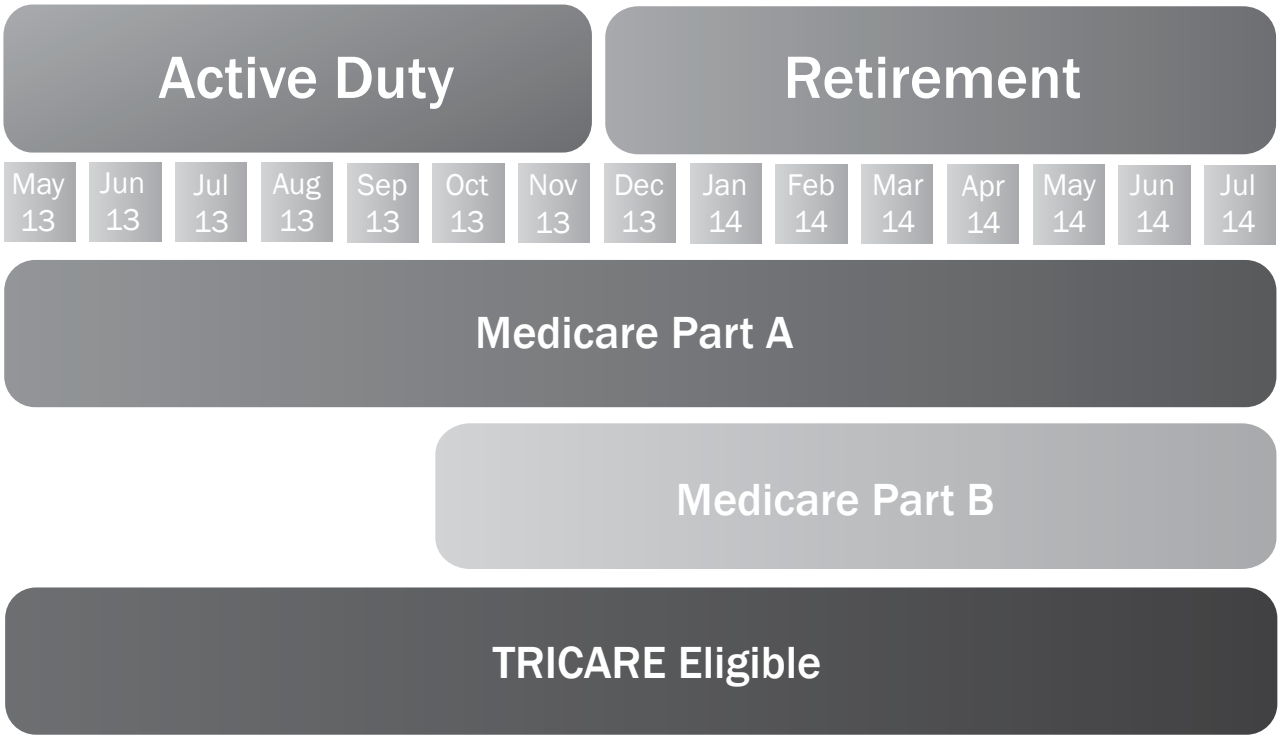
4.3 Scenarios

4.3.1 Scenario 1

Sergeant Williams is a combat-wounded ADSM receiving Social Security disability benefits. He receives notice that his Medicare Part A and Part B effective dates are May 2013. He disenrolls from Medicare Part B because he is on active duty. His service notifies him that his medical retirement date is December 1st, 2013. He decides to enroll in Medicare Part B, while still on active duty, with his Medicare Part B effective October 1, 2013. Though he declined his Medicare Part B when he was first eligible, he enrolled before his retirement. Does he have a break in coverage? When does his TRICARE eligibility begin?

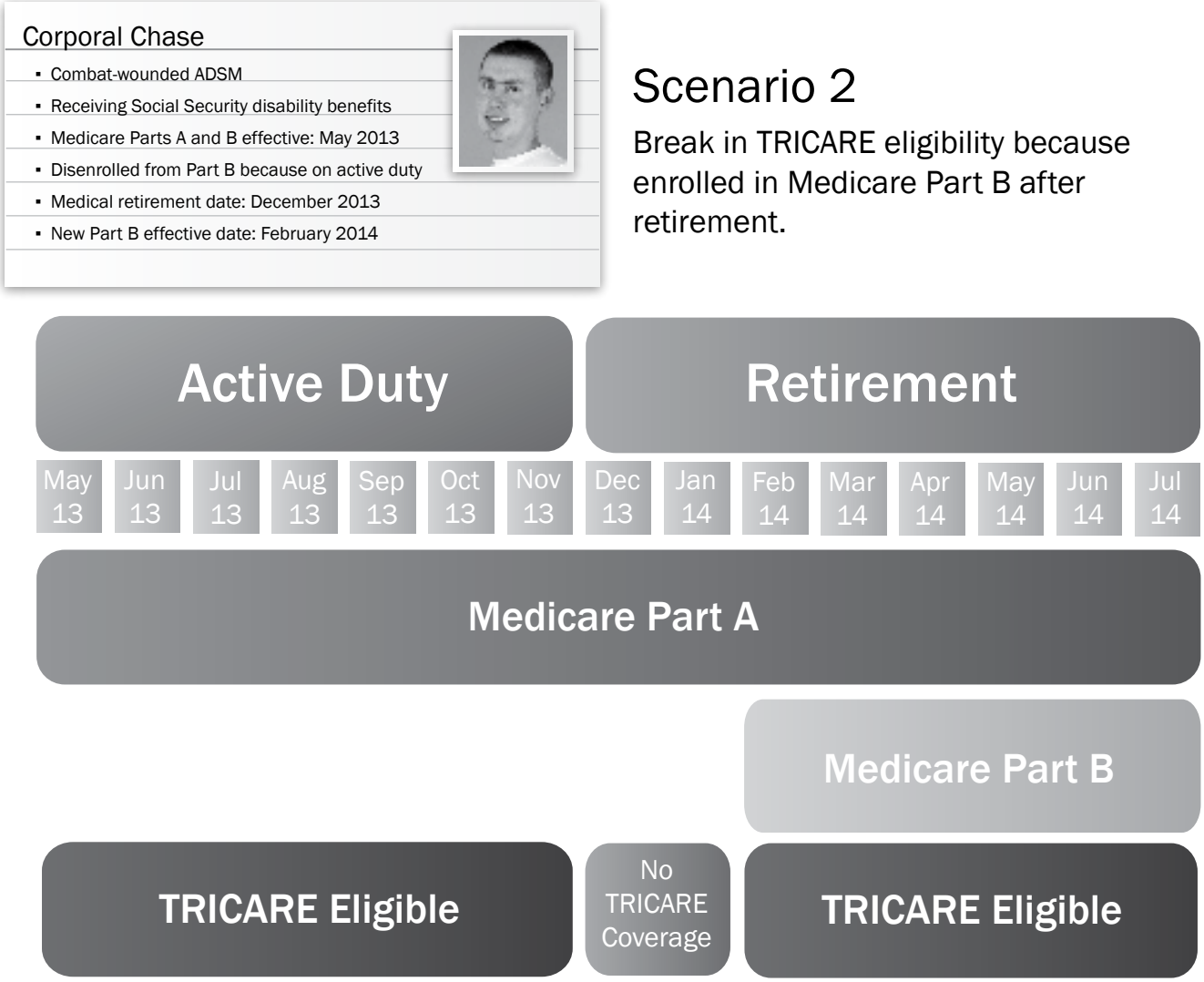
Scenario 1

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



4.3.2 Scenario 2

Corporal Chase is a combat-wounded ADSM receiving Social Security disability benefits. He receives notice that his Medicare Part A and Part B effective dates are May 2013. He disenrolls from Medicare Part B because he is still on active duty. His service notifies him that his medical retirement date is December 1st, 2013. Corporal Chase decides to enroll in Medicare Part B on January 1, 2014. Does he have a break in coverage? When does his TRICARE eligibility begin?



5.0 How TFL Works with Medicare

5.1 Services Covered by Both Medicare and TRICARE:

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

5.2 Services Covered by Medicare, But Not by TRICARE:

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

5.3 Services Covered by TRICARE, But Not by Medicare:

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

5.4 Services Not Covered by TRICARE or Medicare:

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

5.5 Payer Table

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

6.0 How TFL Works with Other Health Insurance (OHI) and Veteran's Affairs (VA) Care

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

- If the beneficiary has group health plan coverage through their current employer, the employer group pays first, Medicare pays second, and TRICARE pays last. (A few exceptions apply, per Medicare policy)
- If the beneficiary is retired or not working and has OHI, Medicare pays first, OHI pays second, and TRICARE pays last.
  - When OHI processes the claim after Medicare, the beneficiary must submit a claim to the TFL claims processor for possible payment of any remaining out-of-pocket costs since the claim won't transfer automatically to TRICARE.
- Medicare can't pay for services received from VA providers. As of October 1, 2013, if TFL beneficiaries are seen at the VA for non-service-connected disability care, TRICARE processes the claim as first payer but only pays 20% of the TRICARE-allowable charge (since Medicare should have been first payer). In these cases, beneficiaries are responsible for any remaining charges the VA wants to bill them.

7.0 Working Beneficiaries Age 65 and Older

- Medicare allows those age 65 and older with group health plan coverage based on current employment to delay Part B and sign up during a special enrollment period. This special period runs for eight months following either (1) retirement, or (2) the end of the group health plan coverage, whichever comes first.
- To remain TRICARE-eligible, these beneficiaries must purchase Medicare Part B when they first become eligible for Part B (typically at age 65). Until they purchase Part B, they're not eligible for TFL.
  - If they don't purchase Medicare Part B when they first become eligible, beneficiaries will have a gap in TRICARE coverage. (For example, if they wait and purchase Medicare Part B two months into their special enrollment period, they won't have TRICARE coverage for those two months.)
  - TFL coverage begins on the same day as the Medicare Part A **and** Medicare Part B effective dates.

?	SgtMaj Gill's wife, Noelle, who is also TRICARE-Medicare eligible, is still employed as a full-time kindergarten teacher. She receives group health insurance through her employer along with TFL and Medicare. After having several weeks of foot pain, her podiatrist recommends she wear an ankle brace. Which of her three coverage providers should receive this claim first? What should she do if it is denied by her primary health care plan?

8.0 Using TFL While Overseas

TRICARE coverage is available to dual-eligible beneficiaries living overseas, as long as they have Medicare Part A and Part B.

- Medicare provides coverage in U.S. territories (Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and Northern Mariana Islands). In these areas, claims are processed as usual, with the provider billing Medicare first. Medicare processes the claim and forwards it to the TFL claims processor.
- For beneficiaries living overseas in areas Medicare doesn't cover, TRICARE is the primary payer (as long as there is no OHI) and no Medicare Summary Notice (MSN) is required.
  - The MSN shows the services and/or supplies billed to Medicare during a three month period, what Medicare paid, and what the beneficiary may owe the provider. It's not a bill.
  - Overseas beneficiaries should be prepared to pay the total billed charges up front and to file their own claims for reimbursement. TFL beneficiaries submit the *TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment* claim form (DD Form 2642) and a copy of the provider's itemized bill to the overseas claims processor.

9.0 TFL Claims Processing

When a beneficiary has Medicare and TRICARE:

- The TFL claims processor handles all claims for TFL beneficiaries, except those living or receiving services overseas where Medicare isn't accepted—those are handled by the overseas claims processor. The TFL claims processor also handles claims for Prime enrollees with Medicare Part A.
- Medicare processes the claim, then issues an MSN to the provider and beneficiary.
- Medicare then electronically forwards the claim to TRICARE for processing (as long as the beneficiary identified him/herself as TRICARE eligible and there is no other OHI).
- TRICARE processes the claim. Beneficiaries then receive a monthly TFL explanation of benefits (EOB) detailing claims processed that month.
    - TFL beneficiaries may receive their EOBs electronically by registering to receive e-mail alerts at www.TRICARE4u.com. The e-mail alert links to a secure website where registered users can view and/or print their TFL EOBs.
- It's important to note that Medicare, as the primary payer, is responsible for determining medical necessity. If Medicare doesn't pay because it determines the care isn't medically necessary, TFL doesn't pay.
    - The beneficiary may appeal Medicare's decision, and if Medicare reconsiders and provides coverage, TFL reconsiders coverage. (See the *Appeals* module for more information).

10.0 Pharmacy and TFL

- The TRICARE pharmacy benefit doesn't change under TFL. TFL beneficiaries don't need to enroll in a Medicare prescription drug plan (Medicare Part D) to keep the TRICARE pharmacy benefit. (See the *Pharmacy* module for more information.)
- If a beneficiary chooses to enroll in Medicare Part D at a later date, he or she doesn't pay a penalty for late enrollment, as the TRICARE Pharmacy Program is considered creditable drug coverage.
- Overseas TFL beneficiaries pay for covered prescription medications up front and file claims for reimbursement with the overseas claims processor; TRICARE deductibles and cost-shares apply.

11.0 Application Exercises

Scenario 1
Mrs. White is a uniformed service retiree who also retired from her civilian job. She has Medicare Part A and Part B, OHI through her former civilian employer, and TFL. TFL will be primary payer. True or False? Why?

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

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

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

Module Objectives

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

Key Terms

- **TRICARE for Life (TFL)**
- **Medicare Part A**
- **Medicare Part B**
- **Other Health Insurance (OHI)**

Appendix A: Medicare Overview

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

Note: TRICARE doesn't cover Medicare Part C premium costs.

Medicare Part B Enrollment Periods

Initial Enrollment Period

- This is a seven-month period. It starts three months before the month the beneficiary is first eligible for Medicare Part B.
  - Individuals with a birthday on the first of the month are eligible for Medicare the month before their 65th birthday.
  - Individuals with a birthday that is other than the first of the month are eligible for Medicare the first of the month in which they turn 65.
- Those who receive Social Security or Railroad Retirement Board (RRB) retirement benefits before age 65 automatically get Medicare Part A and Medicare Part B beginning on the first day of the month they turn age 65, or the month before if their birthday falls on the first of the month.
- Disabled beneficiaries under age 65 automatically get Medicare Part A and Part B starting the 25th month of receiving disability benefits (Social Security Disability Insurance) or disability from the RRB.
- Beneficiaries should receive their Medicare card in the mail about three months before their 65th birthday or three months before their 25th month of disability benefit entitlement (only if they're getting SSA or RRB benefits).

General Enrollment Period

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

Special Enrollment Period

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

During the SEP, individuals may enroll in Medicare:

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

Medicare Part B Premium Penalty

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

Medicare Prescription Drug Benefit — Medicare Part D

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

Medicare Part D Enrollment

- Enrollment window: Beneficiaries can join or switch Medicare drug plans every year during the open enrollment period (October 15–December 7).
- Medicare drug coverage generally begins on January 1 of the following year.
- Penalty: Individuals who don't join a Medicare drug plan when first eligible for Medicare Part A and/or B and go without creditable prescription drug coverage (TRICARE is creditable coverage) for 63 continuous days or more may have to pay a late enrollment penalty to join a Part D plan later.
- TRICARE beneficiaries may disenroll from Part D at anytime and resume the TRICARE pharmacy program benefit coverage.

Appendix B: What If I'm Not Eligible for Premium-Free Medicare Part A?

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

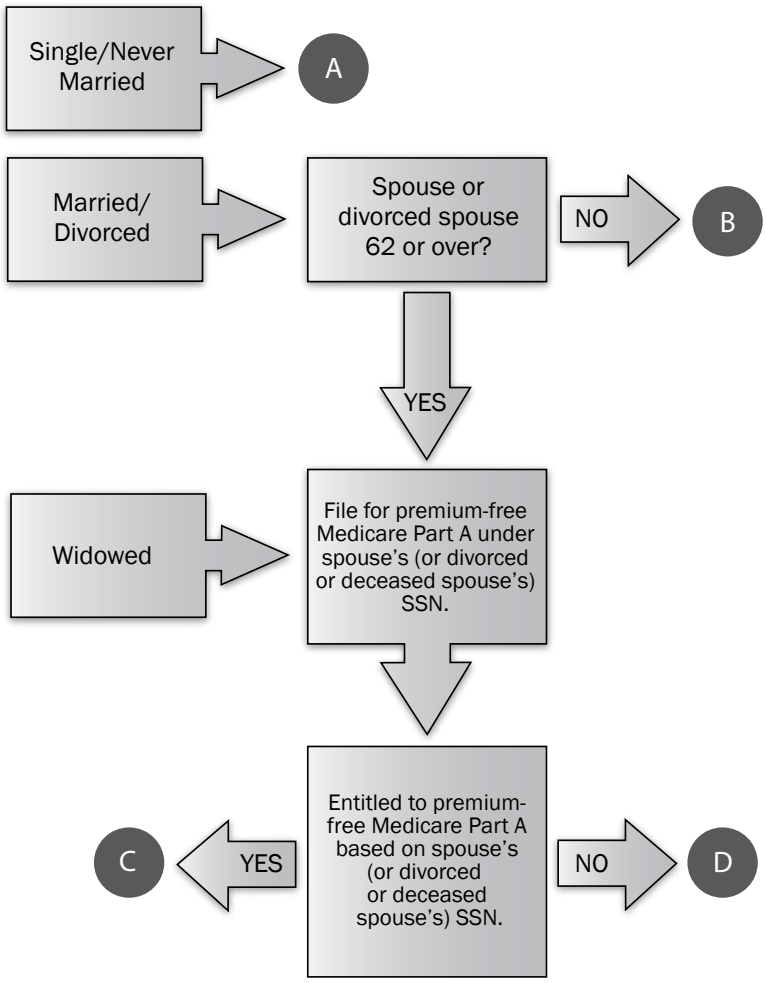
Share the following with the beneficiary in response to this question:

Depending on your eligibility status for premium-free Medicare Part A based on *your* SSN and work history, you receive either a *Notice of Award* or a *Notice of Disapproved Claim* from your regional SSA office.

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

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

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



To Remain TRICARE Eligible

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

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

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

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

TRICARE Fundamentals Course

Claims

10

Participant Guide

References

32 CFR § 199.7, 199.10
2008 TRICARE Operations Manual, Chapters 8–10
2008 TRICARE Reimbursement Manual, Chapter 1

Brainteasers

Each of the eight items below is a separate puzzle.

How many can you figure out?

1. R | E | A | D | I | N | G	2. Go stand	3. LANG4UAGE	4. N I A T P C A
5. dice dice	6. Dribble Dribble	7. GROUND 	8. FRIENDS STANDING FRIENDS miss

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

- **Explain who can file claims and where to submit claims**
- **Describe how other health insurance (OHI) works with TRICARE**
- **Describe how to resolve claims issues**
- **Identify three reasons why the processing of a claim or the issuing of an explanation of benefits (EOB) may be delayed**

Key Terms

- **Claims**
- **Other Health Insurance (OHI)**
- **Explanation of Benefits (EOB)**
- **Fraud**

The content in this module and the next module (Appeals) applies primarily to claims and appeals for health care services, and not to pharmacy or dental claims/appeals. See the Pharmacy module and Dental module appendices for claims and appeals information for those services. Fraud information is provided for all contractors.

?	Throughout this module, you will answer scenario questions on active duty service member Major Stewart and his family.

1.0 Introduction to Claims

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

2.0 Claims Filing

- TRICARE-eligible beneficiaries and TRICARE-authorized providers may file claims. However, **the beneficiary is ultimately responsible for making sure claims are filed** no matter what type of provider the beneficiary uses.
- The spouse, parent, or legal guardian of a minor (under age 18) or an incompetent beneficiary may submit a claim for the dependent beneficiary (certain restrictions apply).

2.1 Filing Deadlines

- Beneficiaries should file claims as soon as possible after receiving services.
- If claims aren't filed within the following time lines, they will be denied.

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

- If a claim is denied, the beneficiary should follow the instructions that come with the denial and, if needed, follow-up with the regional contractor.
- **Note:** There are no filing deadlines for active duty service members' (ADSMs') claims.

3.0 Submitting Claims

- Providers submit claims to the claims processor serving the beneficiary's residential address or Prime enrollment region, except overseas. All claims for overseas care are sent to and processed by the overseas claims processor.
- There are two major TRICARE claims processors:

North, South, and West Regions	Overseas Regions and TRICARE For Life
PGBA	Wisconsin Physicians Service (WPS)

- If a beneficiary sees a network provider, the provider files the claim.
  - The beneficiary remains responsible for making sure a claim is filed.
  - If TRICARE denies a claim because it wasn't timely filed, the network provider can't bill the beneficiary.
- If a beneficiary sees a non-network provider, the provider doesn't have to file the claim, but may choose to do so.
  - The beneficiary is responsible for making sure the claim is filed.
  - The beneficiary is responsible for all costs if the provider doesn't meet the filing deadlines.
- If sent to the regional contractor instead of the claims processor, the contractor forwards the claim to the claims processor.
- If a claim is sent to the wrong claims processor, the claim is either forwarded to the appropriate claims processor or returned to the sender.
- TRICARE-eligible beneficiaries are responsible for keeping their personal contact information up-to-date with their providers so claims go to the correct claims processor and they receive related payments, explanations, instructions, or other information.

Note: For information on submitting US Family Health Plan (USFHP) claims, see the *TRICARE Options* module. For information on submitting Continued Health Care Benefit Program (CHCBP) claims, see the *Transitional Benefits* module.

?	Major Stewart's family is currently enrolled in TRICARE Prime. Recently, his daughter's doctor referred her to a civilian ear, nose, and throat specialist for a chronic sinus condition. If the Stewart's live in Atlanta, GA, who processes the claim for Emily's office visit? When must the claim be filed? Who is responsible for making sure the claim is filed?

4.0 Claim Forms

4.1 Beneficiaries

Beneficiaries use the *TRICARE DoD/CHAMPUS Medical Claim Form* (DD Form 2642*)* to submit claims for services or supplies provided by civilian providers and for prescription drugs. Providers can't use *DD Form 2642*. If they do, the contractor returns the claim. (See Section 4.2 of this module for more information.)

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

4.2 Providers

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

4.3 Items That Accompany a Claim

Beneficiaries need to attach the following when filing a claim:

- An itemized bill from the provider with diagnosis and procedure codes for billed services/supplies. This must be written on the provider's letterhead or on a standard form along with the provider's tax ID number.
- An itemized list of pharmacy charges. This list must be written on the pharmacy's letterhead or billing form.
- Proof of payment for care if the beneficiary paid out-of-pocket for services, especially overseas. The following are accepted as proof of payment:
  - A canceled check, credit card receipt, or electronic funds transfer (EFT) record used to pay the provider
  - The provider's invoice/receipt
  - Proof of cash withdrawal if the beneficiary pays in cash
- Other health insurance (OHI) claim forms: The health plan's payment determination, denial statement, or Explanation of Benefits (EOB) (See Section 8.0 of this module for more information on EOBs.)
- *Statement of Personal Injury—Possible Third-Party Liability, TRICARE Management Activity* (DD Form 2527)
  - Required with *DD Form 2642* when a beneficiary's condition is potentially accident related, work related, or both, and when certain procedure or diagnostic codes indicate there may be third-party liability.
  - Beneficiaries must submit *DD Form 2527* with the initial claim or within 35 days after receiving the form from the regional claims processor.
  - If the beneficiary fails to submit *DD Form 2527* within the time frame noted on the form or claims processor's letter, the claim may be suspended or denied.

?	The specialist Emily saw is a non-network provider. He informed the Stewarts that his office doesn't files claims for beneficiaries, meaning the Stewarts are now responsible for filing the claim. What documents must the Stewart's send to the claims processor?

5.0 Claims Processing Procedures

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

5.1 Processing Criteria

Claims processors verify payment criteria in this order:

1. The beneficiary is eligible.
2. The claim is timely filed.
3. The provider is TRICARE-authorized.
4. The service or supply is a TRICARE benefit.
5. The service or supply is medically necessary and appropriate or is a TRICARE-approved clinical preventive service.
6. The beneficiary is required to pay for the service or supply (when appropriate).
7. The claim has enough information to determine the TRICARE-allowable charge for each service or supply.

5.2 Processing Criteria for Newborn Claims

- The claims processor can process claims for newborns not registered in DEERS as long as:
  - The newborn's date of birth is within 365 days of the contractor's eligibility query; ***and***
  - The sponsor is/was eligible for TRICARE on the date(s) of care listed on the newborn's claim
- Exception: If the sponsor (and family) have TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) coverage, they must submit or postmark a *Reserve Component Health Coverage Request* form (DD Form 2896-1) to the contractor within 60 days of the newborn's birth for coverage to start on the date of birth. The newborn's claims are then paid as a covered family member.
- See Appendix A of the *Key TRICARE Concepts and Terms* module for more information on newborn eligibility.

6.0 TRICARE Overseas Program (TOP) Prime Remote Claims

The following table describes some of the unique processes for submitting TOP claims.

TOP Prime Remote Claims

● The overseas contractor's Call Centers serve as Primary Care Managers (PCMs). When possible, they arrange care with qualified purchased care/host nation providers and issue authorizations for services.
● When a purchased care/host nation provider accepts the contractor's authorization, the provider submits the claim to the overseas claims processor for payment and it's processed as "cashless-claimless" for TOP enrollees.
  ○ When TOP Prime Remote-enrolled ADSMs seek care from a purchased care/host nation provider without an authorization from the TOP contractor, their claims are denied. In these cases, reimbursement should come through the ADSM's service-specific fund.
  ○ When receiving authorized care from a purchased care/host nation provider other than the provider identified by the TOP contractor, enrollees pay up front and file their own claims for reimbursement.
● The TOP Prime Remote procedure for host nation provider claims coordinated through a TOP Prime Remote Point of Contact (POC):
  ○ The POC helps the enrollee complete and submit claims, but they can't sign for the beneficiary.
  ▪ The overseas contractor provides a dedicated P.O. Box, fax number, and e-mail address for POC-submitted claims and correspondence.
  ○ The overseas contractor returns payment (foreign currency/U.S. dollars) and EOBs to the POC for distribution to providers and beneficiaries (when requested).

Note 1: Box 13 on the *DD Form 2642* asks beneficiaries if they would like payment issued in local currency. The term "local" refers to country where services were received. If marked "yes," the claims processor issues payment in that country's currency. If the box is marked "no" or neither "yes" or "no" box is checked, the claims processor issues payment in U.S. dollars.
Note 2: TRICARE doesn't pay for care in U.S. Embassy clinics

7.0 TRICARE and Other Health Insurance (OHI)

By law, TRICARE is the last payer to other health insurance (OHI), medical/hospital insurance, medical service, or health plans. (Exceptions: Medicaid, Indian Health Service, and certain other programs identified by the Director, Defense Health Agency (DHA) [e.g., State Assistance Plans]).

- If a beneficiary has OHI, the beneficiary or the provider must file a claim with that health insurance plan/service before filing with TRICARE.
- After the OHI processes the claim, the beneficiary or provider (if willing) files a claim with the TRICARE claims processor, attaching a copy of the OHI plan's EOB and the itemized bill.
- Beneficiaries must notify their regional contractor or the claims processor about their OHI and any changes in carriers or coverage. The claims processor may delay processing or later recoup on claims if beneficiaries don't tell TRICARE that they have OHI.
- When the OHI doesn't cover a procedure or benefit that is a TRICARE-covered benefit, the beneficiary submits a claim to the TRICARE claims processor along with the OHI's EOB showing the reason for non-payment.
  - If TRICARE approves the claim for payment, TRICARE's deductibles, cost-shares, and copays apply.

7.1 Host Nation Insurance

- Family members who are native to the host country may have host nation insurance coverage.
- Host nation insurance including, but not limited to, German Statutory Health Insurance, Japanese National Insurance, and Australian Medicare is considered OHI and can't be waived.
  - Host nation insurance is primary payer and TRICARE pays last.
  - Beneficiaries submit their claim form, receipts, proof of payment, and a copy of the document showing host nation payment to the overseas claims processor.

8.0 Explanation of Benefits (EOB)

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

8.1 When to Expect an EOB

- For the majority of claims, the beneficiary and the provider should each receive an EOB within six weeks of submitting a claim. Some complex claims may take 60 days or more to complete.
- If the beneficiary doesn't receive an EOB or can't find the claim on the claims processor's website within six weeks of the date of service, tell the beneficiary to contact the provider (or facility) to make sure a claim was filed. This also helps to make sure missing claims are timely filed. If it appears the provider submitted the claim, the beneficiary should follow-up with the regional claims processor or contractor.
- Remind beneficiaries to follow-up with ambulance companies separately to make sure those claims are timely filed.

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

- Wrong address
- Medical necessity isn't documented/justified
- A third-party liability form wasn't received
- Provider delayed submitting a claim
- Diagnosis is missing or inconsistent with services provided
- There is a government-directed delay (possibly because the provider is being investigated)
- Claim is incomplete
- OHI forms are missing
- Claim is complex and requires in-depth review
- Service is non-authorized
- Provider's unique Provider Identification Number or National Provider Identification is missing
- Eligibility is questioned or DEERS information is inaccurate

8.3 Importance of Reviewing EOBs

- Beneficiaries should carefully compare each EOB with services they received and their bills, checking that the right provider(s) are billing for services, and the cost(s) of those services are being reimbursed.
  - Beneficiaries should contact the claims processor about charges for service(s) they didn't receive. Incorrect charges may be due to a provider or claims system error, or an indication of fraud.
- Beneficiaries may contact the regional contractor or claims processor by phone or e-mail.
- Beneficiaries may also seek assistance from the nearest military treatment facility (MTF) or regional Beneficiary Counseling and Assistance Coordinator (BCAC) or Debt Collection Assistance Officer (DCAO) if the regional contractor or claims processor fails to resolve a claims issue.

8.4 Components of an EOB

- **Claims Processor:** The claims processor that processed the claim and issued the EOB. This can be important. Example: A claim could be denied if it is sent to the wrong processor.
- **Date of Notice:** The date the claims processor prepared the TRICARE EOB.
- **Mail to Name and Address:** The beneficiary's (or beneficiary's parent's or guardian's) address as noted on the claim form. The claims processor mails the EOB to this address.
- **Claim Number:** The unique number assigned to each claim that is used for reference if there are questions.
- **Sponsor Social Security Number (SSN)/Sponsor Name:** Claims process using the sponsor's SSN (active duty, retired, or deceased) or the individual's DoD Benefits Number. The sponsor is the ADSM, retiree, or deceased sponsor through whom family members are eligible for TRICARE. Only the last four digits of the SSN appear on the EOB.
- **Beneficiary Name:** The individual who received the service/procedure.
- **Service Provided By:** Lists who provided care/services.
- **Services Provided:** Lists the specific procedure code(s) and a brief description of the services/care billed.
- **Date of Services:** Lists the date(s) the beneficiary received services.
- **Amount Billed:** The amount the provider charged for a particular service(s).
- **TRICARE Allowed:** This is the amount allowed by TRICARE based on the date of service and the geographic location of the provider, or the contracted payment for a network provider.
- **See Remarks:** There may be a code or a number specific to a claims processing action; look at the "Remarks" section for the code description and explanation of how the claim processed.
- **Claim Summary/Beneficiary's Name:** A summary of cost totals on the entire claim/EOB. Includes the following: total amount billed, total allowed amount by TRICARE, non-covered amount (if any), total amount OHI/Medicare paid (if applicable), total amount paid by TRICARE, total cost-share/copay (if any), total amount applied to the deductible (if any), patient responsibility (e.g., total of deductible, cost-share/copay, and possible non-covered services combined).
- **Out-of-Pocket Expense:** Shows the beneficiary's/family's out-of-pocket costs and how much went towards the annual deductible and catastrophic cap (maximum out-of-pocket expense) as of the date on the EOB. Claims processors determine annual deductibles and catastrophic cap expenses by fiscal year.
- **Remarks:** Explains the codes or numbers listed in "See Remarks" section and provides general guidance.
- **Paid To:** Indicates who the claims processor issued the payment check to. This can be the provider, sponsor, or beneficiary, depending on the provider's status and how the claim was filed. If the provider is a network provider, the claims processor issues payment to the provider. If a provider agrees to participate (by accepting assignment on a claim), the claims processor pays the provider unless claim shows that the beneficiary paid —the check then goes to the beneficiary.
- **Amount Paid:** The amount TRICARE pays on the claim.
- **Check Number:** This number identifies the check that goes with the payment. (This can be helpful when the claims processor issues one check for multiple claims.)

8.5 Application Exercises

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

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

1. What is the date of notice?

2. Who is the sponsor?

3. Who received services?

4. Who provided the care and what type of care was provided?

5. How much did the provider bill?

6. How much did TRICARE cover and what is the term for this approved amount?

7. What do the remark codes explain?

8. How much did TRICARE pay?

9. How much (if any) applied to the deductible?

10. What is the cost-share/copay?

11. How much does the beneficiary owe?

12. Who was paid—the provider or the beneficiary?

13. What type of provider is this?

14. Which TRICARE option was the beneficiary using? How do you know?

15. By law, how much can the provider bill Jane Smith?

8.5.2 Practice Scenario

Mrs. Jane Smith just walked into your office, very upset. She recently visited Pierce, Hunnicutt, & Winchester, P.C. She paid the doctor's office $200 at the time of service and was told that she could file with TRICARE for reimbursement of her payment. Mrs. Smith filed her claim with her regional claims processor. She received her EOB, along with a check for $60. She is upset because she wasn't reimbursed the full $200. Mrs. Smith wants this taken care of as soon as possible.

Based on her EOB and your knowledge of TRICARE claims, please help Mrs. Smith understand why she didn't get back the full $200.

Note: It's important for beneficiaries to read their **entire** EOB to find out how much they owe. If TRICARE doesn't pay, the EOB shows no beneficiary liability because the claim/item was denied; beneficiaries need to find out why.

TRICARE EXPLANATION OF BENEFITS

Administered by: TRICARE University

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

Jane Smith
123 S. Christmas Lane
Nice, SC 20315

Date of Notice	January 15, 2014
Sponsor SSN	XXX-XXX-XXXX
Sponsor Name	John Smith
Beneficiary Name	Jane Smith
Claim Number	345678901
Provider Number	XX-XX648
Check Number	512340

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

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

SERVICES PROVIDED BY	DATE OF SERVICE	SERVICES PROVIDED	AMOUNT BILLED	TRICARE ALLOWED	SEE REMARKS
Pierce, Hunnicutt, & Winchester, P.C.	11/29/2013	Outpatient Visit (99214)	$200.00	$80.00	01, 02, 03
Totals:			$200.00	$80.00	

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

OUT OF POCKET EXPENSES

Beginning October 1, 2012	Met To Date	Limit	Beginning October 1, 2012	Met To Date	Limit
Deductible	$150.00	$300.00	Catastrophic Cap	$170.00	$3,000.00

REMARKS

01—Billed amount exceeds allowance.

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

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

PAID TO	AMOUNT PAID	CHECK NUMBER
Jane Smith	$60.00	512340

9.0 Resolving Claims Issues

- To resolve claims issues, beneficiaries should call their regional contractor's toll-free number and select the option for claims assistance.
- If the claim issue remains unresolved, the beneficiary may contact an MTF or TRICARE Regional Office (TRO)/TRICARE Area Office (TAO) BCAC.
- If an unresolved debt results in a collection action, the beneficiary should first contact the regional contractor and then an MTF or TRO/TAO DCAO if he or she needs more help.
- BCACs/DCAOs must register for access to the regional claims processor's online system (www.myTRICARE.com or www.TRICARE4u.com) to review claim status information for their region.

9.1 Assisting the Beneficiary with Claims Issues

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

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

If beneficiaries state they never received an EOB, look up claims information online if access is available or call the claims processor to find out if the provider submitted a claim. If not, tell the beneficiary to ask the provider's office to file a claim or send an itemized bill to the beneficiary to file with a claim. If the beneficiary determines the claim processor didn't receive the claim, the beneficiary or the provider may resubmit.

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

?	Roughly six weeks after submitting the claim for Emily's office visit, the Stewarts receive an explanation of benefits in the mail. They are surprised when the EOB shows that they are responsible for the entire cost of the visit. Because they had a referral, they think something is wrong. What's the first step the Stewarts should take to resolve this issue? Under what circumstances would they be responsible for the entire cost of the visit?

10.0 Program Integrity

- The Defense Health Agency (DHA) Office of Program Integrity:
  - Is the investigative arm of DHA
  - Manages the DHA anti-fraud program
  - Is responsible for national coordination and control of cases through their work with contractors, the Department of Justice (DoJ), and investigative agencies
  - Oversees all contractor program integrity units to make sure they comply with anti-fraud activities
- Program Integrity is responsible for stopping fraud, waste, and abuse through prevention, detection, coordination, and enforcement

10.1 What is Fraud?

- Fraud is any intentional deception or misrepresentation by an individual or entity that could result in an unauthorized TRICARE benefit or payment.
- TRICARE considers the following to be fraudulent acts:
  - Submitting claims for services not delivered or used
  - Falsifying claims or medical records
  - Misrepresenting dates, frequency, duration, or description of services
  - Billing at a higher level than provided or necessary
  - Seeking services beyond what is considered necessary
  - Breaking a provider participation agreement
- Fraud can result in criminal conviction, civil settlement, administrative action by the contractor, termination action, or exclusion action (i.e., removal from the TRICARE program).

10.2 Who Commits Fraud?

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

10.3 Fraud Indicators

- Excessive charges by provider
- Reluctance of provider to submit records
- Written request for rapid claims processing
- Conflicting dates of service
- Diagnosis or treatment not typically associated with a beneficiary's age or sex
- Excessive billing by provider for low cost items or services
- Provider bills the same procedures to every patient, regardless of diagnosis
- Provider uses post office boxes to receive payment
- Claims with too much or vague documentation
- Overlapping services on the same date
- Unusual places of service
- Too many providers for same date of service
- High volume of treatment for a particular condition or diagnosis
- Claims handwritten in the same ink for both the beneficiary and provider portion of claim
- Provider is not in the same geographic area as the beneficiary; particularly when patterns occur
- Claims with misused or misspelled medical terms

10.4 Where to Report Potential Fraud Cases

Defense Health Agency		
Defense Health Agency Attn: Program Integrity 1604 E. Centretech Parkway Aurora, CO 80011-9066 Fax: (303)-676-3981 E-mail: fraudline@tma.osd.mil		
TRICARE North Region: Health Net Federal Services	**TRICARE South Region: Humana Military Healthcare Services**	**TRICARE West Region: UnitedHealthcare Military & Veterans**
Health Net Federal Services P.O. Box 105310 Atlanta, GA 30348-5310 1-800-977-6761 E-mail: program.integrity@healthnet.com	Humana Military Healthcare Services 500 West Main St. Louisville, KY 40202 1-800-333-1620	TRICARE West Region Program Integrity P.O. Box 740826 Atlanta, GA 30348-5493
TRICARE Overseas: International SOS	**TRICARE For Life (TFL): Wisconsin Physician Services**	**TRICARE Pharmacy Program: Express Scripts, Inc.**
1717 W. Broadway P.O. Box 7635 Madison, WI 53707 1-877-342-2503 E-mail: TOPProgramIntegrity@internationalsos.com	1-866-773-0404 E-mail: reportit@wpsic.com	13900 Riverport Dr. Maryland Heights, MO 63403 1-866-216-7096 E-mail: fraudtip@express-scripts.com
Active Duty Dental Program: United Concordia	**TRICARE Dental Program: MetLife**	**TRICARE Retiree Dental Program: Delta Dental**
4401 Deer Path Road, DP-4E Harrisburg, PA 17110 1-877-968-7455	P.O. Box 14181 Lexington, KY 40512 1-800-462-6565	1-888-838-8737

Module Objectives

- **Explain who can file claims and where claims should be submitted**
- **Describe how other health insurance (OHI) works with TRICARE**
- **Describe how to resolve claims issues**
- **Identify three reasons why the processing of a claim or the issuing of an explanation of benefits (EOB) may be delayed**

Key Terms

- **Claims**
- **Other Health Insurance (OHI)**
- **Explanation of Benefits (EOB)**
- **Fraud**

Appendix A: Claims Resources

North Region Claims Processor

North Region Locations
Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P. O. Box 870140 Surfside Beach, SC 29587-9740 1-877-874-2273 www.myTRICARE.com

South Region Claims Processor

South Region Locations
TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 www.myTRICARE.com

West Region Claims Processor

West Region Locations
TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 1-877-988-9378 www.myTRICARE.com

Eurasia-Africa Claims Processor

Eurasia-Africa Locations	
Africa, Europe, and the Middle East	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976
1-877-678-1207 (Stateside) +44-20-8762-8384 (Overseas) www.TRICARE4u.com	

Latin America and Canada Claims Processor

Latin America and Canada Locations	
Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
1-877-451-8659 (Stateside) +1-215-942-8393 (Overseas) www.TRICARE4u.com	

Pacific Claims Processor

Pacific Locations	
Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
Singapore: 1-877-678-1208 (Stateside) +65-6339-2676 (Overseas) Sydney: 1-877-678-1209 (Stateside) +61-2-9273-2710 (Overseas) www.TRICARE4u.com	

TRICARE For Life Claims

United States and U.S. Territories	Overseas
WPS TRICARE For Life (TFL) P.O. Box 7890 Madison, WI 53707-7890 1-866-773-0404 www.TRICARE4u.com	Use the appropriate overseas region address listed above

Appendix B: Sample Explanation of Benefits Statements

The information below gives reference details for the stateside regional contractor's explanation of benefits (EOB) statements. A sample EOB for each regional contractor is included on the following pages. Use the information listed below as a resource when discussing EOBs with beneficiaries.

How to Read a TRICARE EOB

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the North, South, and West regions
2. **Regional Contractor:** The logo for Health Net Federal Services, LLC (North Region contractor), Humana Military Healthcare Service, Inc. (South Region contractor), or UnitedHealthcare Military & Veterans (West Region contractor) appears here.
3. **Mail-to Name and Address:** The TRICARE EOB is mailed directly to the patient (or patient's parent or guardian for minors) at the address on the claim the provider submitted.
4. **Date of Notice:** PGBA prepared the TRICARE EOB on this date.
5. **Insured ID:** The claim is processed using the insured ID of the individual (active duty, retired, or deceased).
   The insured ID is either the sponsor's Social Security number (SSN) or the individual's DoD Benefits Number (DBN). For security reasons, only the last four digits of the insured's ID appear on the EOB.
6. **Patient Name:** The name of the patient who received care and for whom the claim(s) were submitted.
7. **Claims Processed From:** The reporting period for claims shown in the EOB.
8. **Provider of Service:** Lists who provided the care.
9. **Total Paid This Reporting Period:** The total amount paid to the provider(s).
10. **Total Patient Responsibility:** The total amount the provider(s) may bill the beneficiary.
11. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense the beneficiary has paid to date. The annual deductible and maximum out-of-pocket expense are based on the fiscal year (October 1–September 30).
12. **Sponsor Name:** The name of the sponsor.
13. **Patient Name:** The name of the patient who received care and for whom this claim was filed.
14. **Insured ID:** The last four digits of the insured's ID.
15. **Provider:** The provider of services.
16. **Amount Other Insurance Paid:** The amount the beneficiary's primary/other health insurance paid (if there is also coverage from another health plan).

    Amount You Paid: The amount (if any) the beneficiary paid the provider of services, as noted on the claim.
17. **Amount Your Provider May Bill You:** The amount the beneficiary is responsible for after TRICARE cost-shares are applied.

    Amount Paid To Your Provider: Amount TRICARE paid the provider.

    Amount Paid To You: Amount TRICARE paid the beneficiary.
18. **Claim Number:** A unique number assigned by TRICARE for tracking purposes.
19. **Date(s) of Service:** The date(s) the beneficiary received services.
20. **Service Provided:** Describes the type and number of services received, as noted on the claim. It also lists the specific procedure codes that doctors, hospitals, laboratories, and other providers use to identify those services.
21. **APC #:** Ambulatory Payment Classification (APC) program. A number assigned by Medicare or TRICARE that consists of one or more grouped medical procedure codes.
22. **Remarks:** If there is a code or number here, refer to the "Remarks" section at the bottom of the EOB for more information about the code and how it affected the claim.
23. **Claim Summary:** Explains the action taken on the claim, including the following totals: amount the provider charged, amount allowed by TRICARE, and the non-covered amount.
24. **Beneficiary Liability Summary:** If the beneficiary is responsible for a portion or all of the charges, the amount is shown here. It include any charges applied to the beneficiary's annual deductible and any copayment or cost-share the beneficiary must pay to the provider of services. If the summary shows no liability, beneficiaries need to confirm that TRICARE actually paid on the claim; if TRICARE didn't pay, the beneficiary may have to pay for all the charges.

North Region Sample EOB—Page 1

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

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

(2) TRICARE is a registered trademark of the TRICARE Management Activity. All rights reserved.

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

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

(4) June 10, 2011

SUMMARY EXPLANATION OF BENEFITS (5)

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

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

(6) **Patient Name: PATIENT**

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

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

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

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

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

CN: 100524N0000002

North Region Sample EOB—Page 2

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

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

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

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

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

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

(19)

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

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

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

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

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

REMARKS:

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

CN: 100524N0000002

South Region Sample EOB—Page 1

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

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

(2) Humana. Military

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

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

(4) June 10, 2011

SUMMARY EXPLANATION OF BENEFITS (5)

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

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

(6) **Patient Name: PATIENT**

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

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

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

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

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

South Region Sample EOB—Page 2

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

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

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

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

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

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

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

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

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

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

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

REMARKS:

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

CN: 100524S0000002

West Region Sample EOB—Page 1

(1) PGBA, LLC
TRICARE WEST REGION
P.O. BOX 7065
CAMDEN, SC 29020-7065

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

(2) UnitedHealthcare | TRICARE®

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

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

(4) June 10, 2011

SUMMARY EXPLANATION OF BENEFITS (5)

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

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

(6) **Patient Name: PATIENT** (7) **Claims Processed from 05/12/11 to 06/10/11**

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

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

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

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

West Region Sample EOB—Page 2

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

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

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

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

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

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

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

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

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

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

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

REMARKS:

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

CN: 100524S0000002

TRICARE Fundamentals Course

Appeals

11

Participant Guide

References

2008 TRICARE Operations Manual, Chapters 12–13

Module Objectives

- **Explain who can file an appeal**
- **Distinguish between what can and can't be appealed**
- **Describe the types of appeals**

Key Terms

- **Appeal**
- **Provider Sanction**
- **Appeal of Medical Necessity**
- **Appeal of Factual Determination**
- **Appeal of a Dual Medicare-TRICARE Claim**

1.0 Introduction to Appeals

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

1.0.1 Provider Sanction

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

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

1.1 Who Can Appeal?

- An appealing party must be able to prove he or she is eligible for TRICARE benefits, including:
  - Any TRICARE beneficiary, or a parent or guardian of a beneficiary who is under age 18
  - The guardian of a beneficiary who isn't competent to act on his or her own behalf
- A health care provider who was:
  - Denied approval
  - Suspended, excluded, or terminated as a TRICARE-authorized provider
- TRICARE-participating providers (except network providers, who appeal to the regional contractor they have a contract with or a state court)
  - Non-network providers are considered participating when appealing preadmission/preprocedure denials (before services are delivered)
  - Non-network, non-participating providers can't file appeals
- A representative, appointed in writing by a beneficiary or provider
  - While a provider may not directly file an appeal on behalf of a beneficiary, a beneficiary can appoint a provider as a representative by completing an *Appointment of Representative and Authorization to Disclose Information* form, which is available through the regional or overseas contractor.
  - Certain individuals can't serve as beneficiary representatives due to a conflict of interest, including:
    - A legal officer (member of a uniformed service legal office)
    - Beneficiary Counseling and Assistance Coordinators (BCACs) or Debt Collection Assistance Officers (DCAOs)/Health Benefits Advisor (HBA)
    - Employees of the federal government, such as a uniformed service member, military treatment facility (MTF) provider, or an employee of a uniformed service (unless it is an immediate family member)

1.2 What May Be Appealed?

- Facts of a case that may be appealed:
  - Diagnosis
  - The need for inpatient care
  - Pre-authorization denials of services, including mental health
  - Denial of TRICARE payment for services or supplies
  - Denial/termination of TRICARE payment for continuation of services, treatments, or supplies previously authorized
  - Denial of a provider's request for approval as a TRICARE-authorized provider or a provider sanction

1.3 What Can't Be Appealed?

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

- The TRICARE-allowable amount for a particular service (The beneficiary may ask the regional contractor for an allowable charge review, but can't appeal the allowed amount.)
- The contractor's or DHA's decision to ask for more information before acting on a claim or appeal request
- Whether a provider is a network or authorized provider
- A decision on TRICARE eligibility (The services determine eligibility. Beneficiaries must appeal eligibility denial determinations through the sponsor's branch of service.)

2.0 Appeals Process

- If appealing a denial, the appealing party must send a package to the contractor, who then issues a reconsideration decision. The package must include a cover letter with relevant case information, a copy of the denial letter, associated Explanation of Benefits (EOBs), claims, bills, clinical notes, medical history, and/or documents the appealing party feels support overturning the denial decision.
  - Failing to include a copy of the denial letter may delay the review or result in the appeal being sent to the wrong location.
  - If appealing parties can't get all of the supporting documents in on time, they should send in the appeal anyway and state in the cover letter that they plan to submit additional information when it is available.
  - The appealing party should keep originals of all appeal paperwork.
- See the chart on the following page for more information on the process for medical necessity and factual determination appeals.

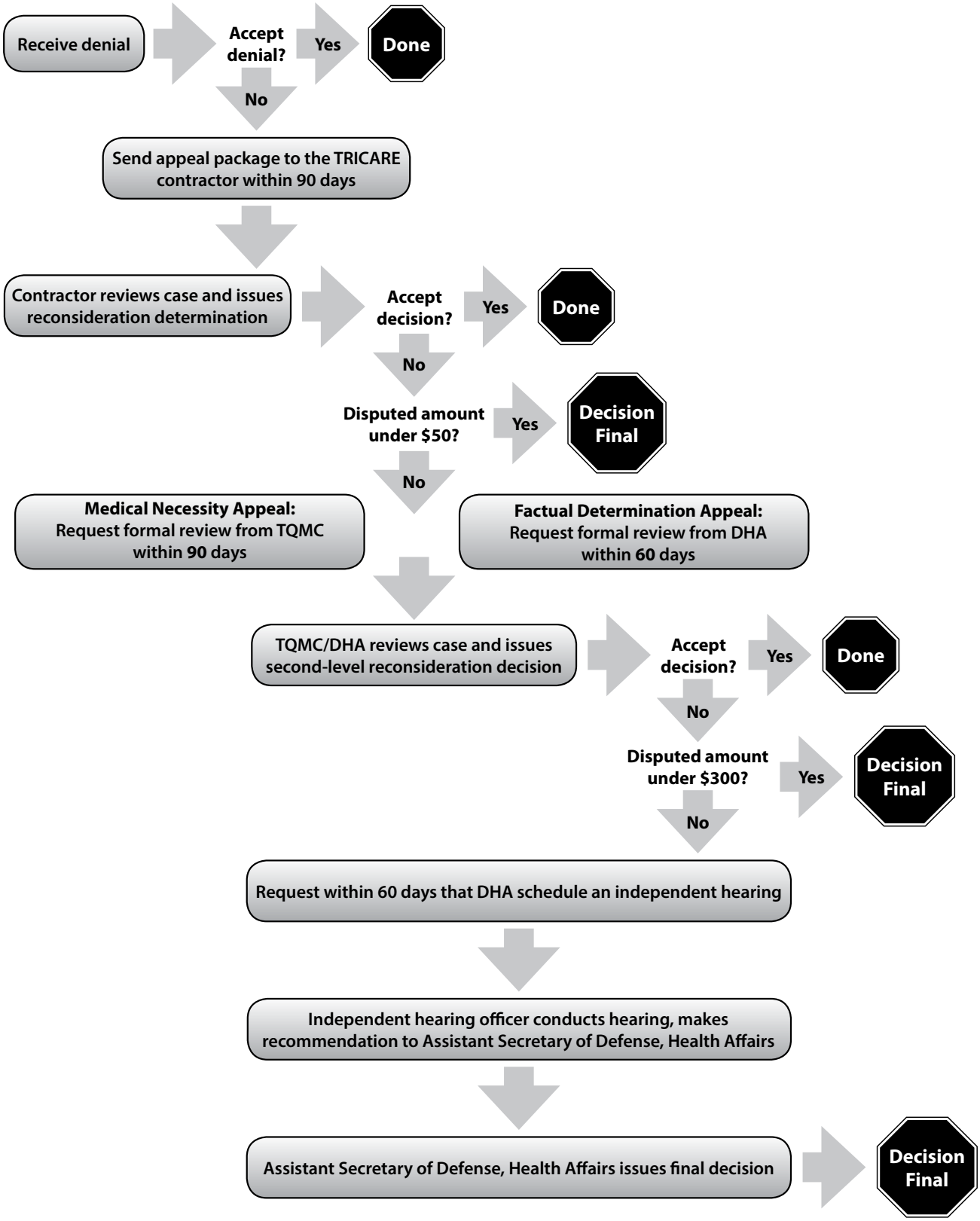
2.1 Appeals of Medical Necessity

- Appeals of medical necessity involve decisions about whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition, including decisions on custodial and mental health services.
- It may be necessary to prove medical necessity for inpatient, outpatient, and specialty care.
- The TRICARE Quality Management Contractor (TQMC) reviews appeals of medical necessity and issues second-level reconsideration decisions for these appeals

2.2 Appeals of Factual Determination

- Appeals of factual determination involve issues other than medical necessity, such as coverage issues and provider authorization (status) requests.
- Medical or peer review may be necessary to reach a factual determination.
- The DHA reviews appeals of factual determination and issues second-level reconsideration decisions for these appeals.

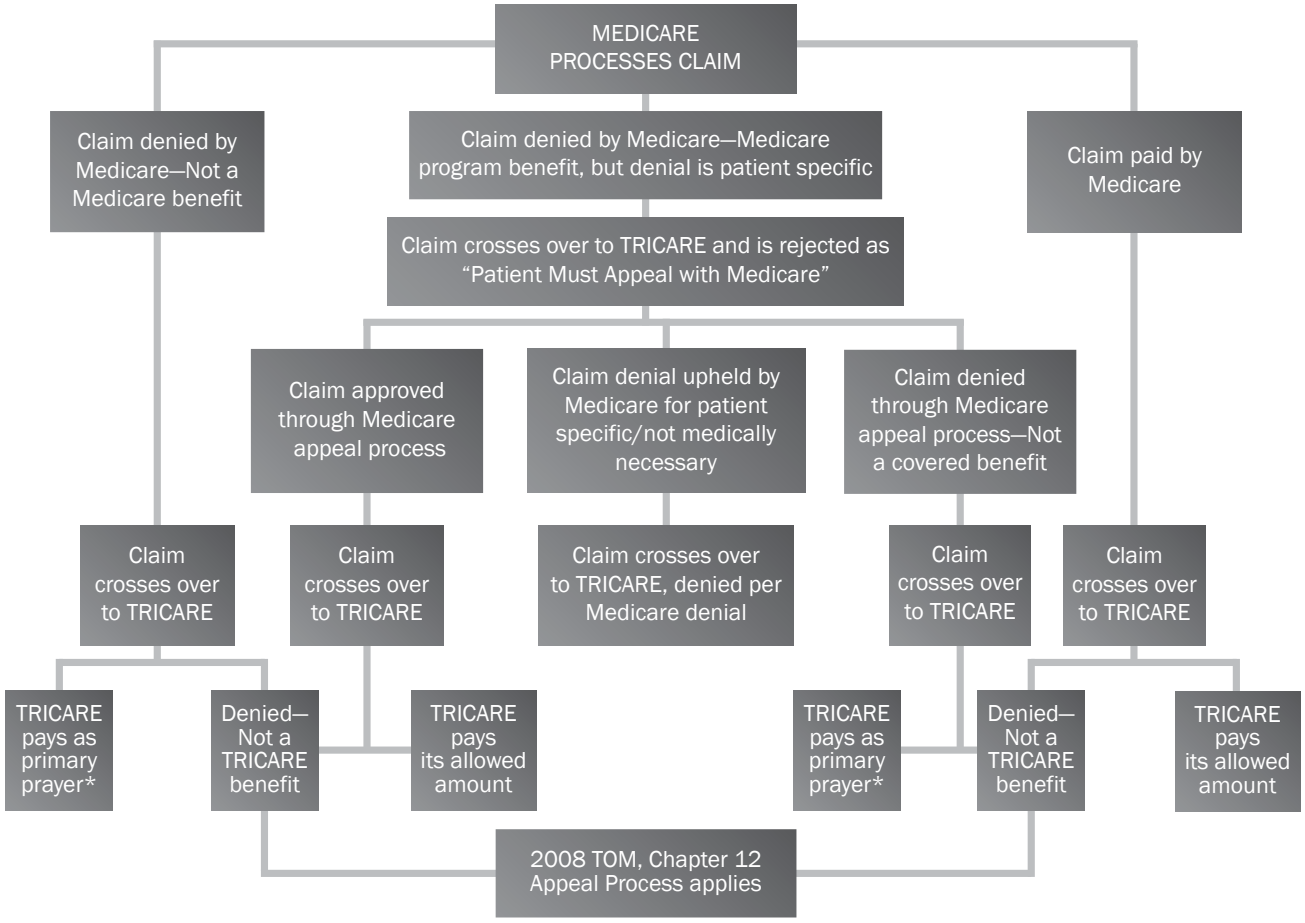
TRICARE Appeals Process*



* *Process does not apply to TRICARE Prime Remote appeals. See Section 4.0 of this module for more information.*

3.0 Appeals of Dual Medicare-TRICARE Claims

- TRICARE won't cover services and supplies denied by Medicare if the denial is appealable under the Medicare appeal process.
  - If a Medicare appeal results in some payment by Medicare, TRICARE considers coverage for these same services and supplies.
  - TRICARE considers payment on services and supplies denied by Medicare if the Medicare denial is non-appealable.



*If a TRICARE-covered benefit

4.0 TRICARE Prime Remote (TPR) Appeals

- If an active duty service member (ADSM) in a designated TPR location (stateside or overseas) doesn't get prior authorization before seeking specialty care, his or her claim may be denied.
  - The ADSM may appeal by first contacting the appropriate authorization authority:
    - The Reserve and Service Member Support Office, Great Lakes (R&SMSO-GL) if the member received care in the United States or the U.S. Virgin Islands
    - MTF staff, if care was based on an MTF referral or the ADSM shows as enrolled in TRICARE Prime at an MTF on the date of service
    - The overseas contractor if the member received care in an overseas location (other than the U.S. Virgin Islands)
  - Questions may be directed to:
    - Army, Marine Corps, Navy, Air Force, and Coast Guard: 1-888-647-6676

      Reserve and Service Member Support Office
      P.O. Box 886999
      Great Lakes, IL 60088-6999

    - U.S. Public Health Service (USPHS): at 1-800-368-2777, option #2.
    - National Oceanic and Atmospheric Administration (NOAA): 1-800-224-6622 (NOAA Commissioned Personnel Center)
- If the request is denied on appeal, the ADSM may then appeal to their service Surgeon General or the senior medical officer of their respective service. The address for this second appeal is provided to the ADSM upon denial of the first appeal.

5.0 Summary

5.1 Where to Get Additional Claims and Appeals Information for Beneficiaries

Direct beneficiaries to the:

- Regional contractor or claims processor
- Nearest MTF
- Reserve and Service Member Support Office (stateside and Virgin Island TPR ADSMs only)

5.2 Beneficiary Appeals Checklist

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

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

Module Objectives

- **Explain who can file an appeal**
- **Distinguish between what can and can't be appealed**
- **Describe the types of appeals**

Key Terms

- **Appeals**
- **Provider Sanction**
- **Appeals of Medical Necessity Determination**
- **Appeals of Factual Determinations**
- **Appeals of Dual Medicare-TRICARE Claims**

TRICARE Fundamentals Course

Resources and Tools

12

Participant Guide

1.0 Important TRICARE Resources

1.1 Important Websites for Customer Service Staff

TRICARE Website	www.tricare.mil
Customer Service Community Website	https://mhs.health.mil/customerservicecommunity/default.aspx
Customer Service Community Directory	www.tricare.mil/bcacdcao
General Inquiry for DEERS (GIQD)	www.dmdc.osd.mil/appj/giqd
Assistance Reporting Tool (ART)	https://art.tma.osd.mil/

1.2 Important Websites for Beneficiaries

Formulary Search Tool	www.pec.ha.osd.mil/formulary_search.php
Frequently Asked Questions (FAQs)	www.tricare.mil/faqs
milConnect	http://milconnect.dmdc.mil
TRICARE Forms	www.tricare.mil/forms
TRICARE Authorized Providers	www.tricare.mil/findaprovider
Beneficiary Web Enrollment	www.dmdc.osd.mil/appj/bwe
RAPIDS Site Locator	www.dmdc.osd.mil/rsl
TRICARE Costs	www.tricare.mil/costs
TPR Look-Up Tool	http://www.tricare.mil/tpr/default_zip.aspx
PSA Look-Up Tool	www.tricare.mil/PSAZIP

1.3 Stateside TRICARE Regional Contractors and TRICARE Regional Offices (TROs)

North Regional Contractor	**Health Net Federal Services** 1-877-TRICARE (1-877-874-2273) www.hnfs.com
South Regional Contractor	**Humana Military Healthcare Services, Inc.** 1-800-444-5445 www.humana-military.com
West Regional Contractor (for dates of service on or after April 1, 2013)	**UnitedHealthcare Military & Veterans** 1-877-988-WEST (1-877-988-9378) www.uhcmilitarywest.com
TRO North	www.tricare.mil/tronorth tronorth@tma.osd.mil
TRO South	www.tricare.mil/trosouth trosouthcs@tros.tma.osd.mil
TRO West	www.tricare.mil/trowest trow-southwest@trow.tma.osd.mil

1.4 TRICARE Overseas Program Contractor and TRICARE Area Offices (TAOs)

	TRICARE Overseas Program Contractor	TRICARE Area Office
Eurasia-Africa **(Africa, Europe, and the Middle East)**	**International SOS** www.tricare-overseas.com TOP Regional Call Center Overseas: +44-20-8762-8384 Stateside: 1-877-678-1207 tricarelon@internationalsos.com Medical Assistance +44-20-8762-8133	www.tricare.mil/eurasiaafrica Toll-Free: 1-888-777-8343, opt.1 Commercial: 0049-6371-9464-2999 Commercial Fax: +49-(0)6302-67-6378 DSN: 1-314-590-2999 DSN Fax: 1-314-496-6378 tma.sembach.medcom-ermc.mbx.teoweb-tao-ea@mail.mil
Latin America and Canada **(Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)**	**International SOS** www.tricare-overseas.com TOP Regional Call Center Overseas: +1-215-942-8393 Stateside: 1-877-451-8659 tricarephl@internationalsos.com Medical Assistance +1-215-942-8320	www.tricare.mil/tlac Toll-Free: 1-888-777-8343, opt. 3 DSN: 94-554-8520 Commercial: +1-210-292-8520 Commercial Fax: +1-210-292-3224 taolac@tma.osd.mil
Pacific **(Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries)**	**International SOS** www.tricare-overseas.com TOP Regional Call Center (Singapore) Overseas: +65-6339-2676 Stateside: 1-877-678-1208, opt. 4 TOP Regional Call Center (Sydney) Overseas: +61-2-9273-2710 Stateside: 1-877-678-1209, opt. 4 Singapore: sin.tricare@internationalsos.com Sydney: sydtricare@internationalsos.com Medical Assistance Singapore: +65-6338-9277 Sydney: +61-2-9273-2760	www.tricare.mil/pacific Singapore: 1-877-678-1208, opt. 4 Sydney: 1-877-678-1209, opt. 4 (Toll-free if calling from the U.S.) Commercial: +81-98-970-9155 Commercial Fax: +81-6117-43-2037 DSN: 315-643-2036 DSN Fax: 315-643-2037 tpao.csc@med.navy.mil

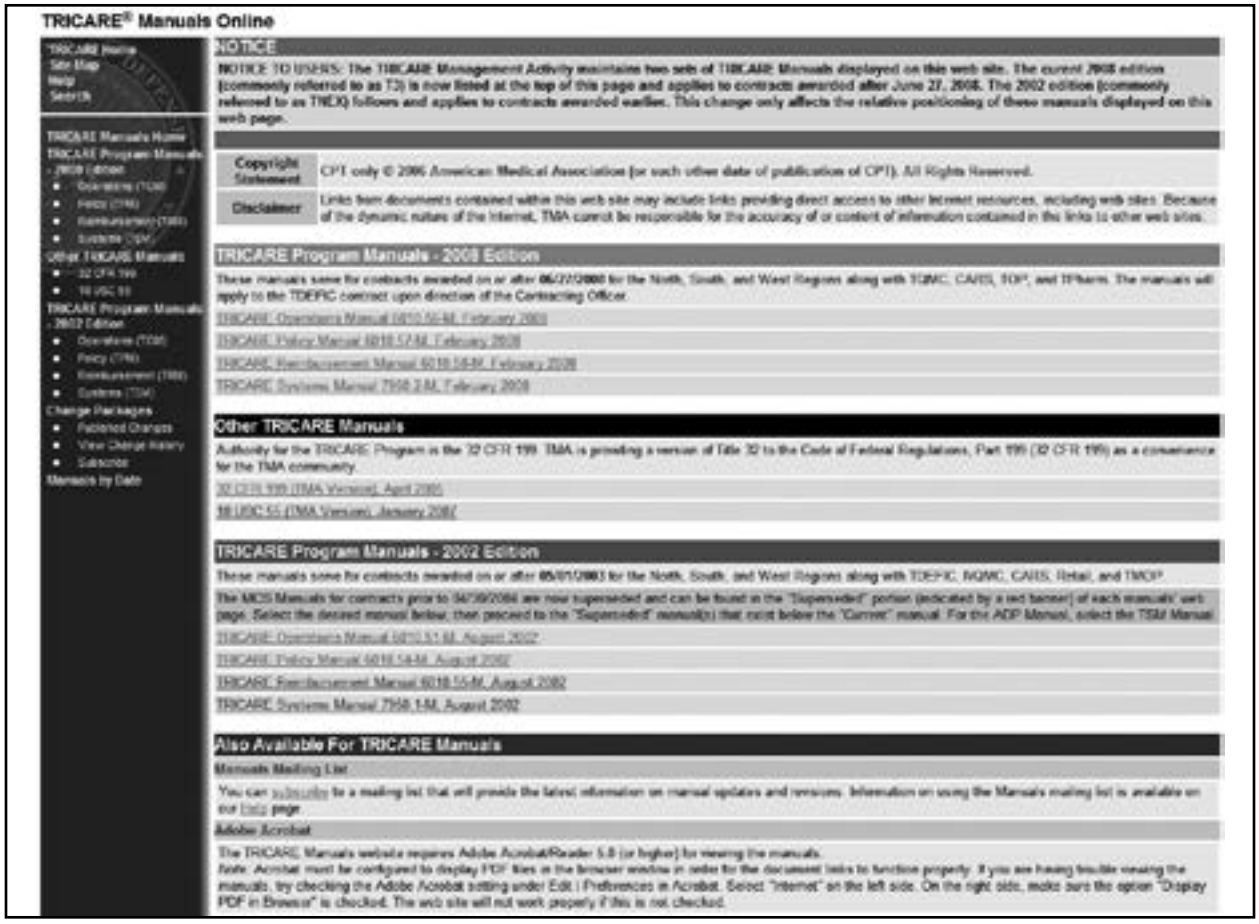
1.5 TRICARE For Life

TRICARE For Life	www.tricare.mil/tfl (for program description) www.TRICARE4u.com (for TFL contractor) 1-866-773-0404, TDD 1-866-773-0405 See the TFL contractor's website for overseas contact information.

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

The TRICARE Manuals are, in most cases, the primary resource for locating official TRICARE policy and benefit information. Each TRICARE manual is posted on the Manuals website (http://manuals.tricare.osd.mil) and incorporates updated, published changes. Although changes may be published, they are not implemented by contractors until they receive direction from the Defense Health Agency Contracting Officer.

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



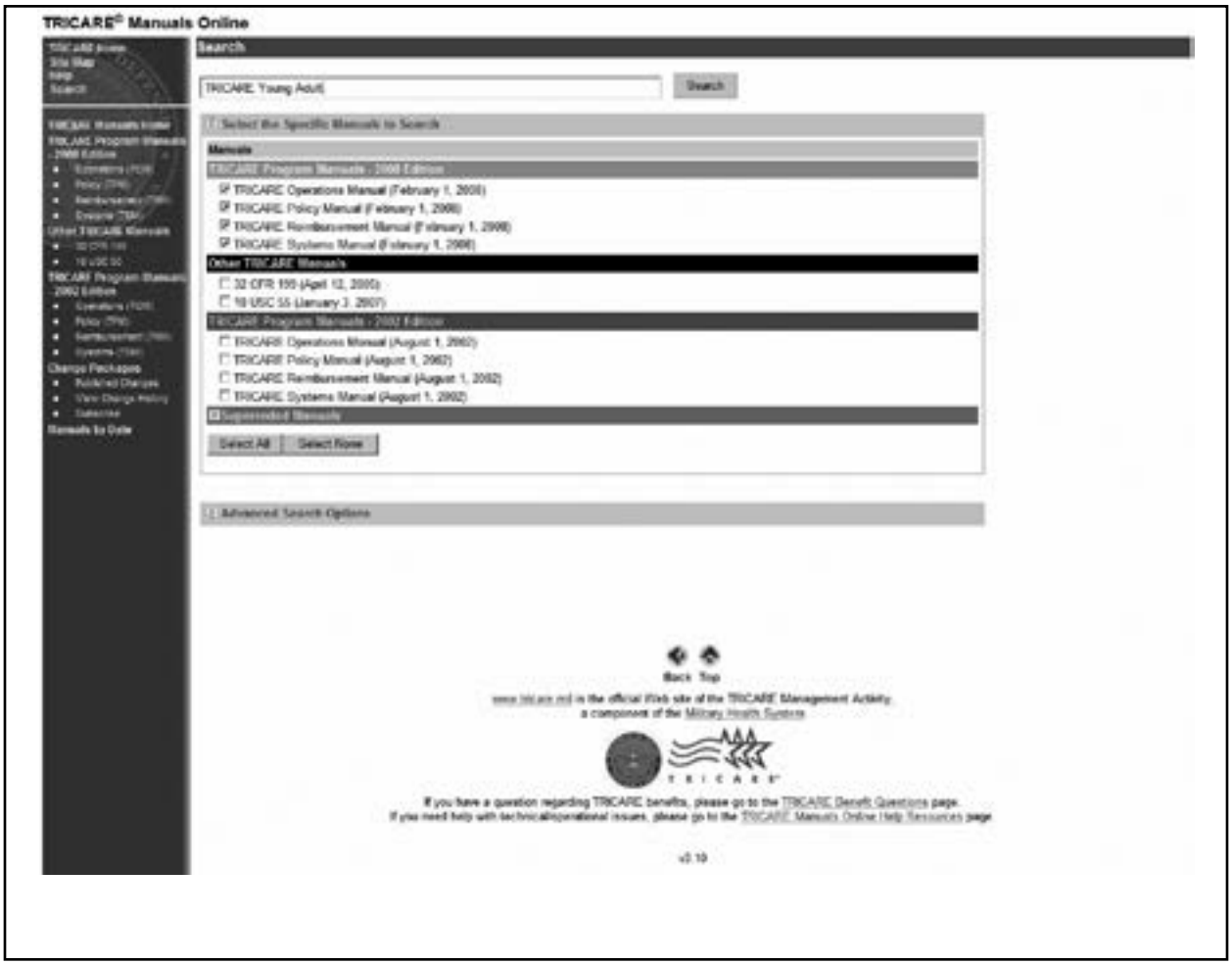
2.1 Basic Search

The TRICARE Manuals website includes features for searching the TRICARE manuals. Customer support staff should search the manuals when verifying benefit information..

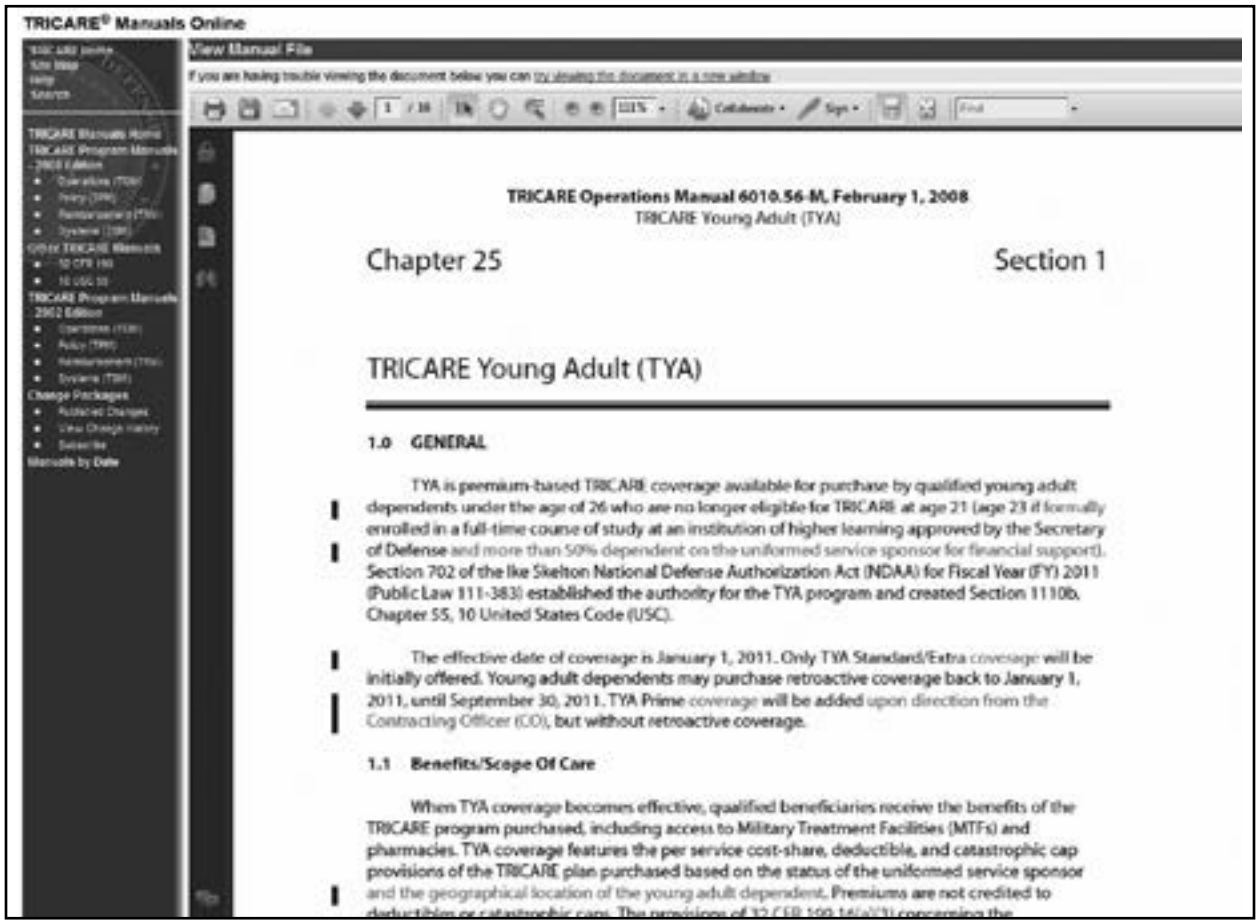
- TRICARE Program Manuals—2008 Edition: Contracts awarded on or after 06/27/2008.

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

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



2.1.2 The website displays the selected manual section



2.2 Subscribing to Manual Updates

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

3.0 Additional Resources

3.1 TRICARE Websites

Basic Websites	
TRICARE Online Website	www.tricareonline.com
Military Health System (MHS) Website	www.health.mil
Defense Health Agency Website	www.health.mil

Educational Sites and Tools	
TRICARE Smart Site	www.tricare.mil/tricaresmart
TRICARE University	www.tricare.mil/tricareu

Links for Providers	
TRICARE Provider Site	www.tricare.mil/providers
Becoming a TRICARE Provider	www.tricare.mil/providers/becomeaprovider.aspx

Social Media	
Media Center	www.tricare.mil/mediacenter
Facebook	www.facebook.com/tricare
Twitter	www.twitter.com/tricare
YouTube	www.youtube.com/tricarehealth
Podcasts	www.tricare.mil/podcast
Sign up for e-mail updates	www.tricare.mil/subscriptions

3.2 Mobile Applications

Available mobile applications (may not be available on all devices):

- milConnect Mobile, provided by the Defense Manpower Data Center (DMDC)
- Express Scripts

3.3 Reserve and Service Member Support Office, Great Lakes (R&SMSO-GL)

Army, Air Force, Navy, Marine Corps, and Coast Guard	1-888-647-6676 www.tricare.mil/mmso [Insert branch of Service] Point of Contact Reserve and Service Member Support Office (R&SMSO) P.O. Box 886999 Great Lakes, IL 60088-6999
United States Public Health Service (USPHS)	1-800-368-2777, opt. 2

R&SMSO Medical Eligibility Verification Reserve Component Form
www.tricare.mil/tma/mmso/pdf/mmsoformmedicaleligibility.pdf

3.4 Dental Resources

Active Duty Dental Program (ADDP) Contractor United Concordia Inc.		
www.addp-ucci.com	1-866-984-ADDP (1-866-984-2337)	E-mail: addpdcf@ucci.com
General Mailing Address United Concordia Companies, Inc. ADDP Unit P.O. Box 69430 Harrisburg, PA 17106-9430	Claims Mailing Address United Concordia Companies, Inc. ADDP Claims P.O. Box 69429 Harrisburg, PA 17106-9429	

TRICARE Dental Program (TDP) Contractor MetLife	
http://mybenefits.metlife.com/tricare	
Stateside: 1-855-MET-TDP1 (1-855-638-8371)	Overseas: 1-855-MET-TDP2 (1-855-638-8372)
TDD/TYY: 1-855-MET-TDP3 (1-855-638-8373)	
Stateside Claims Mailing Address MetLife TRICARE Dental Program (TDP) P.O. Box 14181 Lexington, KY 40512	Overseas Claims Mailing Address MetLife TRICARE Dental Program (TDP) P.O. Box 14182 Lexington, KY 40512 E-mail: OCONUSdentalclaims@metlife.com
General Mailing Address MetLife TRICARE Dental Program (TDP) P.O. Box 14185 Lexington, KY 40512	

TRICARE Retiree Dental Program (TRDP) Contractor Delta Dental of California	
www.trdp.org	Stateside: 1-888-838-8737 International Toll-Free: +866-721-8737
General Mailing Address Delta Dental of California Federal Government Programs P.O. Box 537008 Sacramento, CA 95853-7008	Claims Mailing Address Delta Dental of California Federal Government Programs P.O. Box 537007 Sacramento, CA 95853-7007

3.5 Pharmacy Resources

TRICARE Pharmacy Program Contractor Express-Scripts Inc. (United States and U.S. Territories)	
www.express-scripts.com/TRICARE	1-877-363-1303
General Mailing Address Express Scripts, Inc. P.O. Box 60903 Phoenix, AZ 85082-0903	Claims Mailing Address Express Scripts, Inc. P.O. Box 52132 Phoenix, AZ 85072

Other Pharmacy Resources	
Formulary Search Tool	www.pec.ha.osd.mil/formulary_search.php
DoD Pharmacoeconomic Center	www.pec.ha.osd.mil 1-866-ASK-4PEC (1-866-275-4732)

3.6 Stateside Claims

North Region: **Palmetto Government Benefits Administration (PGBA)**	Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P. O. Box 870140 Surfside Beach, SC 29587-9740 www.myTRICARE.com
South Region: **Palmetto Government Benefits Administration (PGBA)**	TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 www.myTRICARE.com
West Region (for dates of service on or after April 1, 2013): **Palmetto Government Benefits Administration (PGBA)**	TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 www.myTRICARE.com
TRICARE For Life: **Wisconsin Physicians Services (WPS)**	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890 1-866-773-0404 (TDD: 1-866-773-0405) www.TRICARE4u.com

3.7 Overseas Claims

All Active Duty Service Members	TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968 www.tricare-overseas.com
All Other Beneficiaries—Latin America and Canada	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 www.tricare-overseas.com
All Other Beneficiaries—Eurasia-Africa	TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 www.tricare-overseas.com
All Other Beneficiaries—Pacific	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 www.tricare-overseas.com

3.8 Appeals

	Claims Appeals	**Authorization Appeals**
North Region	Health Net Federal Services, LLC TRICARE Claim Appeals P.O. Box 105266 Atlanta, GA 30348-5266	Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 105087 Atlanta, GA 30348-5087
South Region	TRICARE South Region Appeals P.O. Box 202002 Florence, SC 29502-2002	Humana Military Healthcare Services, Inc. Attn: Clinical Appeals P.O. Box 740044 Louisville, KY 40201-7444
West Region (for dates of service on or after April 1, 2013)	TRICARE West Region Claims Department P.O. Box 105492 Atlanta, GA 30348-5492	TRICARE West Region Appeals Department P.O. Box 105493 Atlanta, GA 30348-0862
Overseas (all areas)	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992
Pharmacy (stateside)	Express Scripts, Inc. P.O. Box 60903 Phoenix, AZ 85082-0903	Express Scripts, Inc. P.O. Box 60903 Phoenix, AZ 85082-0903
TRICARE For Life	WPS TRICARE For Life, Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490	WPS TRICARE For Life. Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490

Note: Dental appeals information can be found in the *Dental* module appendices.

3.9 Fraud and Abuse

Defense Health Agency	
Defense Health Agency Attn: Program Integrity 1604 E. Centretech Parkway Aurora, CO 80011-9066 Fax: (303)-676-3981 www.tricare.mil/fraud E-mail: fraudline@tma.osd.mil	
TRICARE North Region: Health Net Federal Services	**TRICARE Region South: Humana Military Healthcare Services**
Health Net Federal Services P.O. Box 105310 Atlanta, GA 30348-5310 1-800-977-6761 E-mail: program.integrity@healthnet.com	Humana Military Healthcare Services, Inc. ATTN: Program Integrity 500 W. Main Street, 19th Floor Louisville, KY 40202 1-800-333-1620
TRICARE West Region: UnitedHealthcare Military & Veterans	
TRICARE West Region Program Integrity P.O. Box 740826 Atlanta, GA 30348-5493	
TRICARE for Life (TFL): Wisconsin Physician Services	**TRICARE Overseas: International SOS**
1-866-773-0404 E-mail: reportit@wpsic.com	1717 W. Broadway P.O. Box 7635 Madison, WI 53707 1-877-342-2503 E-mail: TOPProgramIntegrity@internationalsos.com
TRICARE Dental Program: MetLife	**TRICARE Retiree Dental Program: Delta Dental**
1-800-462-6565	1-888-838-8737
Active Duty Dental Program: United Concordia	**TRICARE Pharmacy Program: Express Scripts, Inc**
1-877-968-7455	1-866-216-7096 E-mail: fraudtip@express-scripts.com

3.10 Other TRICARE Programs

Continued Health Care Benefits Program (CHCBP)	
www.tricare.mil/CHCBP	
Continued Health Care Benefit Program Application www.tricare.mil/forms **Mail to:** Humana Military Healthcare Services, Inc. Attn: CHCBP P.O. Box 740072 Louisville, KY 40201	**Mail Claims to:** PGBA, LLC P.O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 (Monday to Friday 8AM–6PM) www.myTRICARE.com
TRICARE Young Adult (TYA)	
www.tricare.mil/tya	

3.11 US Family Health Plan (USFHP)

USFHP General Information	
1-800-74-USFHP (1-800-748-7347) www.usfhp.com	
US Family Health Plan (USFHP) Designated Providers	
Johns Hopkins Medical Services Corporation Serving central Maryland, Washington DC, and parts of Pennsylvania, Virginia and West Virginia USFHP Customer Service Department 6704 Curtis Court Glen Burnie, MD 21060 1-800-808-7347 www.hopkinsmedicine.org/usfhp E-mail: usfhpcustomerservice@jhhc.com	**Martin's Point Health Care** Serving Maine, New Hampshire, Vermont, upstate and western New York and the northern tier of Pennsylvania US Family Health Plan at Martin's Point P.O. Box 9746 Portland, ME 04104-5040 1-888-241-4556 www.usfhp.com/martinspoint E-mail: shawnm@martinspoint.org
Brighton Marine Health Center Serving Massachusetts (including Cape Cod), Rhode Island and northern Connecticut US Family Health Plan 77 Warren Street Brighton, MA 02139 1-800-818-8589 www.usfamilyhealth.org	**Pacific Medical Centers (PacMed Clinics)** Serving the Puget Sound area of Washington State Pacific Medical Center (Beacon Hill) 1200 12th Avenue South Seattle, WA 98144 1-888-4-PACMED (1-888-472-2633) www.pacmed.org
CHRISTUS Health Serving southeast Texas and Southwest Louisiana US Family Health Plan P.O. Box 924708 Houston, TX 77292 1-800-67-USFHP (1-800-678-7347) www.christus.usfhp.com	**Saint Vincent Catholic Medical Centers of New York** Serving New York City, Long Island, southern Connecticut, New Jersey, and Philadelphia and area suburbs US Family Health Plan 450 West 33rd St. Mezzanine New York, NY 10001 1-800-241-4848

3.12 Additional Resources

Certificates of Creditable Coverage	
1-800-538-9552 (say “proof of insurance”) Fax: 1-831-655-8317, TYY/TDD: 1-866-363-2883 (Note: Only use the fax option when in urgent need of a certificate of creditable coverage) www.tricare.mil/certificate	Written Requests: Defense Manpower Data Center Support Office (DSO) ATTN: Certificate of Creditable Coverage 400 Gigling Rd Seaside, CA 93955-6771

Defense Manpower Data Center (DMDC)/DEERS Support Office (DSO)	
DMDC Website: www.dmdc.osd.mil MilConnect website: http://milconnect.dmdc.mil E-mail: webmaster@osd.pentagon.mil Fax address changes to: 1-831-655-8317	Toll-free: 1-800-538-9552 DSO Research and Analysis (BCACs/DCAOs only): 1-831-583-2500; DSN 1-878-3522/3523 DSO Help Desk (for technical support): 1-800-372-7437 Field Support Help Desk: 1-800-631-2508
Mail address changes to: Defense Manpower Data Center Support Office (DSO) ATTN: COA 400 Gigling Rd Seaside, CA 93955-6771	

Coast Guard Health Benefits Assistance Line	1-800-9-HBA-HBA (1-800-942-2422)
Health Insurance Portability and Accountability Act (HIPAA)	www.tricare.mil/hipaa E-mail: hipaatcsimail@tma.osd.mil
Medicare Services/Centers for Medicare and Medicaid	www.medicare.gov 1-800-MEDICARE/1-800-633-4227
U.S. Army Wounded Warrior Program	www.wtc.army.mil/aw2 1-877-393-9058
Uniformed Services Employment and Reemployment Rights Act (USERRA)	www.dol.gov/vets
U.S. Public Health Service Beneficiary Medical Program	www.usphs.gov 1-800-368-2777
Women, Infants, and Children (WIC) Overseas	www.tricare.mil/wic

Brainteaser Answer Key

Module 2: TRICARE Options

1. Go long
2. Sailing over the seven seas
3. Apartment
4. Neon light
5. Split second timing
6. Man overboard
7. Tennessee
8. Free for all

Module 3: Prime Remote Options

Picture: In your dreams
Riddle: The letter E

Module 4: Transitional Benefits

Picture: Water under the bridge
Riddle: A stop light

Module 5: Pharmacy

1. Toolbox
2. Topless bathing suit
3. Let bygones be bygones
4. 7-Up Cans
5. Ice Cube
6. Son of a gun
7. GI overseas
8. Blood is thicker than water

Module 6: Dental

Picture: Reverse Psychology
Riddle: A nose

Module 7: National Guard and Reserve

1. Paradox
2. Five pounds overweight
3. Mother-in-law
4. Quarterback, halfback, fullback
5. One step forward, two steps back
6. Stuck up
7. West Indies
8. Crossbow

Module 8: Other Benefits

Picture: A man playing a saxophone/A woman's face.

Module 9: TRICARE and Medicare

1. Bridge over troubled waters
2. Tennis shoes
3. Downpour
4. 49ers
5. Final answer
6. Explain
7. Capital City
8. Adding insult to injury

Module 10: Claims

1. Reading between the lines
2. Go stand in the corner
3. Foreign language
4. Captain Hook
5. Paradise
6. Double Dribble
7. Six feet underground
8. A little misunderstanding between two friends

TRICARE Fundamentals Course

Acronyms

13

Participant Guide

References

TRICARE Operation Manual 2008
TRICARE Policy Manual 2008
TRICARE Reimbursement Manual 2008
TRICARE Systems Manual 2008

The following list includes some of the acronyms that customer support staff may encounter when interacting with beneficiaries, working beneficiary cases, interacting with coworkers, or researching the TRICARE manuals.

Note: This list is not all inclusive.

ABA	Applied Behavior Analysis
ACN	Appointment Control Number
ADA	American Dental Association
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AMA	American Medical Association
APN	Assigned Provider Number
APO	Aerial Post Office
ASC	Ambulatory Surgical Center
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AWP	Average Wholesale Price
BCAC	Beneficiary Counseling Assistance Coordinator
BE&S	Beneficiary Education & Support
BLS	Basic Life Support
BMI	Body Mass Index
BRAC	Base Realignment and Closure
BWE	Beneficiary Web Enrollment
CAC	Common Access Card
CATCAP	Catastrophic Cap
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CDCF	Central Deductible and Catastrophic Cap File
CDT	Current Dental Terminology
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program for the Uniformed Service
CHCBP	Continued Health Care Benefits Program
CMAC	CHAMPUS Maximum Allowable Charge
CMS	Center for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
CONUS	Continental United States
COR	Contracting Officer's Representative
CRSC	Combat-Related Special Compensation
CPT	Current Procedural Terminology
CRI	CHAMPUS Reform Initiative
CSS	Customer Service Support
CY	Calendar Year
DAA	Defense Appropriations Act
DBN	Department of Defense Benefit Number
DC	Direct Care

DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DEOB	Dental Explanation of Benefits
DFAS	Defense Financial and Accounting Service
DHA	Defense Health Agency
DHHQ	Defense Health Headquarters
DMDC	Defense Manpower Data Center
DMIS	Defense Medical Information System
DOB	Date of Birth
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoD ID Number	Department of Defense Identification Number
DOES	Defense Online Enrollment System
DOS	Date of Service
DPO	Dental Provider Organization
DPP	Deployment Prescription Program
DRG	Diagnosis Related Group
DS (Logon)	DoD Self-Service (Logon)
DSO	DMDC Support Office
DTF	Dental Treatment Facility
DTS	Defense Travel System
DX	Diagnosis
DXCD	Diagnosis Code
ECHO	Extended Care Health Option
EFMP	Exceptional Family Member Program
EFT	Electronic Funds and Transfers
EHHC	ECHO Home Health Care
EHR	Electronic Health Record
EOB	Explanation of Benefits
EOC	Episode of Care
ER	Emergency Room
ESI	Express Scripts Inc.
ESRD	End Stage Renal Disease
FAQ	Frequently Asked Question
FDA	Food and Drug Administration
FEHB	Federal Employee Health Benefit
FFM	Foreign Force Member
FFS	Fee For Service
FPO	Fleet Post Office
FRC	Federal Records Center
FY	Fiscal Year
GIQD	General Inquiry of DEERS
HA	Health Affairs

HA	Health Affairs
HBA	Health Benefits Advisor
HCF	Health Care Finder
HCPC	Healthcare Common Procedure Code
HEDIS	Health Plan Employer Data and Information Set
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HIPAA	Health Insurance Portability and Accountability Act
HMHS	Humana Military Healthcare Services, Inc.
HMO	Health Maintenance Organization
HNFS	Health Net Federal Services
HNP	Host Nation Provider
IA	Information Assurance
ICN	Internal Control Number
ICD-X-CM	International Classification of Diseases, X Revision, Clinical Modification
ID	Identification
IP	Inpatient
IPPS	Inpatient Prospective Payment System
IRR	Individual Ready Reserve
JFTR	Joint Federal Travel Regulation
LOD/LOD-D	Line of Duty/Line of Duty Determination
LOS	Length of Stay
MCC	Member Choice Center (pharmacy-benefit related)
MCSC	Managed Care Support Contractor (stateside regional contractors)
MHS	Military Health System
MOH	Medal of Honor
MSN	Medicare Summary Notice
MTF	Military Treatment Facility
NARF	Non-Availability Referral Form
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NDAA	National Defense Authorization Act
NEO	Non-Combatant Evacuation Operations
NOAA	National Oceanic and Atmospheric Administration
NOE	Notice of Eligibility
OASD/HA	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	Outside the Continental United States
ODTF	Overseas Dental Treatment Facility
OGC	Office of General Counsel
OHI	Other Health Insurance
OP	Outpatient
OPPS	Outpatient Prospective Payment System

OSD	Office of the Secretary of Defense
OTC	Over-the-Counter
P-PCM	Physician-Primary Care Manager
P&R	Personnel and Readiness
P&T	Pharmacy & Therapeutics
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCP	Primary Care Physician/Provider
PDTS	Pharmacy Data Transaction Service
PEC	PharmacoEconomic Center
PEPR	Patient Encounter Processing Reporting
PDP	Preferred Dental Provider
PGBA	Palmetto Government Benefits Administrators
POC	Point of Contact or Pharmacy Operations Center
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSA	Prime Service Area
PTSD	Post Traumatic Stress Disorder
QLE	Qualifying Life Event
R-ADDP	Remote Active Duty Dental Program
R&SMSO	Reserve and Service Member Support Office
RAPIDS	Real-Time Automated Processing Identification System
RC	Reserve Component
RCPTA	Reserve Component Purchased TRICARE Application
RD	Regional Director
RVU	Relative Value Unit
SELRES	Selected Reserve
SF	Standard Form
SPOC	Service Point of Contact
SSA	Social Security Administration
SSAN	Social Security Administration Number
SSN	Social Security Number
TAD	Temporary Additional Duty
TAMP	Transitional Assistance Management Program
TAO	TRICARE Area Office
TCSRC	Transitional Care for Service-Related Condition
TDD	Telecommunications Device for the Deaf
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program
TDY	Temporary Duty
TED	TRICARE Encounter Data

TFC	TRICARE Fundamentals Course
TFL	TRICARE for Life
TIN	Taxpayer Identification Number (provider claims) or Temporary Identification Number (for DMDC purposes)
TLAC	TRICARE Latin America and Canada
TMA	TRICARE Management Activity (abolished October 1, 2013)
TMAC	TRICARE Maximum Allowable Charge
TOL	TRICARE Online
TOM	TRICARE Operations Manual
TOP	TRICARE Overseas Program
TOPD	TRICARE OCONUS Preferred Dentists
TOP POC	TRICARE Overseas Program Point of Contact
TPL	Third Party Liability
TPM	TRICARE Policy Manual
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TQMC	TRICARE Quality Monitoring Contract
TRDP	TRICARE Retiree Dental Program
TRM	TRICARE Reimbursement Manual
TRO	TRICARE Regional Office
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy Benefit
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TSM	TRICARE Systems Manual
TTY	Teletypewriter
TYA	TRICARE Young Adult
UCCI	United Concordia Companies, Inc.
UHC	UnitedHealthcare Military & Veterans
URFS	Unremarried Former Spouse
USERRA	Uniformed Services Employment and Reemployment Rights Act
USFHP	US Family Health Plan
USMTF	Uniformed Services Military Treatment Facility
USPHS	United States Public Health Service
VA	Veterans Affairs/Administration
VHA	Veterans Health Administration
WIC	Women, Infants, and Children Overseas Program
WPS	Wisconsin Physicians Service
WSM	Wounded Service Member
WTU	Warrior Transition Unit
WWR	Wounded Warrior Regiment

TRICARE Fundamentals Course

Glossary of Terms

14

Participant Guide

References

www.tricare.mil/mybenefit/Glossary

2008 TRICARE Operations Manual, Appendix B

The following glossary lists and defines common terms seen when working with TRICARE beneficiaries. This list is not all inclusive. For additional terms, please consult the TRICARE manuals at http://manuals.tricare.osd.mil.

20th-of-the-Month Rule

The effective start date of certain TRICARE coverage based on the date the contractor processes the enrollment/application form. If received by the 20th of the month, coverage begins on the first day of the next month. If received after the 20th of the month, coverage begins on the first day of the second month following receipt of the enrollment form.

Note: The form must be received and in processing by the 20th of the month, not postmarked by the 20th of the month.

Access Standards

Established standards for accessing care in a timely manner and within a reasonable distance for TRICARE Prime enrollees. In general, Prime access standards are:

- Urgent (acute) care appointment: Prime enrollees should have an appointment within 24 hours (one day).
- Routine appointment: Prime enrollees should have an appointment within seven days.
- Specialty care appointment or wellness visit: Prime enrollees should have an appointment within four weeks (28 days).

Additionally, Prime enrollees should have access to a primary care manager whose office is within 30 minutes of their home (under normal driving circumstances); specialty care should be available within one hour from their home.

Active Duty Service Member (ADSM)

An individual currently serving in one of the seven uniformed services of the United States under a call or order that does not specify a period of 30 days or less.

Adjunctive Dental Care

Dental care that is medically necessary in the treatment of a covered medical (not dental) condition, is an integral part of the treatment of the condition; or is required in preparation for or, as the result of, dental trauma that may be or is caused by medically necessary treatment of an injury or disease.

Appeal

A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a designated representative, to settle a question of coverage, payment, or status.

Authorization for Care

The determination made by a licensed health care professional that a beneficiary's requested treatment, service, procedure, or admission is medically necessary, delivered in the appropriate setting, and is a TRICARE benefit.

Authorized Providers

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

Balance Billing

Occurs when a provider bills a beneficiary for the difference between billed charges and the TRICARE-allowable charge after TRICARE (and any other health insurance) and the beneficiary pay their required deductibles, copays, and cost-shares. Network and participating providers can't balance bill. By law, non-participating providers can only bill beneficiaries up to 15 percent above the TRICARE-allowable charge.

Beneficiary

A person who, by law, is eligible for TRICARE benefits. Beneficiaries include: active duty service members and their families, retired service members and their families, certain National Guard and Reserve members and their families, survivors and widows, certain unremarried former spouses, Medal of Honor recipients and their families, and others identified as being eligible by the respective uniformed services. Family members include spouses and children (biological, adopted, or step) up to age 21, 23, or 26 (depending on the child's eligibility).

Benefit

The TRICARE benefit consists of those services (payment amounts, cost-shares, and copayments) authorized by Title 10 and implemented via the TRICARE manuals. The TRICARE benefit is an entitlement under the law (Title 10 of the U.S. Code and Title 32 of the Code of Federal Regulation) and addresses payment for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specific medical services and supplies provided to eligible beneficiaries from **authorized** civilian sources such as hospitals, physicians, other institutional or individual providers, as well as professional ambulance services, prescription drugs, medical supplies, and rental or purchase of durable medical equipment.

Beneficiary Counseling and Assistance Coordinators (BCACs)

Individuals assigned to military treatment facilities, TRICARE Regional Offices, and TRICARE Area Offices, who serve as beneficiary advocates and are available to answer questions, help solve health care-related problems, and help beneficiaries get health care under TRICARE.

Billed Charge

The total cost of care from a provider, without discounts or reduced fees.

Beneficiary Liability

The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for health care or treatment. For TRICARE purposes, beneficiary liability includes any annual deductible, copayment or cost-share amounts, or amounts above the TRICARE-allowable charge when using a non-participating provider. Beneficiary liability also includes expenses for health care or related services and supplies not covered by TRICARE.

Cashless-Claimless

TRICARE Overseas Program (TOP) Prime/TOP Prime Remote experience when seeking prior-authorized care from a specific, certified host nation provider. The provider files the claim and the TOP contractor pays the provider. The enrollee isn't required to pay up front for services or file a claim. (The enrollee **is** responsible for making sure a claim was filed and processed, as per his or her EOB).

Catastrophic Cap

The maximum out-of-pocket expenses that a TRICARE beneficiary pays for TRICARE-covered services in a given fiscal year (October 1–September 30). The following expenses aren't credited to the catastrophic cap:

- Point-of-service cost-shares and deductibles
- The additional 15 percent above the TRICARE-allowable charge beneficiaries pay to non-participating providers
- TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult premiums
- Costs for services that TRICARE doesn't cover

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

A program of medical care for spouses and dependent children of disabled or deceased disabled veterans who meet the eligibility requirements of the Department of Veterans Affairs.

Claim

A document that reflects a request for payment from a beneficiary, a beneficiary's representative, or a network or non-network provider for health care services, dispensed pharmaceutical agents (i.e., prescription medications), and equipment and supply items.

Clinical Preventive Services

Services, such as health screenings and examinations often conducted at regular intervals, meant to keep individuals healthy or to discover health problems in a timely manner. Preventive services include procedures like pap smears, mammograms, colorectal cancer exams, prostate cancer exams, cholesterol tests, and vaccinations

Confidentiality Requirements

The procedures and controls that assure the confidentiality/privacy of medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, the Privacy Act, and the Health Insurance Portability and Accountability Act (HIPAA).

Contingency Operation

A military operation that results in the call or order to, or retention of, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

Continued Health Care Benefit Program (CHCBP)

A premium-based health care program that offers temporary transitional health coverage for 18 to 36 months after TRICARE eligibility or premium-based program coverage ends for certain former beneficiaries.

Contractor

An organization that the Defense Health Agency contracts with for delivery and payment for services and related administrative support activities, such as enrollment/application processing, claims processing, quality monitoring, or customer service.

Coordination of Benefits

The process by which TRICARE waits to issue coverage determinations or to begin processing on a claim until all other coverage plans (other health insurance, Medicare) complete their claims' process, except for Medicaid, the Indian Health Service, and other programs identified by the Director, Defense Health Agency (e.g., States Victim Assistance Programs).

Copayment

The fixed amount a TRICARE Prime enrollee pays for care in the civilian sector and beneficiaries pay for prescription medications.

Cost-Share

The amount/percentage a beneficiary pays for covered inpatient and outpatient services (as set forth in 32 CFR 199.4, 199.5, and 199.17).

Date of Determination

The date noting completion of a reconsideration determination, formal review determination, or hearing final decision.

Debt Collection Assistance Officer (DCAO)

Individuals located at military treatment facilities, TRICARE Regional Offices, and TRICARE Area Offices, who assist in resolving TRICARE-related debt cases or collection actions. DCAOs work with beneficiaries who have a negative credit rating or were sent to a collection agency for TRICARE-related debt.

Deductible

The amount beneficiaries pay in any one fiscal year before TRICARE begins cost-sharing (doesn't apply to Prime options).

Defense Enrollment Eligibility Reporting System (DEERS)

A system operated by the Defense Management Data Center used to reflect personal, eligibility, enrollment, and catastrophic cap information. Beneficiaries are responsible for making sure their DEERS records are accurate.

Defense Health Agency (DHA)

A Department of Defense Combat Support Agency established on October 1, 2013 responsible for shared services, functions, and activities of the Military Health System (MHS) and other common clinical and business processes.

Defense Manpower Data Center (DMDC)

The office responsible for the Defense Enrollment Eligibility Reporting System (DEERS) and helping beneficiaries with eligibility for TRICARE. DMDC also sends beneficiaries certificates of creditable coverage upon loss of eligibility.

Demonstration

A study or test project looking at other methods of delivery and payment for health services, cost-sharing by eligible beneficiaries, and methods of encouraging efficient and economical delivery of care. Following completion and evaluation of the study/test, TRICARE decides whether the proposed change becomes a TRICARE benefit.

Dental Treatment Facility (DTF)

Uniformed service facilities that provide dental care, primarily to active duty service members. DTFs may see other beneficiaries based on its capacity and capability.

DoD Benefit Number (DBN)

A unique 11-digit family member identifier that ties a family member to a sponsor and identifies the cardholder as one who has DoD benefits, such as health care or base exchanges services.

DoD Identification Number (DoD ID)

A 10-digit electronic DoD identification number that replaces the sponsor's Social Security number on the uniformed services ID and the Common Access Card as a means to identify a specific individual.

Double Coverage

Coverage of a TRICARE beneficiary by another insurance, medical service, or health plan that may duplicate all or part of a beneficiary's TRICARE benefits.

Emergency

A medical, maternity, or psychiatric condition that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition exists; that the absence of medical attention would result in a threat to life, limb, or eyesight and requires immediate medical treatment; or when a condition is so painful that sedative treatment is required to relieve suffering.

Enrollee

A TRICARE beneficiary who elects coverage under a TRICARE Prime option (including the US Family Health Plan).

Enrollment Fees

The amount paid by some categories of beneficiaries to enroll in and receive the benefits of a TRICARE Prime option (including the US Family Health Plan).

Enrollment Transfer (Portability)

A transfer of TRICARE Prime enrollment from one location to another. There are two types of enrollment transfers:

- Between regions—Usually involves a change of contractor and primary care manager (Note: The term "contractors" includes the US Family Health Plan.)
- Within a region—Usually involves a change of address and primary care manager

Exceptional Family Member Program (EFMP)

A mandatory Department of Defense enrollment program that works with military and civilian government agencies to provide comprehensive and coordinated community support, housing, education, health care, and personnel services worldwide to U.S. military families with special needs. EFMP registration is especially important when family members are being screened for approval to accompany their sponsor to an overseas location on permanent change of station orders.

Explanation of Benefits (EOB)

A statement, prepared by insurance carriers, health care organizations, and TRICARE, informing members/beneficiaries and providers of actions taken on a claim.

Exclusion

Exclusion means that items, services, and/or supplies furnished can't be reimbursed/paid for by TRICARE.

Extended Care Health Option (ECHO)

ECHO is a supplemental program to the TRICARE basic program. ECHO provides qualified active duty family members with an additional financial resource for select services and supplies designed to assist in the disabling effects of the family member's qualifying condition, such as moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is home bound.

Fee for Service (FFS)

A payment system in which a beneficiary is billed for individual services received from a health care provider.

Fiscal Year (FY)

The federal government's 12-month accounting period, which runs from October 1–September 30.

Fitness for Duty

Medical and/or dental status of an active duty service member, as determined by the member's service.

Freedom of Information Act (FOIA)

A law enacted in 1967, as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing measures for making information available to the public. TRICARE and its contractors are subject to these measures.

Grievance

A written complaint by a beneficiary on a non-appealable issue who thinks a network provider, contractor, subcontractor, or contracted providers failed to furnish the level or quality of care and or service expected.

Good Faith Payments

Payments made to civilian providers for care to persons who presented as TRICARE eligible but are later determined to be ineligible. (The ineligible person usually possesses an erroneous or illegal identification card.) To receive a good faith payment, the civilian source of care must show it used reasonable measures to identify a person as eligible (e.g., copy of ID card, online inquiry) and billed the former beneficiary for services.

Health Benefits Advisors (HBAs)

Individuals located at military treatment facilities (on occasion at other locations) that are responsible for providing general information on availability and access to care in the uniformed services, direct medical care system, and information on TRICARE benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

An act passed in 1996 designed to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

Health Maintenance Organization (HMO)

A health plan in which a member pays a premium for an assortment of medical services, usually including primary and preventive care. The primary purpose of an HMO is to coordinate care to decrease unnecessary care and costs. HMOs typically have copayments rather than cost-shares. The TRICARE Prime options are similar to HMOs.

Host Nation Provider

A hospital, clinic, laboratory, individual doctor or provider certified to practice or deliver health care in a foreign country.

Initial Determination

The first formal written decision on a TRICARE claim, a request for benefit authorization, a request by a provider for approval as a TRICARE-authorized provider, or a decision sanctioning a TRICARE provider. Explanations of Benefits are considered initial determination documents.

Inpatient Care

Care provided to a patient admitted to a hospital or other authorized institution to receive necessary medical care, with the reasonable expectation the patient will remain in the institution at least 24 hours, with registration and assignment of an inpatient number or designation.

Inquiry

Requests for information or assistance made by or on behalf of a beneficiary, provider, the public or the government. Written inquiries may be made in any format (e.g., letter, memorandum, note attached to a claim). Allowable charge complaints, grievances, and appeals are not included in this definition.

Managed Care Support Contractor (MCSC)

Regional contractors providing managed care support to the Military Health System. The MCSCs are responsible for assisting TRICARE and military treatment facility commanders in operating an integrated health care delivery system, combining resources of the military's direct medical care system and the contractor's purchased care support to provide health, medical and administrative support services to eligible beneficiaries.

Medicaid

Medical benefits program authorized under Title XIX of the Social Security Act for qualified recipients as administered by various state agencies.

Medical Necessity Determination

A collective term for determinations based on medical need, appropriate level of care, custodial care or other reason related to reasonableness, necessity or appropriateness. By law, TRICARE may only pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury. Benefits are restricted to drugs, devices, treatments, or procedures for which the safety and efficacy are proven to be comparable or superior to conventional therapies.

TRICARE uses a hierarchy of reliable evidence to determine whether a drug, device, medical treatment or procedure moves from the status of unproven to the position of nationally accepted medical practice, such evidence includes:

- Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature
- Published formal technology assessments
- Published reports of national professional medical associations
- Published national medical policy organization positions
- Published reports of national expert opinion organizations

Medical Necessity Determination—Pharmacy

A review by the pharmacy contractor as to whether or not a beneficiary pays the full non-formulary copayment for a drug. If medical necessity is justified, a beneficiary pays the formulary copayment for the non-formulary drug. Generally, for medical necessity to be established, one or more of the following criteria must be met:

- The use of the formulary alternative is contraindicated
- The beneficiary experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the beneficiary is reasonably expected to tolerate the non-formulary medication
- The formulary alternative results in therapeutic failure, and the beneficiary is reasonably expected to respond to the non-formulary medication
- The beneficiary previously responded to a non-formulary medication and changing to a formulary alternative would incur unacceptable clinical risk
- There is no formulary alternative

Medical Summary Notice (MSN)

The notice shows what services and/or supplies providers and suppliers billed to Medicare during a three month period, what Medicare paid, and what the beneficiary may owe the provider. This notice isn't a bill.

Medicare

Medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons, persons with end stage renal disease or amyotrophic lateral sclerosis, and individuals of Lincoln County, Montana who have an asbestos-related disease. Medicare is divided into four parts:

- Medicare Part A: Covers inpatient stays, to include hospice and skilled nursing facility care
- Medicare Part B: Covers outpatient services and products, such as doctor's services, outpatient hospital care and other medical services that Part A does not cover (e.g., physical and occupational therapy, x-rays)
- Medicare Part C (Medicare Advantage Plan): Provides all of Medicare Part A and Part B coverage, and may offer vision, hearing, dental and/or health and wellness coverage—a type of Medicare HMO
- Medicare Part D: A prescription drug program available through Medicare-approved private insurance carriers

Military Treatment Facility (MTF)

A hospital or clinic run by the uniformed services, usually located on a military installation.

Military Treatment Facility (MTF)-Referred Care

When MTF Prime enrollees require medical care that isn't available at the MTF, the MTF refers the person to the civilian sector. The regional contractor then issues an authorization determination.

National Defense Authorization Act (NDAA)

The NDAA is under the jurisdiction of the Senate and House Armed Services Committees and provides statutory direction across all DoD programs by establishing, changing, or eliminating programs and activities, to include uniformed services health care services. Established TRICARE in public law.

Negotiated Rate

The negotiated or discounted rate contracted network providers agree to accept for covered services.

Network

The group of contracted providers or facilities (owned, leased, arranged) that link providers or facilities with the contractor as part of the total purchased care delivery system. The agreements for health care delivery made between the contractor and military treatment facilities are also included in this definition.

Network Pharmacies

Retail pharmacies that serve TRICARE beneficiaries through a contractual agreement with the pharmacy contractor.

Network Provider

A professional or institutional provider who signs a contract with a TRICARE contractor to provide services at a negotiated rate. A network provider agrees to follow TRICARE program requirements, file claims, and handle other paperwork for TRICARE beneficiaries and typically administers care to TRICARE Prime enrollees and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option).
A network provider accepts the negotiated rate as payment in full.

Non-Network Provider

Non-network providers don't sign agreements with contractors. They have to be TRICARE authorized for TRICARE to pay on the claim. May be a participating or non-participating provider.

Non-Participating Provider

A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnishes medical services or supplies to a TRICARE beneficiary, but doesn't agree to participate (to accept the TRICARE-allowable charge as payment in full for services). A non-participating provider looks to the beneficiary or sponsor for payment, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, who is then responsible for paying the non-participating provider. He or she may bill the beneficiary up to 15% above the TRICARE-allowable charge. (Some exceptions apply)

Other Health Insurance (OHI)

Health care coverage, medical plan or other entity that offers health care benefits. OHI is obtained through an employer, entitlement program, or other source.

Out-of-Pocket Costs

The amount of money a beneficiary pays for services. This includes enrollment fees, cost-shares, deductibles, copayments, and personal expenses for the point of service option and for non-covered services.

Participating Provider

An authorized provider who agrees to accept the TRICARE-allowable charge (government + beneficiary cost-shares) as payment in full. Non-network providers may choose to participate on a claim-by-claim basis.

Pending Claim, Correspondence, or Appeal

A claim/correspondence/appeal case that was received but a final determination hasn't yet been made.

Point of Service (POS)

This option allows Prime option enrollees to self-refer for nonemergency care to any TRICARE-authorized provider. The enrollee pays a 50% cost-share of the TRICARE-allowable amount when using the POS option.

Preferred Provider Organization (PPO)

An organization of providers who, through contractual agreements with a contractor, agree to provide services to beneficiaries at agreed upon rates and to file claims for beneficiaries. TRICARE Extra is a PPO-like option for Standard beneficiaries who use network providers.

Preventive Care

Periodic screening and testing that isn't needed to treat an existing condition, but instead focuses on maintaining an overall high quality of personal health.

Primary Care

The standard, usual, and customary services provided as routine care. Services include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services include care for routine illness and injury; periodic physical examinations of newborns, infants, children, and adults; immunizations, injections, allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services also include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

Primary Care Manager (PCM)

A military treatment facility provider, team of providers, or a civilian network provider or practice that a Prime-option enrollee is assigned to for primary care services. Enrollees agree to seek all nonemergency, non-mental health care services from their PCMs.

Prime Service Area (PSA)

A geographic area where TRICARE Prime is offered. Regional contractors are required to establish Prime Service Areas around military treatment facilities and at Base Realignment and Closure locations.

Prior Authorization

A process of reviewing requests for medical, surgical, and behavioral health services to ensure medical necessity, appropriateness of care, and TRICARE coverage before services are received (or within 24 hours of an emergency admission). Services requiring prior authorization may vary from region to region.

Privacy Act, 5 USC 552a

A law intended to preserve the personal privacy of individuals and to permit an individual to know what records about him or her are collected, maintained, used, or disseminated, and to have access to and copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. It requires Government activities which collect, maintain, use or disseminate any record of an identifiable personal nature to assure that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual, and that adequate safeguards are in place to prevent misuse or unauthorized release of such information.

Professional Fees

Charges for services provided by individual medical professionals (e.g. doctor, anesthetist, nurse practitioner, therapist, etc.). Hospitals or third-party payers require these fees to be separately identified on an inpatient billing form. Providers themselves bill for their services.

Provider

A hospital or other institution offering medical care or services, a physician or other individual professional provider, or other entity delivering services or supplies in accordance with 32 CFR 199.

Provider Termination

When a provider's status as a TRICARE-authorized provider ends, other than through exclusion or suspension, because the provider doesn't qualify to be a TRICARE-authorized provider.

Reconsideration

A written appeal to a contractor following an initial denial determination from the contractor.

Referral

The process of sending a Prime enrollee to another professional provider for consultation or a health care service the referring provider believes is necessary but is not prepared or qualified to provide.

Region

A geographic area defined by the U.S. Government for contracting of medical care and other services for TRICARE-eligible beneficiaries.

Regional Contractor

A civilian health care entity who provides health, medical, and administrative support services in a specific TRICARE region. The regional contractors help combine the services at uniformed service treatment facilities and those offered by their network of civilian hospitals and providers to meet the health care needs of beneficiaries within the region.

Regional Director

The individual responsible for supporting TRICARE contract administration in all three regions and directing the activities of the TRICARE Regional Offices.

Reserve and Service Member Support Office (R&SMSO)

The Defense Health Agency office responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty for service members in remote locations and the U.S. Virgin Islands. R&SMSO is also responsible for authorizing care related to a line of duty injury, illness, or condition for inactive Guard/Reserve.

Residence

For TRICARE purposes, "residence" is a beneficiary's dwelling place for day-to-day living. A temporary living place during periods of temporary duty or during a period of confinement, such as a residential treatment center, isn't considered a residence. Minor children's residence is the same as the residence of the custodial parent(s) or the legal guardian. Incompetent adult beneficiaries' residence is the same as the residence of the legal guardian. Under split enrollment, when an eligible family member resides away from home (e.g., while attending school), their residence is where they live, not the family's home address.

Respite Care

Short-term care for a home-bound beneficiary to provide rest and change for primary caregivers who care for the beneficiary at home. Respite care consists of providing skilled and non-skilled services so that in the absence of the primary caregiver, management of the beneficiary's qualifying condition and safety are met.

Retiree

A member or former member of a uniformed service who is entitled to retired, retainer, or equivalent uniformed-service pay.

Routine Care

Includes general office visits for the treatment of symptoms, chronic or acute illnesses, diseases or follow-up care for ongoing medical conditions including preventive care. Also known as primary care.

Secondary Payer

The plan or program whose benefits are payable in double coverage situations only after the primary payer processes and determines payment on a claim.

Service Point of Contact (SPOC)

The uniformed services office or individual responsible for coordinating civilian health care for active duty service members (ADSMs) in stateside remote locations and the Virgin Islands, and line-of-duty care for Guard/Reserve members. The SPOC reviews requests for specialty and inpatient care to determine the impact on the ADSM's fitness for duty; determines whether the ADSM receives care related to fitness for duty at a military treatment facility or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for remote ADSMs. SPOCs are assigned to the Reserve and Service Member Support Office (R&SMSO).

Specialty Care

Specialized medical/surgical diagnosis, treatment, or services a primary care physician isn't qualified to provide.

Split Enrollment

Refers to multiple family members enrolled in a TRICARE Prime option under different regional contractors, including stateside and overseas and US Family Health Plan (USFHP) designated providers.

Sponsor

The active duty service member, Guard/Reserve member, or retiree through whom that individual and his/her family members are eligible for benefits, to include TRICARE.

Student Status

A dependent of a member or former member of a uniformed service who has not passed age 23, is enrolled as a full-time student in an accredited institution of higher learning, and is dependent on the sponsor for over 50 percent of his/her financial support.

Supplemental Health Care Program (SHCP)

A program for eligible uniformed service members and other designated patients who require medical care that's not available at a uniformed service clinic or hospital and may be purchased from civilian providers under TRICARE payment rules, pending the approval of clinic/hospital commander or the Director, Defense Health Agency.

Survivor

The status of a spouse three years after his or her active duty sponsor's death, as determined by the sponsor's service. Survivors have the same enrollment fees, cost-shares, and copayments as retiree family members. Also applies to spouses of deceased retired sponsors.

Third Party Liability (TPL) Claims

Claims for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages to the government for care. The Government seeks repayment under the provisions and authority of the Federal Medical Care Recovery Act.

Third Party Payer

An insurance, medical service, or health plan designed to provide compensation or coverage for a beneficiary's expenses for medical services or supplies (e.g., automobile liability insurance, no fault insurance carrier, worker's compensation program or plan).

Timely Filing

The filing of TRICARE claims within prescribed time limits (one year stateside; three years overseas; no limit for active duty service member claims).

Transitional Assistance Management Program (TAMP)

Transitional health care for certain uniformed service members and their eligible family members who separate from active duty.

Transitional Care for Service Related Conditions (TCSRC)

A benefit that extends the health care coverage period for former active duty service members with certain service-related conditions. The TCSRC coverage period is 180 days from the date the diagnosed condition is validated by a DoD physician. Family members are not eligible for this benefit.

Transitional Survivor

A TRICARE-eligible family member whose sponsor was on active duty at his or her time of death. Transitional survivors are eligible to receive the same health care benefits as active duty family members, to include coverage under a Prime option, for as long as they maintain TRICARE eligibility. Spouses of the deceased sponsor are considered transitional survivors for three years from the date of the sponsor's death. Eligible dependent children (including qualifying students over 18) of the deceased sponsor remain transitional survivors as long as they remain TRICARE eligible.

TRICARE

The DoD's managed health care program for active duty service members and their families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard, TRICARE Extra, and TRICARE Prime.

TRICARE-Allowable Charge

The maximum amount TRICARE pays for a particular covered service. By law, the TRICARE-allowable charge matches Medicare rates whenever practical.

TRICARE Area Office (TAO)

The office responsible for the development and execution of a plan for the delivery of health care, using uniformed service and overseas host nation providers, within designated areas in the overseas region, including Eurasia-Africa, Latin America and Canada, and the Pacific.

TRICARE-Authorized Provider

A provider who meets TRICARE's licensing and certification requirements and is certified to provide care to TRICARE beneficiaries. There are two types of TRICARE-authorized providers: network and non-network (participating and non-participating).

TRICARE Dental Program (TDP)

A voluntary premium-based dental insurance program available to eligible active duty family members, members of the National Guard and Reserve and their families, transitional survivors, and other select beneficiaries.

TRICARE Extra

An option similar to a preferred provider organization (PPO) where Standard beneficiaries choose to receive care from civilian network providers and pay lower cost shares.

TRICARE for Life (TFL)

A TRICARE program combining TRICARE Standard coverage with Medicare Part A and Medicare Part B to provide wrap-around medical coverage to beneficiaries eligible for Medicare and TRICARE. These are also known as dual-eligible beneficiaries. TRICARE beneficiaries entitled to premium-free Medicare Part A are required by federal law to have Medicare Part B to remain TRICARE eligible (with some exceptions).

TRICARE Management Activity (TMA)

A Department of Defense Activity abolished on October 1, 2013 when the Defense Health Agency was established.

TRICARE Overseas Program (TOP)

The Department of Defense's health care program in all geographic areas and territorial waters outside of the 50 United States and the District of Columbia.

TRICARE Overseas Program Prime (TOP Prime)

A TRICARE option that offers the benefits of TRICARE Prime in overseas locations near uniformed service clinics and hospitals. TOP Prime enrollees are assigned a primary care manager who delivers and/or manages routine and urgent medical care and coordinates care with the overseas contractor as needed. TOP Prime enrollees pay no copayments, cost-shares or deductibles for care from their PCM or for authorized services from a purchased care/host nation provider. TOP Prime is only available to active duty service members and command-sponsored family members.

TRICARE Overseas Program Prime Remote (TOP Prime Remote)

A TRICARE option that offers the benefits of TRICARE Prime to active duty service members permanently assigned to designated remote overseas locations, and to their eligible command-sponsored family members. The TOP contractor has networks of licensed, purchased care/host nation providers in these remote overseas locations to deliver health care to TOP Prime Remote enrollees. The TOP contractor acts as the enrollee's primary care manager and authorizes care provided by host-nation providers.

TRICARE Plus

A primary care enrollment program offered at select military treatment facilities (MTFs). All beneficiaries eligible for care at MTFs (except those enrolled in TRICARE Prime or a health maintenance organization [HMO]) may seek enrollment for primary care at select MTFs based on the Commander's guidance.

TRICARE Prime

A health management organization (HMO)-like option where beneficiaries residing in designated Prime Service Areas voluntarily enroll in a program offering TRICARE Standard benefits and enhanced primary and preventive benefits with established copayments. TRICARE Prime enrollees are assigned a primary care manager (PCM) from a military treatment facility (uniformed service clinic or hospital) or the regional contractor's network and follow Prime rules for getting specialty care services (except when enrollees choose to use the point-of-service option).

TRICARE Prime Remote (TPR)

A TRICARE Prime option that provides health care coverage through civilian network or TRICARE-authorized providers for uniformed service members assigned to duty stations and residing in remote areas, typically 50 or more miles from a military treatment facility. TPR requires enrollment.

TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

A TRICARE Prime option that offers health care coverage through civilian network or TRICARE-authorized providers for family members of uniformed service members who are assigned to duty stations and reside in certain designated remote areas, typically 50 or more miles from a military treatment facility (uniformed service clinic or hospital). TPRADFM requires enrollment, and family members must reside with the sponsor (with some exceptions).

TRICARE Regional Office (TRO)

A division of TRICARE that oversees the integrated health care delivery system in the three United States-based TRICARE regions: North, South, and West.

TRICARE Reserve Select (TRS)

A premium-based health care plan qualified Selected Reserve members may purchase for themselves and eligible family members. TRS offers TRICARE Standard benefits.

TRICARE Retired Reserve (TRR)

A premium-based, worldwide health plan qualified Retired Reserve members may purchase for themselves and eligible family members. TRR offers TRICARE Standard benefits.

TRICARE Retiree Dental Program (TRDP)

A voluntary, premium based dental insurance program available for purchase by retired service members and their family members.

TRICARE Standard

A fee-for-service option in which beneficiaries seek TRICARE-covered services from any TRICARE-authorized provider. Beneficiaries are responsible for payment of an annual deductible and cost-shares, and may be responsible for other costs.

TRICARE Young Adult (TYA)

Voluntary premium-based coverage that extends TRICARE to certain family members under the age of 26 who have lost or will lose TRICARE eligibility due to age (typically 21 or 23).

Uniform Formulary

A list of TRICARE-covered prescription medications and supplies.

Uniformed Services

The seven uniformed services of the United States are: U.S. Army, U.S. Marine Corps, U.S. Navy, U.S. Air Force, U.S. Coast Guard, Commissioned Corps of the United States Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). The services determine TRICARE eligibility.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA provides employment/reemployment protection to uniformed service members who perform military service. USERRA is overseen by the Department of Labor.

United States Public Health Service (USPHS)

An agency within the U.S. Department of Human Health Services with a Commissioned Corps whose members are classified as members of the uniformed services.

Unproven Drugs, Devices, and Medical Treatments or Procedures

Drugs, devices, medical treatments or procedures are considered unproven if:

- Food and Drug Administration (FDA) approval is required and hasn't been given
- If the device is a FDA Category A Investigational Device Exemption (IDE)
- If there is no reliable evidence that shows the treatment or procedure was the subject of well-controlled studies of clinically meaningful endpoints that determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis
- If the reliable evidence shows that the consensus among experts regarding the treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis

Urgent Care

Medically necessary services required for illnesses or injuries that won't result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

US Family Health Plan (USFHP)

A TRICARE Prime-like option available in six geographic locations across the United States that offers benefits to active duty family members, retirees and their eligible family members, survivors, certain former spouses and other eligible beneficiaries. Active duty service members cannot enroll in USFHP.

Veteran

A person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable. Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," (which refers to payments of a continuing nature and are payable at fixed intervals from the Government for military service) neither the veteran nor his or her family members are eligible for benefits under TRICARE.