Welcome To **The TRICARE® Fundamentals Course** January–March 2016

This course takes three days. You have to pass a 50-question final exam, scoring at least 80% to pass. You also have to fill out an online evaluation to get your training certificate. We'll e-mail your certificate within seven business days after you complete the evaluation.

This TFC Participant Guide is a training and reference tool. It's updated quarterly. To get the most current version, visit www.tricare.mil/tricareu/participant-guide.aspx.

Once you go back to work:

- Visit www.tricare.mil for benefit information and sign up for TRICARE e-mails at https://public.govdelivery.com/accounts/USMHSTMA/subscriber/new
- Visit the customer service community website at: https://mhs.health.mil/customerservicecommunity/default.aspx
- Visit http://www.tricare.mil/bcacdcao_user to sign up for e-mails for customer service staff

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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.

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TRICARE Fundamentals Course

Key TRICARE Concepts and Terms

1

Participant Guide

References

2008 TRICARE Operations Manual
2008 TRICARE Policy Manual
2008 TRICARE Reimbursement Manual
2008 TRICARE Systems Manual
10 USC
32 CFR § 199, 199.2

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 made up of the organizations who manage health care for the uniformed services.
- The MHS includes those employed or contracted by the Department of Defense (DoD) to give care on the battlefield, on ships, in the air, and in uniformed service and civilian hospitals and clinics.
- Understanding health care under the MHS means understanding of two distinct types of care:
  - Direct care—health care 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 sets up 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 health service regions around the world: three in the United States and one overseas. Each region has a regional contractor who administers and coordinates health care services between uniformed service hospitals and clinics, and network and non-network civilian hospitals and providers. (We refer to regional managed care support contractors and the overseas health services support contractor as regional contractors).

1.2.1 Stateside

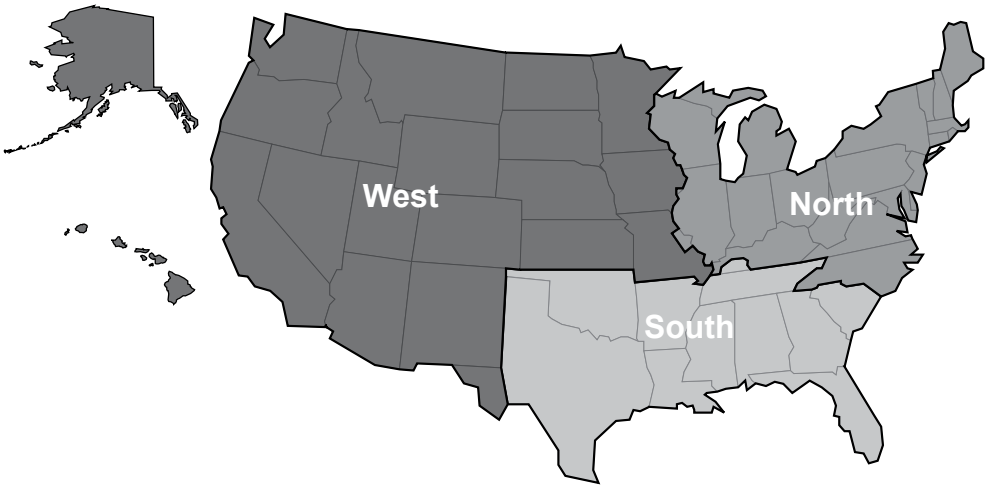
The government office overseeing each of the three stateside TRICARE regions is known as a TRICARE Regional Office (TRO): TRO-North, TRO-South, and TRO-West. The TROs make sure regional contractors carry out their contractual responsibilities.

- **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 with health care/medical benefits. 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 covers beneficiaries living or 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 stateside physicians may be performed by a physician's assistant, depending on the country)
- TRICARE Area Offices (TAOs) monitor care in the overseas region and develop and deliver plans for health care services. There is one Overseas Region divided into three overseas areas:
  - TRICARE Eurasia-Africa (includes Africa, Europe, and the Middle East)
  - TRICARE Latin America and Canada (TLAC) (includes Canada, the Caribbean basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)
  - TRICARE Pacific (includes Asia, Guam, India, Japan, Korea, New Zealand, Australia, 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 system for DoD personnel and health care benefit information.
- DEERS is the one source for benefit and entitlement eligibility information for:
  - Uniformed service members
  - Uniformed service retirees
  - U.S. sponsored foreign military members
  - DoD and Uniformed Services civilians
  - Eligible family members
  - Others as directed by the DoD
- DEERS shows TRICARE eligibility, TRICARE option coverage, primary care manager (PCM) assignment, catastrophic caps, deductibles, enrollment fee totals, and other health insurance (OHI) information.
- **Remember, DEERS doesn't determine eligibility, it only reports it**. Beneficiaries should contact the DMDC Support Office (DSO), or the nearest identification (ID) card-issuing facility for eligibility questions.

2.1 When to Update DEERS Records

DEERS will update some records automatically, but 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 mailing or e-mail address • Death	• Marriage or divorce • Birth or adoption • Death • Relocation or change of mailing or e-mail address • Medicare eligibility gain or loss • 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, sponsors and family members 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 Disapproved 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 Personal Contact Information in DEERS (Address, Phone Number, E-mail)

It's important for beneficiaries to keep personal information (mailing addresses, phone numbers, and especially e-mail addresses) current to receive important TRICARE notices.

- **In Person—**Beneficiaries go to the nearest uniformed services personnel office or ID card-issuing facility to update contact information. To locate the nearest ID card-issuing facility, visit www.dmdc.osd.mil/rsl.
- **By Internet—**Registered beneficiaries submit contact changes at http://milconnect.dmdc.mil. Users securely login with a CAC, DFAS (myPay) account, or with a DS Logon and then select the "update address" link.
- **By Fax—**DSO: 1-831-655-8317
- **By Mail—**Mail changes 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 location information is 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: 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 getting health care 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 show in DEERS?

3.0 TRICARE and Veterans Affairs Benefits

- Certain retired 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 an earlier episode of care.
- TRICARE doesn't pay for VA care (direct or authorized) or beneficiaries' VA cost shares.

4.0 TRICARE Providers

Beneficiaries may see different types of providers.

4.1 Military Treatment Facilities (MTFs)

- Military treatment facilities (MTFs) are usually located on or near a uniformed service installation and are medical clinics or hospitals where 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.
- Those not enrolled in TRICARE Prime receive MTF care on a space-available basis.

4.2 Authorized Providers (Civilian)

- An authorized provider is any individual, institution/organization, or supplier licensed by a state, accredited by a national organization, or meets other standards of the medical community and is certified to provide TRICARE benefits.
- It's up to the beneficiary to make sure a provider is TRICARE-authorized.
- Regional contractors verify a provider's authorized status before they pay on 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 certified host nation individual, institution, or organization serving overseas TOP Prime or TOP Prime Remote enrollees through an established agreement with the TOP contractor Provides "cashless, claimless"** authorized care to TOP Prime option enrollees
Non-Network Participating Provider	An authorized provider who has no contractual agreement with the regional contractor and accepts the TRICARE-allowable charge as payment in full for covered services May require beneficiaries to pay up front and file their own claims	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

* *Network providers are only "network" for the region where contracted (e.g., A North region network provider isn't considered "network" for South region Prime enrollees seeking preventive care in the North region).*

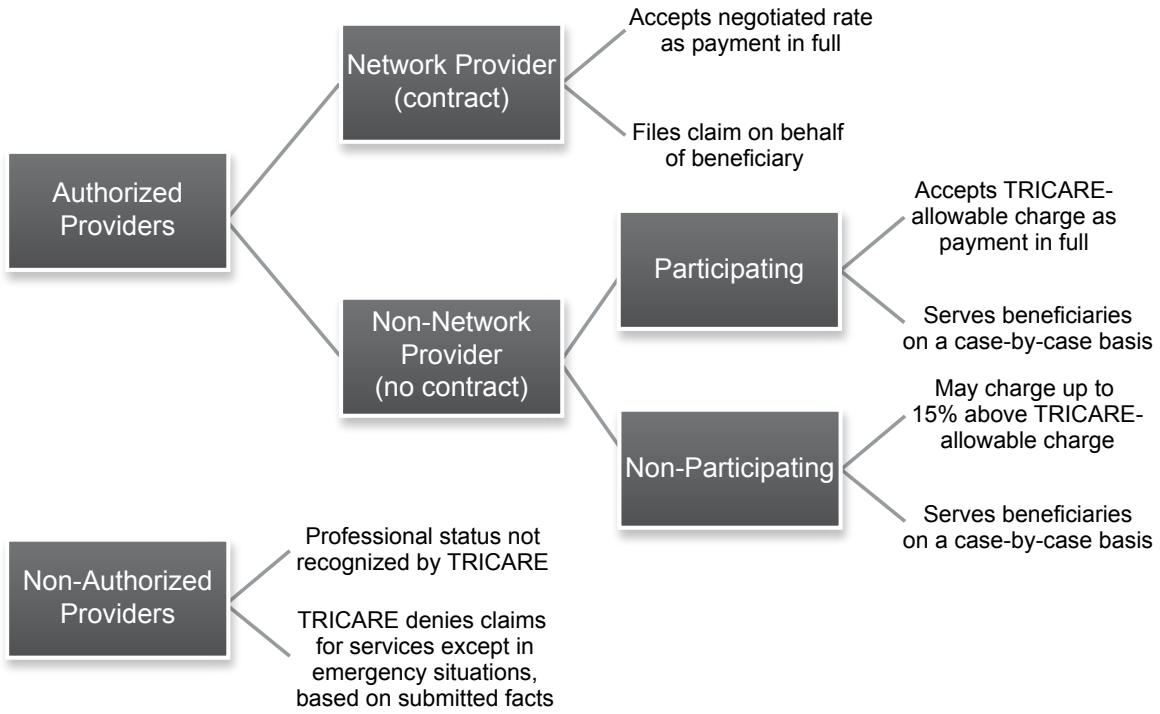
** *"Cashless, claimless" means the overseas contractor authorized a visit and pays the network provider; the enrollee doesn't have upfront costs.*

4.2.2 Non-Authorized Providers

A non-authorized provider is a provider whose professional status TRICARE doesn't recognize. 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 for emergency care; TRICARE then bases coverage on submitted claims and supporting documentation (if needed).
- If beneficiaries ask if their provider can become authorized, refer them to www.tricare.mil/providers or the regional contractor.

4.2.3 Illustration of Provider Types



?	Mrs. White is searching for a new dermatologist. If she chooses a non-network, non-participating provider, will the provider accept the TRICARE-allowable charge as payment in full?

4.3 Finding a Provider

- Stateside: Before getting care, beneficiaries should ask providers if they're TRICARE-authorized network or non-network participating providers. 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 subject to change. A listing doesn't guarantee the provider's information is current or is accepting new patients; beneficiaries should call the provider's office to confirm their 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 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 pay under a Standard option.
Copayment	The fixed amount TRICARE Prime option enrollees pay for care in the civilian provider network. This term also applies to TRICARE pharmacy out-of-pocket costs.
Premium	The pre-determined charge an individual pays for medical or dental coverage for a defined period of time.
Enrollment Fee	The amount some beneficiaries pay to enroll in and receive Prime benefits (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: ● 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 billed charges and the TRICARE-allowable charge (stateside only).
Explanation of Benefits (EOB)	A statement, prepared by insurance carriers, health care organizations, and TRICARE, showing actions taken on a claim.
Foreign Fee Schedule (Overseas Specific)	A country-specific payment determination for provider services that calculates deductibles and cost-shares (currently only used in the Philippines and Panama).
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 ADFMs. See Appendix A 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 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 eligibility and claims problems by registering/enrolling 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 aren't TRICARE eligible; TRICARE won't pay their claims. (See the *TRICARE Options* module for more information about newborn coverage under TRICARE Prime.)
  - **Note**: TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR)-enrolled sponsors may purchase coverage upon a child's birth or adoption. The regional contractor must receive an application postmarked no later than 60 days after this qualifying life event for the child to be eligible from the date of birth or adoption. After 60 days, coverage starts on the first of the month after the regional contractor receives an updated application.
- Pre-adoptive, adopted children, and court-ordered wards must be registered in DEERS to be TRICARE eligible; claims deny until they are registered. Pre-adoptive children are those whose legal adoption isn't final.
- To establish eligibility in DEERS, 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 can't sign in person, the spouse must present a power of attorney/notice or 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 in a U.S. civilian or military treatment facility) or consular report of live birth for children born overseas
    - Before the final adoption, a record of adoption or a letter of the child's placement in the home from a recognized placement or adoption agency (the 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 requires to establish eligibility. Locations and contact information for ID card-issuing facilities are 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 from a uniformed service clinic or hospital/MTF.

- Eligible dependent parents and parents-in-law must be registered in DEERS; 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 get prescriptions filled at an MTF pharmacy. When they become Medicare-eligible they can get prescriptions filled through Home Delivery or at TRICARE network pharmacies, as long as they have 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. The sponsor's service determines eligibility and reflects it 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).
  - The requirements to live with the sponsor and be command-sponsored don't apply to transitional survivors living overseas.
- 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, TOP Standard, Point of Service, or a non-network pharmacy.

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 survivor status and TRICARE benefits continue at retiree payments rates and rules.
  - 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); however, they may continue to receive Applied Behavior Analysis (ABA) under the Autism Care Demonstration.
- Survivors are eligible for TRICARE Standard and TOP Standard and pay retiree cost-shares and deductibles for TRICARE-covered services
- Survivors may enroll in TRICARE Prime, but must re-enroll and pay retiree enrollment fees and copayments.
  - Fees are frozen at the rates in place when their status changes to survivor and they first enroll in Prime and pay Prime enrollment fees.
- Survivors must purchase Medicare Part B if they become entitled to Medicare.
- Survivors pay applicable pharmacy copayments when using the TRICARE Pharmacy benefit.

Unremarried Former Spouses

- Certain unremarried former spouses are TRICARE-eligible if the former sponsor's service component determines and reflects their eligibility in DEERS.
- The 20-20-20 rule. To be eligible as an unremarried former spouse:
  - Sponsor must have 20 years of creditable service (active or reserve) 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 20 years of the sponsor's creditable service.
- The 20-20-15 rule allows some former spouses to qualify for medical benefits for one year from the date of the divorce decree.
  - Sponsor must have 20 years of creditable service (active or reserve) towards determining retirement pay.
  - 15 years of marriage to the same sponsor/service member.
  - All 15 years of marriage overlap the 20 years of creditable service, active or reserve, that counted toward the sponsor's retirement.
- The following documentation must be presented 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, the service sends the spouse a letter confirming eligibility. He or she should pick up a new ID card under his or her own name. The unremarried former spouse then uses his or 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:

- They remarry, even if the remarriage ends in divorce or death of the spouse, unless they gain TRICARE eligibility under a new spouse
- They purchase or are covered by an employer-sponsored health plan

Note: TRICARE-eligible unremarried former spouses who are offered group health coverage through their employer may be able 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 service 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 lost their retirement status 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**

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.
- Standard is a fee-for-service-like option—TRICARE pays providers the allowable charge for billed services.
- Standard beneficiaries have a larger number of authorized providers to choose from and don't need 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."

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

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 present 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 medically necessary and considered proven inpatient and outpatient care.
- Certain services are only available if 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 a referral to be seen by a TRICARE-authorized or purchased care/ host nation provider for TRICARE-covered services.
- Standard beneficiaries must get prior authorization from their regional contractor for the following:
  - Adjunctive dental care (e.g., temporomandibular joint disorders)
  - Inpatient non-emergency 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 doesn't require 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.
- Standard beneficiaries may seek routine and urgent care from any TRICARE-authorized or purchased care/ host nation provider, including certain preventive services. They may also been seen at an MTF if space is available.

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 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 TRICARE Standard? What happens to their cost-share if they use a network provider?

1.4 TRICARE Standard and TRICARE Extra Costs

Overseas and some stateside providers may require Standard beneficiaries to pay for 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; after that, the government and the beneficiary share costs. 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 more than the 15%.
- Beneficiaries should check their explanation of benefits (EOB) to make sure they weren't billed more than the allowed 15% and follow up with the provider or regional contractor if they were.

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; 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's cost-share	$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: Though the total amount charged is $1,000.00, the provider can't legally hold the beneficiary responsible for the total amount. The beneficiary owes 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). With an HMO, enrollees have one primary care manager for all routine health care needs; enrollees usually need a referral before seeing other health care professionals (except in an emergency).
- Prime is available in established geographic locations, referred to as Prime Service Areas (PSAs).
  - PSAs 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 overseas.

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 routine, non-emergency, and urgent health 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 enrollee if the individual's PCM isn't available
- PCMs may be:
  - Internists, family practitioners, pediatricians, general practitioners, or obstetricians/gynecologists
  - Physician assistants, nurse practitioners, and certified nurse midwives
- Beneficiaries may note the type of PCM they would like on their enrollment form. PCM assignment is based on the sponsor's status, beneficiary's address, PCM availability, and MTF Commander's guidance (which is given to the contractor for processing MTF enrollments and assigning PCMs).

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 case, 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 living 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 an overseas location* ● ADFMs on service-funded orders 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 the sponsor's activation

* *Only ADFMs who meet the Joint Federal Travel Regulation (JFTR) definition of command sponsored, are eligible for TOP Prime enrollment, except for 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 and PCM Assignment

Enrollment is required.

- ADSMs are automatically covered under TRICARE Prime. They must enroll to be assigned a PCM and are to follow service-specific guidance based on their assignment and location.
- PCM assignment is effective the date the contractor received the enrollment request.
- ADFMs of sponsors who are E-1–E-4 and who live within a PSA are assigned an MTF PCM upon request when they enroll in Prime.
- Non-ADSMs may enroll on an individual or family basis (voluntary enrollment).
- Beneficiaries may enroll one of three ways:
  - Use the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe
    - Only available to those who live or want to enroll in a PSA
  - Call the regional contractor
  - Mail
    - Print out a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) and mail it to the regional contractor, along with the initial enrollment fee (if applicable).

2.3.1 For Other than Active Duty Service Members

- **Stateside,** the regional contractor must receive the enrollment request/fee by the 20th of the month for Prime to start on the first day of the following month. If received after the 20th, Prime begins on the first day of the second month (20th-of-the month rule).
- **Overseas**, TOP Prime coverage begins on the date a complete, signed enrollment form is received; a complete enrollment request includes **required** command sponsorship orders for family members.
  - The 20th-of-the-month rule doesn't apply to TOP Prime.
- Eligible beneficiaries (non-ADSMs) are covered under TRICARE Standard until TRICARE Prime starts.
- Each enrollment period is one fiscal year (October 1–September 30); enrollment renews automatically, unless one of the following occur:
  - Enrollee chooses to disenroll (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 aren't 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.)

2.3.2 Prime Enrollment Fees

- ADSMs and ADFMs don't pay enrollment fees.
- All other enrollees pay an annual enrollment fee (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 eligible family members freeze at the rate in effect when classified in DEERS and first enrolling in Prime. (This doesn't include TRICARE Young Adult Prime, see the *Other Benefits* module.)
    - The fees remain frozen as long as 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 include an initial three-month payment with their completed enrollment form. All ongoing 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 they avoid paying Prime enrollment fees for themselves when they become Medicare entitled.
- For current Prime enrollment fees visit www.tricare.mil/primecosts.

2.3.3 Prime Lockout and Disenrollment

- Prime enrollees, other than ADSMs, may disenroll at any time. The regional or TOP contractor may then deny re-enrollment (lockout) to the following:
  - ADFMs of sponsors who are E-5 and above who change their enrollment status (i.e., enroll and disenroll) more than twice in an enrollment year for any reason
    - The 12-month lockout 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 services provided to ADSMs and their Prime-enrolled family members, as long as they receive nonemergency/routine/urgent care from their assigned PCM and have the right referrals and authorizations for specialty or urgent care not available from their PCM.
- There are pharmacy/prescription drug cost shares for Prime enrollees other than ADSMs. (See the *Pharmacy* module for more information.)
- Costs 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-ADSM** Prime enrollees to receive nonemergency care from any TRICARE-authorized, purchased care/host nation provider without a PCM referral.
- Prime enrollees pay higher out-of-pocket costs using the POS option. POS has its own deductible. POS out-of-pocket costs don't apply to the annual catastrophic cap.

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 network providers
- 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 care for adopted children for 60 days stateside/120 days overseas when first registered in DEERS (See Section 7.0 of this module for more information.)
- Other health insurance (OHI) exists. 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 or authorization from the regional contractor.
- 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 difference(s) between their TRICARE Prime and Standard benefits? What do the Matthews' have to do to show as Prime in DEERS?

4.0 Prime Access Standards and Types of Care

- "Access to care" refers to established standards so TRICARE Prime enrollees 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 enrollee's home	Within 30 minutes of enrollee's home	Within 60 minutes of enrollee's home	Within 30 minutes of enrollee's home
Wait Time in Office	Not to exceed 30 minutes for non-emergency situations			

- **Emergency care** refers to medical, maternity, or psychiatric emergencies that lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe a serious medical condition exists; that no medical attention would result in a threat to life, limb, or eyesight and immediate medical treatment is needed; or when a condition is so painful sedative treatment is required to relieve suffering.
- **Urgent care** is generally defined as non-emergency 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 enrollees can't contact their PCM, they should contact the regional contractor, Nurse Advice Line, or the TOP Call Center before seeking urgent care. They should contact their PCM the next business day for a referral (if needed).
- **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 for routine care.
- **Specialty care** is generally defined as care the PCM can't provide.
- **Preventive care** includes services, such as health screenings and vaccinations, often done at specified ages or stages of life, which are aimed to keep beneficiaries healthy or find health problems in a timely manner (e.g., mammograms, pap smears, cholesterol testing).
- **Nurse Advice Line**: Stateside beneficiaries or overseas beneficiaries traveling or moving stateside may call the Nurse Advice Line (NAL) 24 hours a day, 7 days a week for advice on urgent health concerns. Registered nurses help beneficiaries decide if self-care is the best option, or if they should see a health care provider. If immediate treatment is needed, the NAL helps beneficiaries locate the nearest health care facility or writes a referral for MTF Prime enrollees. The NAL can be reached by calling 1-800-874-2273, option #1.

4.1 Getting Emergency Care

- Prime enrollees should go to the nearest emergency room.
  - **Stateside**: Prime enrollees must notify their PCM or regional contractor within 24 hours of receiving emergency care or admission 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 admission to an inpatient facility, stateside or overseas.
- Copies of emergency treatment records may be needed for claims processing purposes. If the ER diagnosis doesn't support the need for emergency services, the claim may process as POS. The ER record may show the condition at the time of arrival may have met the definition of emergency care.
- See Appendix A of this module for information on active duty 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 appointments to avoid POS charges.
- Enrollees may be required to receive specialty care at an MTF.
- Getting the referral authorized is a multi-step process:

Stateside	● The PCM submits the referral electronically or by fax. ○ Under the MTF right of first refusal (ROFR), the MTF has 90 minutes to accept urgent referrals and two business days to accept routine referrals. If not accepted within those time frames, the referral is considered denied by the MTF and returns to the contractor for action. ○ 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 care is authorized for, to include the type and number of visits. ○ Before making an appointment, enrollees may call the regional contractor's toll-free number 3-5 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 ask for a different 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. ● 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 from a certified host nation provider, gives the TOP Prime enrollee information on the specialty care provider, and may assist in coordinating the specialty appointment. ○ Before scheduling an appointment, the enrollee must confirm the authorization through his or her Regional or Country-specific Call Center. ● 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's no network specialist within access standards.

- Authorizations don't carry over from one region to another or when an enrollee goes from active duty to retiree status or from active duty to inactive status after separation.
- When they move to a new region, enrollees need to get new specialty care referrals and authorizations from their new PCM/regional contractor.

?	Bill's current medication isn't effective, so his PCM writes a referral to a specialist. What are the access standards in this situation? How could he get a referral for a *civilian* specialist?

4.2.1 Stateside TRICARE Prime Travel Benefits for Specialty Care

- When stateside **non-ADSM** TRICARE Prime enrollees are referred for and authorized to receive medically necessary, non-emergency 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 isn't negotiable when determining if the Prime travel benefit applies. (There is an exception for Coast Guard ADSMs. For more information, see the 2008 TRICARE Reimbursement Manual, Chapter 1, Section 30.)
- ADSM 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 enrollment (move between regions) or select new PCMs (move within one region).
- Stateside and overseas Prime enrollees may complete both enrollment transfer and PCM change by:
  - Calling the losing or gaining contractor
  - Using the BWE website at www.dmdc.osd.mil/appj/bwe
  - 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 (use BWE, milConnect, or call DMDC) or notify the regional contractor of their address change.
- Enrollees confirm PCM assignment by calling the contractor or checking milConnect.

5.2 Transferring Prime to a Different Region

- When moving to a new region, Prime enrollees **shouldn't** disenroll from their current region until they arrive at their new location. Remaining enrolled ensures they have no break in TRICARE Prime coverage. Enrollees must update their address in DEERS for the transfer to take place.
- While traveling to the new location, enrollees must get referrals from their PCM and authorization from their current regional contractor before getting non-emergency, specialty, or inpatient care to avoid POS charges. Enrollment transfers are effective the date the gaining regional contractor processes a new enrollment or confirms transfer via phone call (ADSMs and ADFMs may also confirm transfers with their old regional contractor).
- The gaining regional contractor assigns a new PCM and 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 update their address in DEERS.
- Prime-enrolled retirees and their family members who move from one region to another and back to their original region can transfer their enrollment twice 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 or soon becoming Medicare-eligible they should consider paying their enrollment fees quarterly or monthly since TRICARE won't refund the unused portions of an annual enrollment fee.

5.4 Transferring to a Location Outside of a Prime Service Area

- Enrollees can be covered by TRICARE Prime while moving 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 qualifying ADFMs only)
  - Disenroll and use Standard/Extra (other than ADSMs)
- If an enrollee moves outside of a PSA, but wants to remain Prime, he or she must note on their enrollment form they are willing to waive Prime drive time standards. Enrollment is then based on where they live and if there are Prime network providers available within 100 miles of their residence.
  - 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 other family members are enrolled in another. The sponsor or legal guardian must enroll family member(s) to the regional contractors where other family member(s) live.
- Enrollment fees:
  - The family may pay a family enrollment fee to one regional contractor or split the family fee between two contractors. Regional contractors can help with this process.
  - Enrollment fee payment is recorded in DEERS.

?	Six months after the family's first move, SrA Matthews is told he's being transferred to a 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 access to care 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 and authorization from a regional contractor.
- When overseas, Prime enrollees must contact the TOP contractor to get an authorization when seeking urgent or specialty care.
  - Prime enrollees must submit all claims for overseas care to the overseas claims processor, **not** the stateside claims processor where they're enrolled.
- When Prime enrollees receive care onboard commercial seagoing vessels outside U.S. territorial waters, they pay up front and then file a claim with the overseas claims processor.

6.2 TOP Prime Enrollees Seeking Care When Traveling Stateside

When traveling in the United States, TOP Prime enrollees have the same access to care 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 overseas 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 non-emergency care at MTFs whenever possible.
  - Non-emergency 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 referrals and authorizations if seeking care outside of their region.

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

7.1 Newborn Coverage

- Beneficiaries are encouraged to formally enroll their newborn in Prime as soon as possible so the child is assigned a PCM for appropriate and timely well-child care.
- By policy, TRICARE Prime covers a newborn for 60 days after birth, as long as another family member is already enrolled in a Prime option ("deemed Prime").
- After the initial 60 days, newborn claims process 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 Prime for 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 stateside or 120 days overseas as of the date of placement by the court or approved adoption agency, as long as another family member is enrolled in a Prime option.

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 based on 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.) ● Those eligible for TRICARE Young Adult (TYA) Prime. ● 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 can't remain enrolled in 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. ● 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.
- Beneficiaries may enroll in one of three ways:
  - Use the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe
  - Call the USFHP contractor
  - Print out a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) and mail it along with any enrollment fees to the appropriate US Family Health Plan
- Enrollment renews automatically each fiscal year, unless one of the following occurs:
  - Enrollee chooses to disenroll
  - Enrollee isn't eligible for USFHP or TRICARE benefits (i.e., lives outside the USFHP area, a sponsor separates or is deactivated, family members age out)

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.
  - 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 applicable copayments and POS costs.
- USFHP costs mirror TRICARE Prime.

8.6 USFHP Prescription Coverage

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

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 enrollee needs emergency care and the nearest emergency room is an MTF
  - When the enrollee needs services USFHP doesn't cover, such as routine hearing tests (if there is space available at the MTF)
  - When the enrollee has a referral and authorization to get care at an MTF, based on a memorandum of agreement between the MTF and USFHP.
- Medicare Part A or Part B (except for services USFHP doesn't routinely cover, 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.
- Prime enrollees may also transfer between a Prime option and USFHP as long as it's available in their area.
- If enrollees move to an area where USFHP is offered through a different USFHP 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 disenroll and are covered under TRICARE Standard or TFL, depending on their Medicare status.

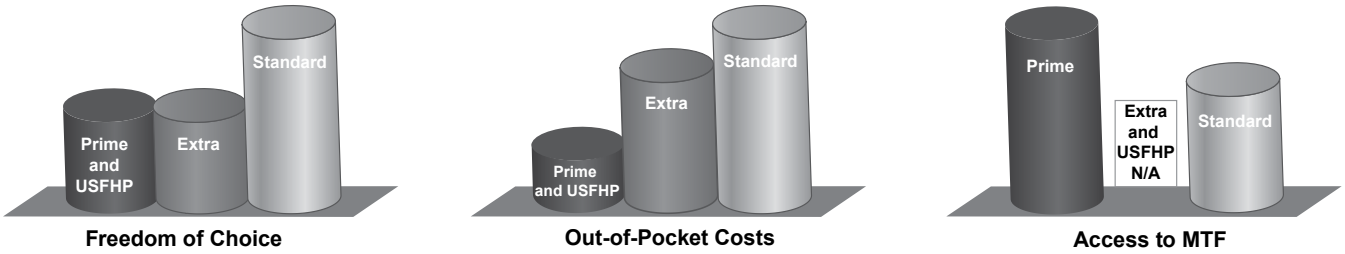
8.9 Accessing Medical Care While on Vacation

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 (stateside and overseas) should be sent to the address on the enrollee's USFHP enrollment card.

9.0 TRICARE Options Overview

- **TRICARE Standard** offers the freedom to seek care from any TRICARE-authorized provider.
  - No enrollment forms or fees
  - Available overseas (including U.S. territories) as TOP Standard
  - Deductibles and cost-shares apply
  - Beneficiaries may have to file claims
- **TRICARE Extra** allows a Standard beneficiary to receive a cost-share discount for using a TRICARE network provider.
  - No enrollment forms or fees
  - Not available overseas
  - Five percent cost-share discount
  - No claims to file (network provider files for beneficiary)
- **TRICARE Prime** is an option where care is coordinated through a primary care manager.
  - Enrollment required
  - Specialty care requires a PCM or regional call center referral and contractor authorization
  - Available overseas as TOP Prime
  - Fixed copayment for most services for other than ADSMs/ADFMs
  - No claims to file (network provider files for enrollees)
- **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
  - Enrollment required
  - Specialty care requires a PCM referral and USFHP authorization; have to use USFHP providers
  - Not available overseas
  - Costs mirror TRICARE Prime
  - No claims to file (USFHP provider files for enrollees)

9.1 Comparing TRICARE Options



- If freedom of choice is the most important factor to a beneficiary (other than an ADSM), he or she should choose TRICARE Standard
- If cost savings is the most important factor, TRICARE Prime or USFHP (if available) is the best option if living within a PSA. TRICARE Extra is next best due to the cost-share discount.
- If access to an MTF is the most important factor, TRICARE Prime is the best option. 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 these 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 getting care at an emergency care center or when admitted as an inpatient. Timely reporting of emergency care is needed for possible visits/transfer to another Canadian facility or to the United States.
- TOP Prime enrollees who are age 17 or younger and live in Ottawa should get emergency care from Children's Hospital of Eastern Ontario (if it's the nearest emergency facility).

Specialty Care in Canada

- To receive specialty care outside of the CFHF, ADSMs and their enrolled family members are to get Canadian Blue Cross Blue Shield (BCBS) insurance.
  - To do this, ADSMs and eligible family members must complete a BCBS registration form and get it to their TRICARE Overseas Program Point of Contact (TOP POC); the POC then faxes it to the to the Canadian BCBS Headquarters. The TOP POC is at the nearest U.S. embassy.
- Specialty care is referred by the CFHF to purchased care/host nation providers.
- 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

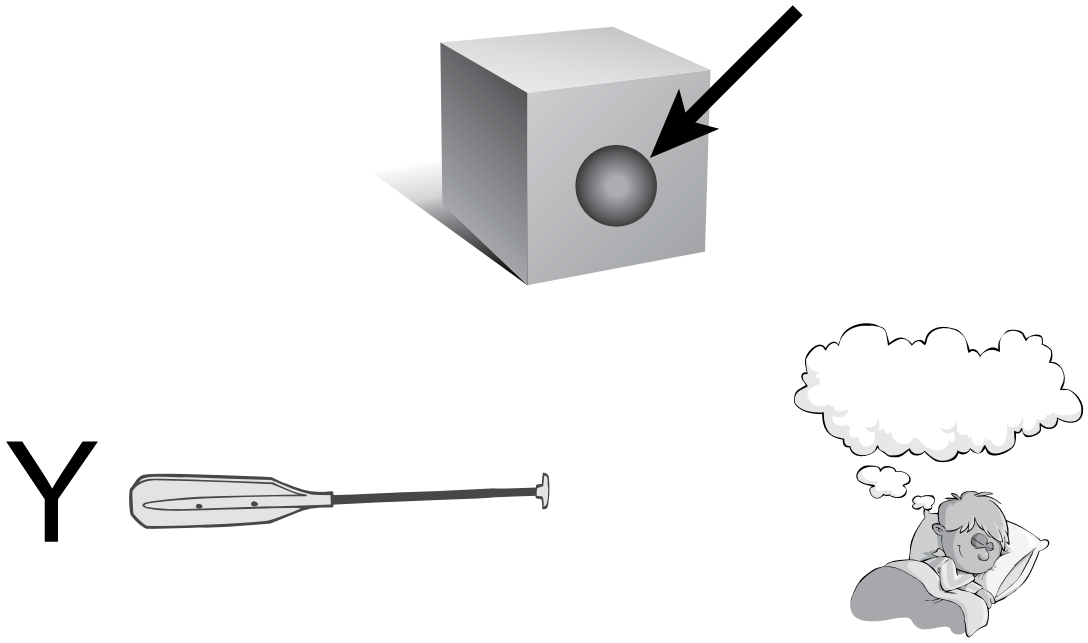
Participant Guide

References

10 USC
32 CFR § 199, 199.20
National Defense Authorization Act (NDAA)
2008 TRICARE Operations Manual, Chapter 16; Chapter 24: Sections 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 Defense Health Agency – Great Lakes (DHA-GL) (formerly known as MMSO) 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**
- **Defense Health Agency – Great Lakes (DHA-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 use a stateside network provider and get authorization from the regional or overseas contractor.
- Toll-free access to health care information, referrals, and authorizations
- Medical evacuation (overseas)

Sponsors must make sure their address, unit, and family member information is in the Defense Eligibility Enrollment Reporting System (DEERS) so they can 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]). TPR covers: care from civilian network or TRICARE-authorized providers; TRICARE-covered specialty services and urgent care that can't be provided by the member's PCM require referral and authorization.

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 live with their active duty sponsor in designated stateside TPR locations (there are some exceptions 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) can enroll in TOP Prime Remote.

Note: In this module, TPR, TPRADFM, and TOP Prime Remote are referred to as "Prime Remote" unless information only applies to one option.

2.0 Prime Remote Enrollment Eligibility

- ADSMs, Guard/Reserve members on active service for more than 30 consecutive days, eligible family members, and transitional survivors can enroll.
- The following can't enroll:
  - 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
- Eligible newborns and adoptees can be enrolled in TPRADFM/TOP Prime Remote. (See the *TRICARE Options* module for more information.)

Stateside (TPR/TPRADFM) Enrollment Eligibility
TPR ● To qualify for TPR, ADSMs and eligible Guard/Reserve members must be permanently assigned to **and** live more than 50 miles (based on ZIP code) or more than a one hour drive from an MTF. ○ To see if they qualify, direct ADSMs to the *TPR ZIP Code Look-up Tool* at www.tricare.mil/tpr. ● Most active duty members living within 50 miles of an MTF can't enroll in TPR. However, if conditions mean they have to drive more than one-hour to get to the MTF, they may ask to enroll and get a civilian network provider. ○ These ADSMs should complete a *TRICARE Prime Remote (TPR) Determination of Eligibility Enrollment Request Form* and submit it through their unit commander to the TRICARE Regional Office (TRO). For information and the form, direct service members to: ▪ North Region: www.tricare.mil/TPRFormNorth ▪ South Region: www.tricare.mil/TPRFormSouth ▪ West Region: www.tricare.mil/TPRFormWest
TPRADFM The following may enroll in TPRADFM: ● ADFMs, as long as: ○ The sponsor is enrolled in TPR ○ The ADFMs live/reside with the sponsor ("resides with" is defined as the address where the family lives while the sponsor is enrolled in TPR, as recorded in DEERS) ● Transitional survivors living in Prime Remote-designated locations ● Activated Guard/Reserve family members, as long as: ○ They lived with the Guard/Reserve sponsor when he or she was activated ○ The activated sponsor's address in DEERS was in a TPR ZIP code ○ The family members continue to live at that same address **Note:** These sponsors don't need to be enrolled in TPR for his/her family to enroll in TPRADFM.

Overseas (TOP Prime Remote) Enrollment Eligibility
The following may enroll: ● ADSMs with a permanent duty assignment at a designated remote overseas location ● Guard/Reserve members on active service for more than 30 consecutive days with a permanent duty assignment at a designated remote overseas location ● Command-sponsored ADFMs or Guard/Reserve family members whose sponsor is assigned overseas* ● ADFMs on service-funded orders to move to a remote overseas location without the sponsor ● Transitional survivors who live in TOP Prime Remote-designated locations ● Activated Guard/Reserve family members, as long as the family members lived with the sponsor in a TOP Prime Remote location when he or she was activated

* *Only ADFMs who meet the Joint Federal Travel Regulation (JFTR) definition of command sponsored, can enroll in TOP Prime (exceptions are 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. The nearest MTF is 45 miles away, but due to the terrain, it would take about an hour and a half to drive there. Can Corporal Williams and his wife enroll in TRICARE Prime Remote? If so, what do they need to do?

3.0 Enrollment

- When an ADSM or an activated Guard/Reserve member qualifies for TPR or TOP Prime Remote, he or she must enroll 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 is based on the sponsor's work unit location, not his or her home address.
- Enrollment is voluntary for ADFMs; they may enroll on an individual or family basis.
  - Those who 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 TPRADFM as long as they live at the same TPR address they lived at before the sponsor moved (as noted in DEERS).
- Guard/Reserve family members may remain TPRADFM at the same TPR address, no matter where the sponsor is assigned, enrolled, or temporarily living, as long as the sponsor is on active duty.

3.0.2 Ongoing Overseas Enrollment

- When a TOP Prime Remote 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 remain command sponsored.

Note: These family members remain TOP Prime Remote while the sponsor is on unaccompanied orders, but for no more than two years. (Most unaccompanied tours are less than 24 months.)

?	Corporal Williams' wife, Allison, isn't sure she wants to enroll in Prime Remote. Does she have other options?

3.1 Enrollment Processing

- Beneficiaries may enroll one of three ways:
  - Use the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe
    - Only available to those who live or want to enroll in a PSA
  - Call the regional contractor
  - Mail
    - Print out a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) and mail it to the regional contractor, along with the initial enrollment fee (if applicable).
- Coverage begins as follows:
  - TPR—the date the contractor receives the *DD Form 2876* or the member calls to enroll.
  - TPRADFM—the 20th-of-the-month rule. (See the *TRICARE Options* module for information on the 20th-of-the-month rule.)
  - TOP Prime Remote—the date the sponsor calls or TOP contractor receives the *DD Form 2876* and orders showing 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 TRICARE eligibility.
- Overseas, Points of Contact (POCs) assist ADSMs and their command-sponsored family members in TOP Prime Remote sites by accepting and forwarding enrollment forms and orders to the overseas contractor.

Note: If enrolling by phone, ADFMs confirm command sponsorship by giving the contractor their sponsor's order number and the date on the orders.

3.2 Lockouts and Disenrollment

- The same lockout and disenrollment rules for Prime-enrolled ADFMs apply to Prime Remote enrollees. (See the *TRICARE Options* module.)
  - ADSMs and family members are disenrolled from Prime Remote when the sponsor retires (since remote options are only available to ADSMs and ADFMs); they are TRICARE Standard/Extra if 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 within or between regions, and between Prime Remote and Prime. Enrollees must meet required enrollment criteria (e.g., live and work in a designated overseas remote area, 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.
- ADFM enrollment transfers are effective on the date requested, as long as the family's address in DEERS reflects the new location, and command sponsorship is confirmed (overseas).
- When moving or traveling, Prime Remote enrollees follow TRICARE Prime and TOP Prime rules. (See the *TRICARE Options* module on transferring TRICARE coverage when moving and 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. Otherwise, they may seek care from any TRICARE-authorized provider. (This provider is considered the enrollee's primary care provider.) ● 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 new enrollees.
Overseas (TOP Prime Remote)
● The overseas contractor's call centers serve as PCMs and coordinate 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 issues an authorization for covered services so the enrollee has a "cashless and claimless" experience. ○ "Cashless, claimless" means the TOP Prime Remote enrollee doesn't pay up front for TRICARE-covered services. The provider files the claim and the contractor pays the provider.

6.0 Defense Health Agency – Great Lakes (DHA-GL) (Stateside)

- DHA-GL (formerly known as the Military Medical Support Office [MMSO]) coordinates health care services for TPR-enrolled ADSMs with the Army, Navy, Marines, and Air Force. The Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration (NOAA) oversee their TPR enrollees.
- DHA-GL authorizes ADSM TPR enrollee's specialty care and acts as a liaison between remote ADSMs, the services, and regional contractors.
- DHA-GL reviews:
  - Referrals and medical claims to determine the ADSM's fitness-for-duty and if the member needs to go to an MTF
  - Certain deferred medical claims from regional contractors and approves or denies payment (e.g., claim sent in before DHA-GL authorized the care, the provider didn't seek prior authorization, etc.)
- DHA-GL questions may be directed to:
  - Defense Health Agency-GL
    Suite 304
    2834 Green Bay Road
    North Chicago, IL 60064-3091
  - 1-888-647-6676
  - www.health.mil/GreatLakes
  - 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 DHA-GL for help with TPR-enrolled service members' cases. (See the *2008 TRICARE Operations Manual, Chapter 16, Section 2, Paragraphs 5.2 and 5.3* for basic guidelines on the types of services that need DHA-GL fitness-for-duty review.)

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 illnesses and diseases, and follow-up care for an ongoing medical condition. Enrollees should be offered an appointment within seven days.

Stateside Routine Care (TPR/TPRADFM)
● TPR/TPRADFM enrollees should be offered an appointment with their assigned PCM or chosen primary care provider within seven days.
Overseas Routine Care (TOP Prime Remote)
● Routine care is usually received from 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.

7.2 Urgent Care

Urgent care is generally defined as medically necessary treatment for an illness or injury that won't result in disability or death if not treated immediately. Enrollees should be offered an appointment within 24 hours.

Stateside Urgent Care (TPR/TPRADFM)

● TPR enrollees should contact their PCM, civilian primary care provider, or regional contractor.
● If the PCM or primary care provider can't provide the care, the enrollee needs a referral from their PCM/ provider, otherwise claims may be denied (ADSMs) or processed as POS (ADFMs). The regional contractor authorization decision is based on medical necessity and benefit review.
  ○ The contractor forwards TPR-enrolled ADSMs' referrals to DHA-GL for fitness-for-duty review and an authorization determination. DHA-GL may require ADSMs to go to an MTF or may authorize care from a network or authorized provider.
  ○ Enrollees and PCMs should work directly with the regional contractor (network provider) or DHA-GL to get an authorization.

Overseas Urgent Care (TOP Prime Remote)
● Urgent care is coordinated through the overseas contractor's Regional or Country-specific Call Centers.

7.3 Specialty Care

Specialty care is generally defined as care a PCM isn't able to provide. Enrollees should be offered an appointment within 28 days.

- All Prime Remote enrollees must have a referral and prior authorization for specialty care. Stateside, the PCM or primary care provider sends the referral to the regional contractor. The regional contractor conducts a medical necessity and benefit review, coordinates with DHA-GL on ADSM referrals, and then issues an authorization or a denial. See the table below for information on overseas specialty care.
- Regional contractors notify enrollees of authorization determinations. If approved, the authorization lists the provider's name, the type and frequency of visits, and the end date for services. The contractor gives the specialty provider the same information.
- If a Prime Remote-enrolled ADFM self-refers for specialty care, POS charges apply. (See the *TRICARE Options* module for more on POS.)

Stateside Specialty Care (TPR/TPRADFM)
TPR ● The regional contractor directs specialty care and inpatient referrals for TPR-enrolled **ADSMs** to DHA-GL for fitness-for-duty and care authorizations. The contractor sends the authorization notice to the enrollee and the provider. **TPRADFM** ● Enrollees should confirm care is authorized before being seen to avoid POS charges or care denials.
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 sends authorization and payment to the purchased care/host nation provider. ● 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 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 setting. 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 regional contractor as soon as possible after being seen. The member's provider or the member needs to get a referral to the regional contractor. DHA-GL reviews the referral and makes an authorization determination. Follow-up care goes 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 referrals and authorizations for the emergency care and follow-up specialty care.
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 ongoing care can be coordinated and authorized. ○ Enrollees give the emergency care setting's contact information and/or a copy of the bill to the contractor. ● 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 selected 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 with return travel after medical evacuation or hospital discharge.
  - TRICARE Area Offices (TAOs) develop and deliver area-specific POC Program booklets outlining POC duties and responsibilities. The TAO offices also conduct area-specific POC training.
    - POCs should reach out to TAO staff for help.
    - See Appendix C for contact information.

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

9.1 When Care Isn't Available in the TOP Prime Remote Area

- When needed medical care (including diagnostic services) isn't available in an overseas remote location, the overseas contractor contacts the TAO to arrange for medical care (travel and appointments) at the nearest MTF or purchased care/host nation medical facility. Part of this process involves determining medical necessity. Facility choice is based on the availability of care and travel, as well as per diem costs.
  - ADSMs put on medical Temporary Additional Duty/Temporary Duty (TAD/TDY) should work with their POC to get care and command or service-level funding for travel, per diem, and other 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 new referrals/authorizations. Multiple visits may be authorized based on the 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:
  - TOP Prime Remote enrollees
  - ADSMs who are deployed, TAD/TDY, or in an authorized leave status overseas
  - Stateside Prime-enrolled ADSMs and ADFMs traveling outside of the United States.
- The TOP contractor:
  - Determines medical necessity
  - Identifies the most appropriate method of evacuation
  - Schedules the evacuation
  - Authorizes necessary care
  - Arranges transfer of medical records
  - Coordinates 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 must review their travel orders and itinerary before traveling.
  - Enrollees are told that any change from the approved itinerary won't be paid for.
- POCs should give enrollees the number of the travel order-issuing authority. Enrollees may then contact the travel authority if the approved itinerary doesn't provide enough travel time in either direction.
- POCs should tell enrollees that commercial travel is only covered as noted in the fund site memorandum; commercial travel to other than the TAD/TDY location won't be covered.

9.2.3 Aeromedical Evacuations and Fund Sites

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

- 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 don't 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 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 in the United States, payment is based on the provider's address.
    - If the provider isn't licensed to practice in the United States, payment follows the same rules as other purchased care/host nation provider claims.
    - See the *Claims* module for more information.

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 on ADSM physicals is described below. TRICARE coverage information can be found at www.tricare.mil/CoveredServices 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 prior-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

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

10.5 Sports and Other Physical Exclusions

- TRICARE doesn't cover sports physicals (they're not considered 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 that has maternity care, the enrollee should receive care at the MTF.
- If the enrollee isn't near an MTF or care is unavailable, the enrollee's PCM refers 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 Remote ADFMs may also use the point-of-service option to self-refer for maternity care; 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, which lets them stay on or near a military hospital or clinic with 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, 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.
  - Special policies 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 area or region.

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 where they are during his deployment.

Given what you've 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 Defense Health Agency – Great Lakes (DHA-GL) (formerly known as MMSO) 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**
- **Defense Health Agency – Great Lakes (DHA-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: 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 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 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): 1-877-777-8343 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

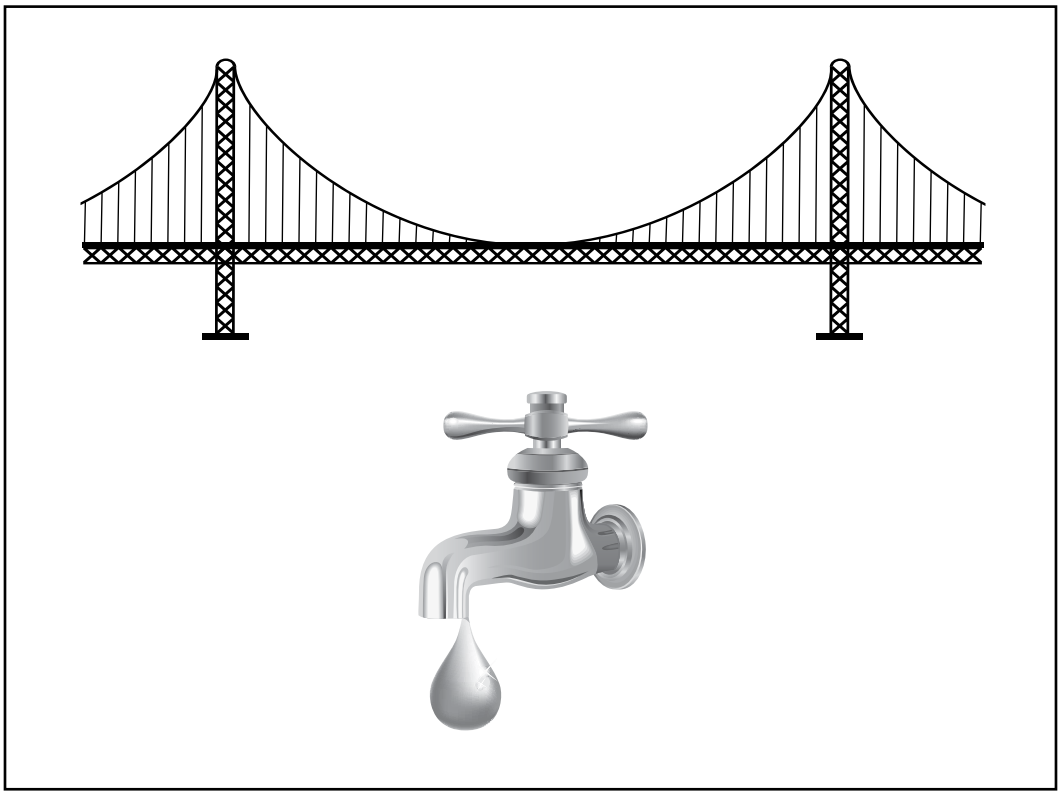
Participant Guide

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)**

Key Terms

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

?	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

TRICARE helps certain active duty service members (ADSMs), eligible National Guard or Reserve members, eligible family members, and others losing TRICARE eligibility by continuing to offer TRICARE benefits.

Military retirees remain TRICARE eligible. Certain other individuals 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 separating from active duty after being involuntarily retained (stop-loss) in support of a contingency operation
- A member involuntarily separated from active duty under honorable conditions
- A member 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: Involuntarily separated or service members who believe they may be TAMP eligible 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/re-enrollment required)
  - TRICARE Overseas Program (TOP) Standard
  - TOP Prime (enrollment/re-enrollment required)
  - US Family Health Plan (USFHP) (enrollment/re-enrollment required)
- 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 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 or re-enroll in TRICARE Prime, TOP Prime, or USFHP after the sponsor separates.

Stateside	Overseas
● TAMP eligibles enrolled in TRICARE Prime or USFHP before the sponsor's separation may reenroll without a break in coverage as long as they request enrollment before the TAMP period ends (can't re-enroll in TPR or TPRADFM). ● Those eligible may submit enrollment requests to the regional contractor in one of three ways: ○ Phone ○ Mail ▪ *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) ○ BWE if living in a PSA. ● The enrollment effective date is the date the eligible sponsor separated from active duty. ● TAMP eligibles who weren't enrolled in a Prime option 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 *Definitions* module.)	● TAMP eligibles enrolled in TOP Prime before the sponsor's separation may reenroll 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 by submitting a new enrollment request. ● Those eligible may submit requests to the overseas contractor in one of two ways: ○ Phone ○ Mail ▪ Must submit a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876). ○ Coverage begins when the completed enrollment request and copy of command sponsorship orders for family members is received. ● 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 applies to family members who want to remain enrolled in TRICARE Prime, TOP Prime, or USFHP:
  - If enrolled in TRICARE Prime or TOP Prime when their sponsor is reactivated, TAMP-eligible family members may continue their enrollment with no break in coverage if they submit a new enrollment within 30 days of their sponsor's return to active service.
  - If they don't submit a new enrollment within 30 days, they become TRICARE Standard or TOP Standard. If they enroll later, the "20th-of-the-month" rule applies and they have break in Prime coverage.

?	Before Sergeant McDonald separated from active duty, he and his family were TRICARE Prime and would like to continue their enrollment. Can they enroll in Prime under TAMP? If so, how can they avoid a break in coverage?

2.3 Dental Coverage During TAMP

- During TAMP, former ADSMs may receive dental care at uniformed service dental treatment facilities (DTFs) on a space-available basis.
  - Once a member separates, his or her family members aren't eligible for the TRICARE Dental Program (TDP) (unless the sponsor goes into the Guard/Reserve and qualifies to purchase TDP). They should receive a letter showing TDP ended when the sponsor separated.
- 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 during TAMP.
  - They may receive space-available care at a 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 under 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. Under TAMP, all claims, to include former member's, process as active duty family member claims; active duty family member deductibles, copayments, 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 extends transitional health care coverage to certain former service members with certain service-related conditions.

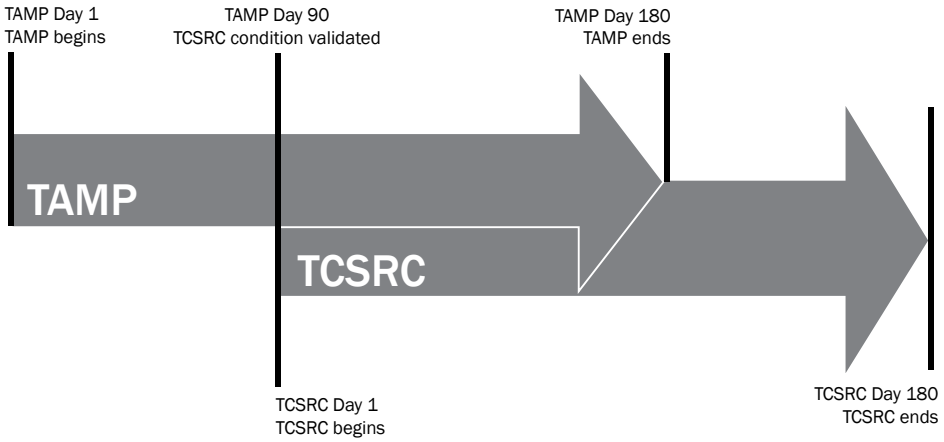
3.1 Eligibility

- Eligibility is limited to TAMP-eligible former service members with a “newly diagnosed” or “newly discovered” medical condition.
  - Family members aren’t eligible for TCSRC.
- The medical condition has to meet the following criteria:
  - Must be service-related
  - Must be diagnosed by the member’s provider during the TAMP period and validated by a DoD physician
  - Must require treatment and be able to be resolved within 180 days of the validation date
- These members may receive extended transitional care for that condition and that condition only.
- TAMP-eligible former service 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. Tell the former member he or she has to request and send supporting documents to DHA-Great Lakes to be considered for the benefit.

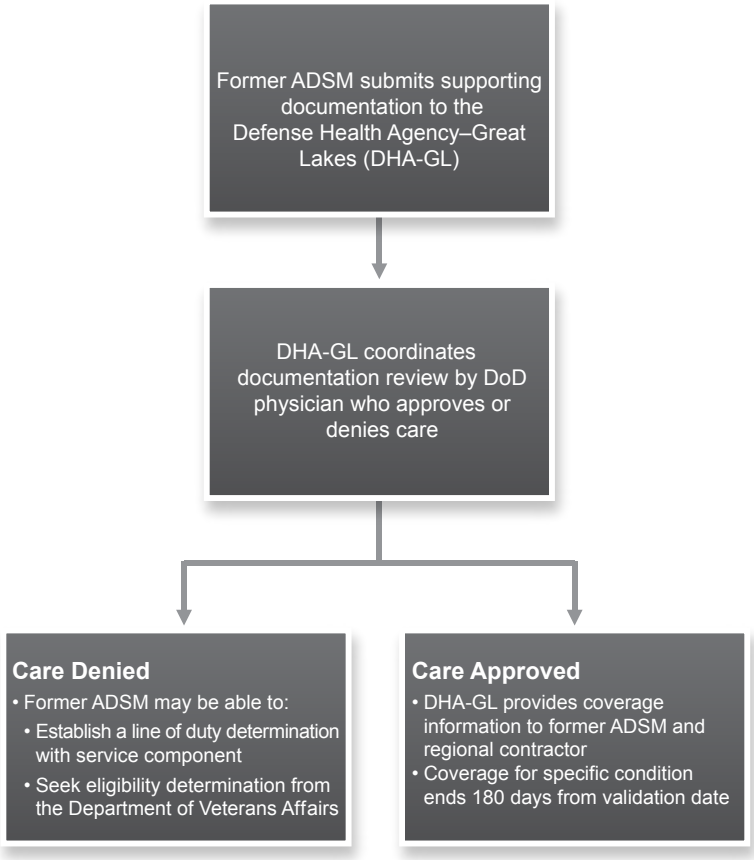
Note: If a former ADSM has a service-related condition that can’t be resolved within the 180 days and so can’t be approved for the TCSRC benefit, he or she may be eligible to receive care for this condition through the Department of Veteran’s Affairs (VA). The VA determines eligibility for VA benefits. 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 ends 180 days from the DoD physician’s validation date.



3.3 TCSRC Process



?	A month into Sergeant McDonald's TAMP period, 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 service-related. Is Sergeant McDonald eligible for the TCSRC benefit? Will DHA-GL accept the diagnosis by Sergeant McDonald's family physician?

4.0 Continued Health Care Benefit Program (CHCBP)

The Continued Health Care Benefit Program (CHCBP) is a premium-based program offering 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 enrollees aren't eligible to use MTF pharmacies.
- Health care is limited to TRICARE-covered services.
- All CHCBP questions, regardless of region, should go 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
- Payment in full for the first 90 days of coverage
- Required documentation as noted on the enrollment form, to include copies of:
  - *Certificate of Release or Discharge from Active Duty* (DD Form 214)
  - Final divorce decree, if applicable

?	Following the end of Sergeant McDonald's TAMP coverage, he and his wife enroll in CHCBP. How is this coverage different from 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 claims 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:

  CHCBP Claims
  PGBA
  P.O. Box 7031
  Camden, SC 29021-7031

- 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.

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)**

Key Terms

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

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
Defense Health Agency Great Lakes 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 Program**
- **Identify who is eligible for pharmacy benefits**
- **Compare the pharmacy options**
- **List pharmacy costs**

Key Terms

- **TRICARE Formulary**
- **Basic Core Formulary**
- **Home Delivery**
- **Network Pharmacy**
- **Non-network Pharmacy**

1.0 Pharmacy Benefits

- The TRICARE Pharmacy Program covers most prescription drugs approved for marketing by the U.S. Food and Drug Administration (FDA).
- All prescriptions must be written by health care providers who are licensed in the U.S. or U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).
- The TRICARE Pharmacy Program offers four options to fill prescriptions:
  - Military pharmacies
  - Home Delivery (including specialty drugs)
    - Overseas restrictions apply (See Section 5.1 of this module for details.)
  - TRICARE network pharmacies (U.S. and U.S. territories)
  - Non-network pharmacies
    - Overseas pharmacies are non-network pharmacies. Beneficiaries are responsible for the total cost of the drug up front and must file a claim with the overseas contractor for reimbursement.
- As of October 1, 2015, all beneficiaries except active duty service members (ADSMs), beneficiaries living overseas, and beneficiaries who have other health insurance with a prescription benefit have to fill some maintenance drugs through Home Delivery or a military pharmacy (if available).
  - Maintenance drugs are those taken regularly for a chronic condition (i.e., high blood pressure, high cholesterol). Beneficiaries can call Express Scripts to find out if their maintenance drug is affected, or check the TRICARE Formulary at https://www.express-scripts.com/static/formularySearch/2.0.4/#/formularySearch/drugSearch

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

2.0 TRICARE Formulary

2.1 TRICARE Formulary and Basic Core Formulary

- The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee decides which drugs are covered, when they're covered, if there are specific rules for some drugs, and adds drugs to one of the three tiers:
  - Tier 1: Generic Formulary
  - Tier 2: Brand-Name Formulary
  - Tier 3: Non-Formulary
- The DoD P&T Committee also makes recommendations for the Basic Core Formulary. The Basic Core Formulary is a list of drugs full-service military pharmacies must carry.

2.2 TRICARE Formulary Search Tool

- The TRICARE Formulary Search Tool can be found at: https://www.express-scripts.com/static/formularySearch/2.0/#/formularySearch/drugSearch.
- Beneficiaries and providers can use the Search Tool to:
  - See what drugs are on the Basic Core Formulary
  - Find out if a drug is covered by TRICARE
  - Find drug cost information, including injectables
  - Learn about generic substitutes of brand-name drugs, quantity limits, and prior-authorization requirements
  - View and print prior-authorization and medical-necessity forms

2.2.1 Generic Drug Policy

- Generic drugs are just as strong, pure, safe, and reliable as brand-name drugs. The FDA requires all generic drugs pass strict testing to prove they act the same.
- Beneficiaries who get a prescription for a brand-name drug may get a generic substitute unless:
  - There isn't a generic. Beneficiaries then pay the brand-name copay.
  - Their provider submits and Express Scripts approves a prior authorization request. Beneficiaries then pay the brand-name copay.
    - If Express Scripts doesn't approve the request, beneficiaries then pay the full cost of the drug.

2.2.2 TRICARE Formulary and Medical Necessity

- The DoD P&T Committee determines medical necessity criteria for non-formulary drugs.
- Beneficiaries, to include ADSMs, may get non-formulary drugs at the formulary/brand name copay from a TRICARE network pharmacy or Home Delivery if they meet medical necessity criteria.
- Their providers must complete the medical necessity form for the non-formulary drug, which can be found at https://www.express-scripts.com/static/formularySearch/2.0/#/formularySearch/drugSearch.

2.2.3 Prior Authorization and Quantity Limits

- The TRICARE Pharmacy Program requires beneficiaries to get prior authorization for drugs that:
  - Have dangerous side effects or can be harmful when combined with other drugs
  - Should only be used for certain health conditions
  - Are often misused or abused
  - Have age limits
  - Are prescribed for more than the normal limit
- Some prescription drugs have quantity limits to make sure they're used safely, meaning beneficiaries can only get a limited amount each time they fill their prescription.
- Beneficiaries can use the TRICARE Formulary Search Tool to look up quantity limits for their prescription drug.
- Exceptions may be made if their provider submits a prior authorization request and Express Scripts approves it.

Note: MTFs or TRICARE may identify a beneficiary as showing "drug-seeking behavior" and choose to limit how and where he or she gets prescriptions filled. The provider, nurse case manager, and pharmacy contractor work together on these types of cases.

?	TSgt Clarkson is an ADSM. Her doctor gave her a prescription for a brand-name FDA-approved drug to treat high cholesterol. Can TSgt Clarkson get the brand-name drug? What determines if she gets a brand-name or generic version?

3.0 Eligibility

The TRICARE Pharmacy Program is available to:

- Active duty service members (ADSMs) and active duty family members (ADFMs)
- Activated National Guard and Reserve Members and families
- Retired service members and their families
- Survivors, widows, widowers, and certain former spouses
- Medal of Honor recipients and their families

- 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 must be registered in the Defense Enrollment Eligibility Reporting System (DEERS).

?	After being on the cholesterol drug for six months, TSgt Clarkson gets married. Her spouse is TRICARE-eligible as an active duty family member. He needs a monthly maintenance drug. When is he eligible for TRICARE pharmacy benefits?

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

- Parents and parents-in-law who meet their sponsor's Service criteria to become dependents and their sponsor is on active duty for more than 30 days may fill their prescriptions at a military pharmacy.
- Dependent parents and parents-in-law who have Medicare Part A because of age and have Part B, may get prescriptions at TRICARE network pharmacies or through Home Delivery.

Note: Dependent parents and parents-in-law who turned 65 before April 1, 2001, don't need to have Part B.

4.0 Military Pharmacies

- Each military pharmacy has to stock medications listed on the Basic Core Formulary.
  - Non-formulary drugs generally aren't available at military pharmacies. Based on the level and type of care the military hospital or clinic provides and the beneficiary population it serves, a military pharmacy may add certain drugs to its local formulary.
- Beneficiaries can get up to a 90-day supply. There may be exceptions for controlled substances (prescription drugs identified by the Drug Enforcement Agency (DEA) as having potential for abuse) and narcotics.
- Military pharmacies can fill prescriptions written by licensed civilian providers.
- $0 copay.
- Local civilian providers may electronically send prescriptions to military pharmacies.
- CHCBP beneficiaries **can't** get prescriptions filled at military pharmacies. They must use Home Delivery, network, or non-network pharmacies.
- US Family Health Plan (USFHP) enrollees must use USFHP network pharmacies.

?	TSgt Clarkson and her husband live in a Prime Service Area, 10 miles from a military pharmacy. Recently, TSgt Clarkson's was authorized to see a civilian provider, who gave her a new prescription. Can the military pharmacy fill this prescription? How much does TSgt Clarkson pay out of pocket at the military pharmacy for her prescription?

5.0 Home Delivery

- The Home Delivery option is a cost-effective and convenient way for beneficiaries to get medications they take on a regular basis.
- Beneficiaries can also get specialty drugs filled through Home Delivery if the drug is on the TRICARE Formulary.
  - Specialty drugs are self administered, high-cost, oral, or injectable drugs that treat serious chronic conditions.
- A 90-day supply and 3 refills are available for most drugs.
  - Some drugs, such as controlled substances, may have a 30-day or other limit based on federal law or TRICARE quantity limits.

5.1 Home Delivery—Overseas

- There are unique restrictions for Home Delivery overseas (not including U.S. territories); prescription drugs are subject to local customs and policies.
  - Outside of the U.S. and U.S. territories, Home Delivery is only available to beneficiaries with Army Post Office (APO), Fleet Post Office (FPO), or Diplomatic Post Office (DPO) addresses.
  - Home Delivery isn't available in Germany (even to APO/FPO/DPO addresses) because German law doesn't allow the shipment of prescription drugs through the postal service.
  - Refrigerated drugs can't be shipped to APO/FPO/DPO addresses.
  - Prescriptions must be written by U.S.-licensed providers.
- Overseas 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.
- Deployed service members may get prescription drugs mailed overseas through the Overseas Deployment Prescription Program. (See Appendix A of this module for more information.)

5.2 Creating an Online 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 3 ways:
  - 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
- Registered users have online access to account and general prescription drug information.

5.3 Using Home Delivery

- There are 3 ways to fill new prescriptions via Home Delivery.
  - Electronically - Sent by the beneficiary's provider to the pharmacy contractor.
  - Fax - Sent by the beneficiary's provider (with a fax cover sheet) to the pharmacy contractor.
  - Mail - Sent by the beneficiary to the pharmacy contractor.
    - Beneficiaries must fill out the New Patient Order Form and the following information must be on each written prescription
      - Patients's full name
      - Date of birth
      - Address
      - 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
    - Beneficiaries mail the completed form, written prescription(s), and copayment(s) to the pharmacy contractor.

- Payment can be by credit card, check, or money order.
- Once the prescription processes (usually 10-14 days), the contractor send the drugs to the beneficiary.
- The contractor recommends beneficiaries have a 30-day supply on hand while they set up their Home Delivery account.

Note: Beneficiaries must send prescriptions for controlled substances by mail.

5.3.1 Refills

- Refills are based on the refill date on the drug label. There are 4 ways to order prescription refills via Home Delivery:
  - Online—through the pharmacy contractor's website.
  - Express Scripts Mobile App—Beneficiaries must download the "Express Scripts" Mobile App from their device's app store.
  - Phone—Beneficiaries must have their sponsor's ID number, their prescription, and credit card ready.
  - Mail—Beneficiaries fill out the Prescription Refill form included with their first prescription.
    - Beneficiaries mail the completed form and copayment to the pharmacy contractor.
- If beneficiaries already have a credit card on file, the pharmacy contractor bills the card automatically.
- Beneficiaries can also set up worry-free auto-refills.
- Beneficiaries can switch their retail or military pharmacy prescriptions to Home Delivery by going online or by contacting the pharmacy contractor.

6.0 Network Pharmacy

6.1 Network Pharmacy

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

6.2 Using Network Pharmacies

- Beneficiaries must show their uniformed services ID card and written prescription.
  - Licensed providers may e-prescribe, fax, or phone-in prescriptions, depending on pharmacy laws for that state or territory.
- Beneficiaries can find network pharmacies by using the Pharmacy Locator at www.express-scripts.com/TRICARE or by calling 1-877-363-1303.

7.0 Non-network Pharmacy

- A non-network pharmacy doesn't agree to be part of the TRICARE pharmacy network.
- TRICARE Prime enrollees who use a non-network pharmacy will pay 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 pharmacy, beneficiaries, including ADSMs, pay the total cost up front and file claims for reimbursement (minus their cost-shares, deductibles, or copays).

7.1 TRICARE Pharmacy Services in the Philippines

- TRICARE beneficiaries living or traveling in the Philippines must get prescription drugs from either a TRICARE-certified licensed retail pharmacy or TRICARE-certified hospital-based pharmacy.
- TRICARE won't reimburse beneficiaries for drugs purchased in a Philippine provider's office.
- Beneficiaries can get help finding a TRICARE-certified licensed retail pharmacy by:
  - Calling the TRICARE Overseas Program Singapore Regional Call Center at +65-6339-2676 (overseas) or 1-877-678-1208 (stateside).
  - Searching the Philippine Approved/Certified Provider Search tool at http://tricare-overseas.com/ProviderSearch/Beneficiary_PhilippineDemonstration_ProvSearch.aspx

8.0 Pharmacy Program Cost Overview

8.1 U.S. and U.S. Territories

- By law, annual changes in pharmacy copays are based on retiree cost-of-living adjustments (COLAs) or congressional direction. Costs may change at the start of each calendar year. Current costs are:

	Formulary Drug		Non-formulary Drug
	Generic	Brand Name	
Military Pharmacy (up to a 90-day supply)	$0	$0	Not Applicable (generally not available at MTFs)
Home Delivery* (up to a 90-day supply)	$0	$20	$49
Network Pharmacy* (up to a 30-day supply)	$10	$24	$50
Non-network 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: $20 or 20% of the total cost, whichever is more, 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: $47 or 20% of the total cost, whichever is greater, after annual outpatient deductible is met

* *ADSMs don't pay anything for their prescription drugs. They are reimbursed 100% of the cost even if they use a non-network pharmacy.*

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

8.2 Overseas

- Overseas beneficiaries getting prescriptions via Home Delivery pay the same copays as stateside beneficiaries.
- Beneficiaries filling prescriptions at overseas 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.
  - TOP Standard or TRR members 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 from a military pharmacy to get her prescriptions filled there. She knows she has other options, and is trying to decide if she should sign up for Home Delivery or use her local network 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

- The pharmacy benefit doesn't change under TRICARE For Life (TFL).
- Medicare's prescription drug coverage is known as Medicare Part D. It 's only available in the U.S. and U.S. territories.
  - Medicare-TRICARE eligible beneficiaries don't have to sign up for Medicare Part D to keep their TRICARE benefits. TRICARE is creditable coverage (i.e., equal to Medicare Part D basic coverage) for Medicare purposes.
  - For most TFL beneficiaries, there is almost no advantage to signing up for Medicare Part D.
  - If a TFL beneficiary shows in DEERS as having Medicare Part D but doesn't, the beneficiary should contact the DEERS Support Office to get his or her record corrected.
    - Phone: 1-800-538-9552 (worldwide) or 1-866-363-2883 (TTY/TDD)
    - In person: To find a DEERS Support Office, visit www.dmdc.osd.mil/rsl
- TFL beneficiaries who live overseas (other than U.S. territories) should contact the overseas contractor with pharmacy-related questions. Overseas contact information is available in Appendix B.

10.0 Other Health Insurance (OHI) with Pharmacy Benefits

- For beneficiaries who have OHI with pharmacy benefits and TRICARE pharmacy coverage; federal law requires the OHI to be primary payer. TRICARE is secondary.
- Beneficiaries with OHI pharmacy benefits can't use **Home Delivery**, unless:
  - The drug isn't covered by the OHI; or
  - The beneficiary met the OHI's benefit cap for the current year.
- Beneficiaries must show both their OHI and uniformed services ID cards at retail pharmacies.
- Beneficiaries in the U.S. and U.S. territories who have 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 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 pharmacy.
  - The beneficiary shows OHI card and uniformed services ID card.
  - The pharmacy submits the claim online to both plans: OHI first, TRICARE second.

Note: Medicaid, TRICARE supplements, and Indian Health Services plans aren't considered OHI. In these cases, TRICARE processes claims first.

11.0 Pharmacy Claims

- Beneficiaries need to file a claim for reimbursement if they:
  - Get their prescription filled at a non-network pharmacy
  - Have OHI with pharmacy benefits
- Beneficiaries must fill out a TRICARE DoD/CHAMPUS Medical Claim-Patient's Request for Medical Payment (DD Form 2642), available at www.tricare.mil/forms
- 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 U.S. and U.S. territories must be filed no later than 1 year from the date of service.
  - Overseas locations (other than U.S. territories) must be filed no later than 3 years from the date of service.
- Claims filing addresses are in Appendix B or at www.tricare.mil/Resources/Claims/PharmacyClaims.aspx.
  - Regional contractors process claims for medications dispensed in a provider's office, by a home health care agency, or specialty pharmacy (not the pharmacy contractor).
- TRICARE will reimburse for prescriptions filled at U.S. Embassy clinics. The beneficiary pays out-of-pocket and then files a claim.

Note: Guard/Reserve members with an approved Line of Duty or Notice of Eligibility (LOD/NOE) condition always pay out of pocket for prescription drugs. They then 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 on LOD/NOE claims.

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 of the decision.
- Beneficiaries must include a copy of the claim decision and must state what they disagree with.
- If beneficiaries need to send additional documentation to support their appeal but can't do it within the 90-day time frame, they can indicate in their initial appeal package that they will be sending additional documentation later.
- U.S. and U.S. territories appeals should be sent to:

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

- Overseas appeals should be sent to the overseas claims processor. See the *Appeals* module for overseas appeals filing addresses.

Module Objectives

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

Key Terms

- **TRICARE Formulary**
- **Basic Core Formulary**
- **Home Delivery**
- **Network Pharmacy**
- **Non-network Pharmacy**

Appendix A: Home Delivery and the Deployment Prescription Program

- Beneficiaries can fill prescriptions through the Deployment Prescription Program if they are:
  - A deployed service member
  - Working as a deployed contractor or civil service employee and they're eligible for TRICARE.
  - Getting health care through the Transitional Assistance Management Program (TAMP)
- Before they deploy, they must:
  - Register for a Home Delivery account
  - Register for the Deployment Prescription Program (done at the pre-deployment site)
    - The pre-deployment site sends the Deployment Prescription Program Registration Form with the prescription to the pharmacy contractor.
  - Get a 180-day supply of their prescription from their pre-deployment pharmacy (usually the pharmacy at their military hospital or clinic).
    - Only requested drugs will be filled
- Drugs aren't automatically sent. The pharmacy contractor sends an e-mail to deployed beneficiaries 2 months into deployment asking them to update their online registration with their current mailing address (APO/FPO).
  - Beneficiaries who don't get an e-mail 2 months after deploying should contact the Deployment Prescription Program Team
    - Phone: Toll Free 855-215-4488 or Direct: 314-684-7506
    - E-mail: DeployedPrescriptionProgram@express-scripts.com
- The pharmacy contractor sends another e-mail to deployed beneficiaries 4 months into deployment reminding them to order their drug.
  - Beneficiaries should then log in to their Home Delivery account. The pharmacy contractor will send the prescription to the address provided when ordering the medication.
  - Average shipping time to an address in theater is approx. 3-4 weeks.
- Beneficiaries should keep their e-mail and mailing address information current. Prescription drugs will be mailed to the address on file.
- Deployed beneficiaries with questions about the Deployment Prescription Program can contact the Deployment Prescription Program Team by:
  - Phone: Toll Free 855-215-4488 or Direct 314-684-7506
  - E-mail: DeployedPrescriptionProgram@express-scripts.com
  - Mail:

    Express Scripts, Inc.
    P.O. Box 60903
    Phoenix, AZ 85082-0903
- More information on the Deployment Prescription Program is available at www.tricare.mil/dpp

Appendix B: Pharmacy Contact Information

Pharmacy Contact Information	
General Correspondence in the U.S. and U.S. Territories	**Phone:** 1-877-363-1303 **Online:** www.express-scripts.com/tricare **Mail:** Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072
Overseas	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 **All other overseas areas**: 1-866-ASK-4PEC/1-866-275-4732
Pharmacy Operations Division	**Phone:** 1-210-295-1271 (DSN: 421-1271) **Online:** www.health.mil/pod
TDD (Toll free)	1-877-540-6261
E-mail	DOD.customer.relations@express-scripts.com

Pharmacy Claims Filing and Contact Information: U.S. and U.S. Territories
Express Scripts, Inc. P.O. Box 52132 Phoenix, AZ 85082 1-877-363-1303 www.express-scripts.com/TRICARE

Pharmacy Claims Filing and Contact Information: Overseas Areas, Excluding U.S. Territories	
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
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
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
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
mybenefits.metlife.com/tricare
www.tricare.mil

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 TRICARE determines premiums 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

Dental coverage is separate from TRICARE's medical coverage. TRICARE covers dental care through:

- 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) get dental care at uniformed service dental treatment facilities (DTFs). ADSMs must get prior-authorization before getting care from a civilian or overseas dentist if:
  - The DTF can't provide the needed care
  - Members are assigned to, on temporary duty, or traveling in remote locations stateside or overseas
- Active duty service members who need to get dental care from a civilian dentist use the Active Duty Dental Program (ADDP)
  - The ADDP service area includes the U.S. and U.S. territories
- All other overseas locations
  - Some non-remote overseas locations have DTFs; these 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 handles all dental care in overseas areas for ADSMs.

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

2.1 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 get delayed-effective-date active duty orders
- Certain members under the Transitional Assistance Management Program (TAMP)
- Guard/Reserve members who had a dental illness or injury while on active duty status are only eligible for DTF or civilian dental care with a valid LOD/NOE determination by their service.

Note: Commissioned Corps officers of the Public Health Service are covered by the Public Health Service Active Duty Dental Program (PHS ADDP). More information is available at http://phsaddp.com/

2.2 Active Duty Dental Program (ADDP)

The ADDP covers civilian dental care when eligible service members:

- Get a referral to a civilian dentist from a DTF (known as DTF-referred care). (See Section 2.2.2 for more information.)
- Live and work more than 50 miles from a DTF. (See Section 2.3 for more information.)

2.2.1 Dentists

- ADSMs must use a network dentist
  - If one isn't available, the ADSM or the DTF must contact the ADDP contractor for an authorization to use a non-network dentist. If he or she doesn't, the ADSM may have to pay for all services received.
- For a list of network dentists:
  - Visit www.addp-ucci.com
  - Call 1-866-984-2337
  - E-mail: addpdcf@ucci.com

2.2.2 ADDP Dental Treatment Facility (DTF)-Referred Care (U.S. and U.S. Territories)

DTF-referred care is for ADSMs who live and work within 50 miles from a DTF. When the DTF can't provide the care, the DTF will work with the ADDP contractor to allow the ADSM to get care from a civilian dentist.

The DTF prints the Referral Request Confirmation page which shows the appointment control number (ACN) and the authorized services. The DTF may make the appointment for the ADSM. If not, the ADSM may:

- Make his or her own appointment with an ADDP network dentist. The ADSM is responsible for payment of care if he or she chooses to use a non-network dentist without prior approval.
  - A list of network dentists is available at www.addp-ucci.com
- Contact the ADDP contractor to schedule an appointment. An appointment for:
  - Routine dental care must be available within 21 calendar days of the request
  - Specialty dental care must be available within 28 calendar days of the request
- The ADSM must give the dentist the ACN listed on his or her referral and take a copy of the referral to the appointment.
- The ADSM may only get the services listed on the Referral Request Confirmation.
- If the civilian dentist decides the ADSM needs other services not listed on the referral, the dentist must contact the DTF to discuss and get approval.
- If the ADSM chooses to get services that aren't on the referral, he or she will be responsible for all costs associated with that care.

2.2.3 Cancelled and Missed Appointments

- If an ADSM can't keep an appointment, the ADSM should cancel or reschedule it with the civilian dentist at least 24 hours before the scheduled visit.
- If the ADSM gets a bill for a missed appointment, he or she should contact the ADDP contractor.

2.2.4 Dental Emergencies

- All non-remote ADSMs must follow the emergency dental care policies and procedures of their DTF. Non-remote ADSMs who are traveling (leave, duty-related) and aren't within 50 miles of a DTF may get emergency care from any civilian dentist, including non-network. (See Section 2.4.1 for authorization information.)
  - Non-remote ADSMs should use an ADDP network dentist for emergency dental care whenever possible because the ADDP contractor may not authorize them to use a non-network dentist for follow-up care.

2.3 Remote Active Duty Dental Program

- Remote dental care is available through the Active Duty Dental Program if the service member:
  - Lives and works more than 50 miles from a DTF in the U.S.
  - Lives and works in a U.S. territory (Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, the Northern Mariana Islands)
  - Is covered by the Transitional Assistance Management Program (TAMP) following activation of more than 30 days for a contingency operation
  - Was activated early on delayed-effective-date orders for more than 30 days in support of a contingency operation
  - Is a wounded warrior
  - Is a foreign military member
  - Has an approved line of duty dental determination (subject to mileage requirements noted in the first bullet)

Note: NOAA members are automatically covered by the remote ADDP, regardless of location.

- ADSMs in remote locations must have civilian dentists complete and submit an authorization request form:
  - If the dental care is more than $750 per procedure or appointment
  - If the total cost of a treatment plan is more than $1500 when completed within one year
  - For specialty care (e.g., crowns, bridges, dentures, periodontal treatment)
  - For dental care from a non-network dentist
- **ADSMs must make sure care is authorized before getting services**, otherwise they may be responsible for payment.
  - ADSMs get prior-authorization from the ADDP contractor.

2.3.1 Managing Remote Dental Care—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 appointments (preferred)
    - (2) the ADDP contractor's Dental Care Finder makes the appointment.
  - The ADSM has to get an ACN (through the contractor's phone or online system) before getting services.
  - Information on making appointments is found at https://secure.addp-ucci.com/dwaddw/adsm/landing.xhtml
- Specialty 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 to the address on the bottom of the form.
  - When approved, the contractor assigns an ACN and notifies the ADSM and the specialty dentist on what care is authorized; the ADSM then schedules the appointment.
  - ADSMs who need dental implants 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.

2.4 Overseas Dental Care

ADSMs assigned overseas must get their care from either a DTF or from an overseas dentist if there's no DTF. ADSMs must call the overseas contractor via Regional or Country-specific Call Centers to arrange dental care.

2.4.1 Dentists

- ADSMs must use overseas dentists; appointments must be coordinated through the overseas regional contractor.
- For help and appointment coordination, ADSMs should call their Regional or Country-specific Call Center. Contact information is available at www.tricare-overseas.com.

2.4.2 Managing Overseas Remote Dental Care—Routine and Specialty Care

- Routine care:
  - TOP Prime Remote enrolled ADSMs must call 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 call 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 need to get 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 (very 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 DTF. His DTF dentist decides the care CPO Gorman needs isn't available at the DTF. The DTF refers CPO Gorman to a civilian dentist. Who issues the authorization? What steps must be taken to set up an appointment?

2.5 Payment and Claims Filing

ADDP
● Network dental providers submit claims to and are paid by the ADDP contractor. ● When ADSMs get emergency dental services or get **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 the dentist for and submit an American Dental Association claim form or documentation showing what services were received and billed. ○ 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 https://secure.addp-ucci.com/dwaddw/adsm/article.xhtml?content=claims-adsm ○ It should be printed, completed, and mailed to the contractor's address on the top of the form. ● Claims pay at the network rate.

Overseas
● ADSMs should coordinate all dental care through their Regional or Country-specific Call Centers. If seeing an overseas 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 also be submitted by TOP Points of Contact for ADSMs. ● When filing a claim, the ADSM must submit the following with the *DD Form 2642*: ○ Date(s) of service ○ Specific dental problem ○ Procedure code(s) ○ A complete description of the service performed, including applicable tooth/teeth numbers, if a procedure code isn't provided ○ Total charges ○ A dentist's bill or statement of charges if the specific service(s)/charge(s) aren't on the claim form ○ LOD/NOE documentation, when applicable ▪ Guard/Reserve members who get treatment for LOD conditions don't show as eligible in DEERS. ▪ LOD service members should work with their unit to verify eligibility. Claims must include proof of eligibility (i.e., orders, roster). ● Claim payment is based on billed charges.

- If the contractor doesn't get the dental claim within the following timelines, the claim is 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 Availability

TDP	TRDP
● The TRICARE Dental Program (TDP) offers voluntary, premium-based coverage. ● Available worldwide in 2 service areas: ○ CONUS: U.S., Guam, Puerto Rico, and the U.S. Virgin Islands ○ OCONUS: All other locations	● The TRICARE Retiree Dental Program (TRDP) offers voluntary, premium-based coverage. ● Available worldwide under the following group plans: ○ Enhanced TRDP: U.S., Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, and Canada ○ Enhanced-Overseas TRDP: all other locations

3.2 Eligibility

TDP	TRDP
● Those eligible for TDP coverage include: ○ Active duty family members (ADFMs) ○ Family members of Guard/Reserve members ○ Inactive Guard/Reserve members ○ Members of the Selected Reserve who are involuntarily separated under other than adverse conditions (These members and their families are eligible to continue buying 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 started ▪ Members/families are automatically disenrolled after 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 ○ Unremarried surviving spouses and children ● Sponsor must have at least 12 months left on his or her service commitment at the time of enrollment. ● Eligibility is verified through DEERS.	● Those eligible for TRDP coverage include: ○ Retired services members and their family members ○ Retired Guard/Reserve members, including those who aren't 60 years old, and their eligible family members ○ Unremarried surviving spouses and children of a deceased member who died ▪ On retired status ▪ While on active duty for more than 30 days in a row (once their eligibility for the TDP Survivor Benefit ends) ○ Medal of Honor recipients and their eligible family members ○ Eligible family members of certain non-enrolled retirees. Under most circumstances, the retiree must enroll so eligible family members can enroll. (See Appendix B of this module for more information.) ● Eligibility is verified through DEERS.

?	CPO 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 TRICARE. Is she eligible for coverage? If so, will she and CPO Gorman both be covered under the same dental program? Why or why not?

3.3 Enrollment

TDP	TRDP
● Enrollment is required. ○ Must complete 12-month commitment period ○ After the 12 months, enrollment continues on a month-to-month basis ● Options: ○ Single (one person) ○ Family (two or more people) ▪ If one family member enrolls, all eligible family members must enroll except in certain situations. (See Appendix A of this module for the exceptions.) ● Coverage starts: ○ On the 1st day of the **next month** if the person enrolls **by the 20th** of the month ○ On the 1st day of the **second month** if the person enrolls **after the 20th** of the month ○ TDP cards shows the coverage start date **Note:** In order for the TDP contractor to process the enrollment, they must confirm eligibility, receive the initial premium payment, and the form must have all the necessary information. Enrollment is processed according to the date received by the TDP contractor (not the postmark date). ● Guard/Reserve members must enroll under a single enrollment and enroll their family members separately. ● A one-month initial payment is required. ● Beneficiaries can enroll online, by phone, or by mail (See Appendix A of this module for more details.)	● Enrollment is required. ○ Must complete 12-month enrollment period ○ After the 12 months, enrollment continues on a month-to-month basis ● Options: ○ Single-person enrollment ○ Two-person enrollment ○ Family enrollment (three or more persons) ● Only the sponsor (or surviving family member) can enroll or add family members. ● Coverage starts the 1st day of the month after the TRDP contractor processes a complete enrollment package. ● A two-month initial payment is required. ● ADSMs and their eligible family members may enroll the month before the sponsor's retirement effective date. ● Beneficiaries can enroll online or by mail (See Appendix B of this module for more details.)

3.4 Disenrollment

TDP	TRDP
● Individuals can only disenroll after their 12-month commitment period ends. There are some exceptions (See Appendix A of this module). ● Individuals may disenroll: ○ By going to the Beneficiary Web Enrollment (BWE) website ○ By calling the TDP contractor ○ By downloading the TDP Enrollment/Change Authorization and mailing it to the TDP contractor	● 30-day grace period from the coverage start date to disenroll. ● Only the sponsor (or surviving family member) can disenroll family members. ● If enrollees don't disenroll during their grace period, they can only disenroll after their 12-month commitment period ends. ● Those who disenroll before their 12-month commitment period ends are locked out for 12 months before they can re-enroll. ● The TRDP contractor must get the disenrollment request at least 30 days before the 1st day of the 13th month.

3.5 Premiums

TDP	TRDP
● Benefit year is May 1-April 30 ● Premiums depend on type of plan and the sponsor's status ● TDP is a "pay ahead" program, meaning each payment is for the next month of coverage. ● Premiums change every February; enrollees start paying the new premium in January (for February coverage) ● If the sponsor has a military payroll account, TDP collects premiums through a uniformed services finance center. ● Credit card, debit card, or electronic funds transfer ongoing payment options are only available if the enrollee's military payroll account isn't enough to cover the premium or if the enrollee is a Guard/ Reserve member or eligible family member. ● If the TDP contractor can't get the premium payment from the sponsor's military payroll account for any reason, the contractor will direct bill the enrollee. ● See Appendix A of this module for more information.	● Benefit year is January 1-December 31 ● Premiums depend on the enrollee's home ZIP code and the number of family members enrolled. ● Premiums change January 1 ● TRDP collects premiums through Retired pay allotment ● Autopay through the enrollee's bank account or recurring credit card payment are only available if the enrollee doesn't get retirement pay or if their retirement pay isn't enough to cover the premium. ● Enrollees must complete an Authorization for Electronic Funds Transfer (EFT) form (http://www.trdp.org/downloads/eftauthorization-form.pdf) to pay premiums from their bank account ● Premiums are available at http://www.trdp.org/ retirees/premiums.html

3.6 Provider Types and Claims

TDP	TRDP
CONUS Includes the U.S., Puerto Rico, Guam, and the U.S. Virgin Islands. ● Enrollees may get care from a Preferred Dentist Program (PDP) or non-network dentist. ● PDP dentists: ○ Sign a contract with the TDP contractor and agree to follow TDP rules for providing care and accepting payments ○ Complete and file claims for enrollees ● Non-network dentists: ○ Don't have a contract with the TDP contractor ○ May make enrollees pay up front for services ○ Enrollees are responsible for filing claims ● Claims must be filed within 1 year from the date of service. ● See Appendix A of this module for more information on claims.	**Enhanced TRDP** Includes the U.S., Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, the Northern Mariana Islands, and Canada. ● Enrollees may get care from a participating TRDP network dentist or an out-of-network dentist (there are 2 categories of out-of-network dentists). ● Participating TRDP network dentists: ○ Sign a contract with the TRDP contractor and agree to follow TRDP rues for providing care and accepting payments ○ Complete and file claims for enrollees **Note:** There are no participating network dentists in American Samos, the Commonwealth of the Northern Mariana Islands, or Canada. ● Out-of-network dentists may make enrollees: ○ Pay up front for services ○ File claims ● Claims must be filed within 1 year from the date of service. ● See Appendix B of this module for more information on claims.
OCONUS Includes all other locations. ● Enrollees may get care from a TRICARE OCONUS Preferred Dentist (TOPD) or a non-TOPD dentist. ● TOPDs: ○ Won't make enrollees pay the full amount at the time of service ○ Complete and file claims for enrollees ● Non-TOPD dentists: ○ May make enrollees pay up front for services ○ Enrollees are responsible for filing claims ● Claims must be filed within 3 years from the date of service. ● See Appendix A of this module for more information on claims.	**Enhanced-Overseas TRDP** Includes all other locations. ● There are no participating TRDP network dentists so enrollees may see any dentist. ● Enrollees will need to pay in full at the time of service and must file their claims. ● Claims must be filed within 3 years from the date of service. ● See Appendix B of this module for more information on claims.

3.7 Costs

TDP	TRDP
CONUS ● Cost-shares are based on the treatment or procedure and the sponsor's pay grade. ● Enrollees who visit a non-network dentist must pay their cost share, plus the difference between TDP's allowance and the amount charged by the non-network dentist. ● Visit www.tricare.mil/costs for TDP cost-shares.	**Enhanced TRDP** Includes U.S., Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, the Northern Mariana Islands, and Canada ● Annual deductible: $50 per person but no more than $150 per family. ● Cost-shares apply after meeting the deductible and are based on treatment or procedure. ● Enrollees who visit an out-of-network dentist, must pay their cost share, plus the difference between the TRDP-allowed amount and billed charges. ● Visit www.tricare.mil/costs for TRDP cost-shares.
OCONUS ● Command-sponsored enrollees pay a reduced cost-share. ○ Reduced cost-shares don't apply when command-sponsored enrollees get care CONUS ● Visit www.tricare.mil/costs for TDP cost-shares.	**Enhanced-Overseas TRDP** Includes all other locations ● Same deductibles and cost-shares as the Enhanced TRDP. ● Since there are no participating TRDP network dentists, enrollees must pay their cost share, plus the difference between the TRDP-allowed amount and billed charges. ● Visit www.tricare.mil/costs for TRDP cost-shares.

3.8 Annual and Lifetime Maximums

TDP	TRDP
● TDP has some limits on how much it will pay per person. Annual maximum is the most the government will pay in a benefit year. ○ Annual maximum for non-orthodontic services: $1,300, per benefit year (May 1-April 30) ○ Annual maximum for accident care (additional to annual maximum): $1,200, per benefit year (May 1-April 30) ○ Orthodontic lifetime maximum: $1,750 ▪ Orthodontic *diagnostic* services are applied to the annual maximum.	● TRDP has some limits on how much it will pay per person. Annual maximum is the most the government will pay in a benefit year. ○ Annual maximum: $1,300, per benefit year (January 1-December 31) ○ Annual maximum for accident care (additional to annual maximum): $1,200, per benefit year (January 1-December 31) ○ Orthodontic lifetime maximum: $1,750

?	CPO Gorman's father is soon to be a retired uniformed service member. To continue dental coverage for he and his wife, they send 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? What is a known cost difference between these two programs?

4.0 General Anesthesia for Dental Treatment

- General anesthesia is a **TDP/TRDP-covered** benefit when given by a dentist. Enrollees have a cost-share.
- The TRICARE **medical benefit** covers general anesthesia services for dental treatment for beneficiaries with developmental, mental, or physical disabilities and children age 5 or under. Although this is for dental procedures, it's covered under the TRICARE medical benefit.
  - How much the medical claims processors (regional or overseas) pay for general anesthesia and institutional charges depend on the beneficiaries' TRICARE program option. These costs don't count against the TDP/TRDP $1,300 annual maximum.
  - Prior authorization from the medical contractors (regional or overseas) is needed before getting anesthesia 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

CONUS (U.S., Guam, Puerto Rico, and the U.S. Virgin Islands)	OCONUS (all other locations)
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-TDP3 (1-855-638-8373) 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). Individuals may only call Delta Dental if they're already enrolled.
- If you're not enrolled in the TRICARE Retiree Dental Program, contact Delta Dental:
  - Online: TRICARE Retiree Inquiry Form (http://www.trdp.org/customer-inquiry.html)
- Mail:

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 TRICARE determines premiums 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

- Single: includes one ADFM, one Guard/Reserve family member, or one inactive Guard/Reserve sponsor.
- Family: includes two or more eligible ADFMs or eligible Guard/Reserve family members.

Special Types of Enrollment

Under TDP family enrollment, if one family member enrolls, all eligible family members must enroll, except in the following situations:

- **Guard and Reserve Sponsors**
  - If the sponsor enrolls, he or she must submit a separate, single enrollment form
  - Sponsors may enroll their family members, without enrolling themselves
  - If called to active service for more than 30 days in a row and showing as eligible in DEERS, the sponsor is automatically disenrolled and re-enrolled upon deactivation. (See the chart on the next page for more information.)
  - All members of the Guard and Reserve must have an annual dental exam.
    - TDP-participating dentists complete the *DoD Active Duty/Reserve Forces Dental Examination* form (DD Form 2813) at no cost to the sponsor (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. They are automatically enrolled the month they turn 4 as long as other family members are enrolled. Coverage starts the 1st day of the month after their birthday. The premium rate then changes from a single to a family rate.
- **Active Duty Family Members In Need of Special Treatment**: For dental care that requires a hospital or special treatment environment (due to a medical condition, physical handicap, or behavioral health condition), the family member doesn't have to enroll in TDP and may continue to get care from an military hospital or clinic or DTF. Before getting care, the ADFM's sponsor must send a written request to end enrollment and to the TDP contractor with documentation, such as a signed letter or from the provider or administrator, confirming the need for special treatment.

Note: If a family has 2 sponsors, they can't enroll the same family member(s). The sponsors must decide which children are enrolled under each sponsor. When both spouses are service members, neither one can enroll in TDP as a family member—they each enroll as their own sponsor.

Na i l Guard and Reserve
Ac ı i /Deac ı i

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.

FA I

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
Fa ily members enrolle
ı ı ı i l or fa ily
plan **within 30 days** of
sponsor ac ı i
*ific contingency
operations*) pay the
reduced pre ı .

SPONSOR ACTIVATED
Fa ily members who
enroll ı ı ı i l or
fa ily plan **more than
30 days** after sponsor
ac ı i , or whose
sponsors are not ac ı
ı ı ı
i , pay the
reduced pre ı .

SPONSOR DEACTIVATED
Fa ily members' coverage
automa i lly canceled
upon sponsor's deac ı ı .
_____ no ı
ı ı ily
member reenrollmen
ı ı .

SPONSOR DEACTIVATED
Fa ily members' coverage
con ı i
li le Na i l Guard
and Reserve pre ı .
_____ lete rem i
1 ı i
llment req ı .

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

Reduced Premium Rate: Government pays 60 percent, enrollee pays 40 percent
Na ı ı . - i

TDP Survivor Benefit

- When a sponsor dies, the surviving spouse and children are eligible for the TDP Survivor Benefit, whether or not they were enrolled in the TDP before the sponsor's death.
  - The TDP survivor benefit also applies to 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 his or her death.
- The government pays 100% of the TDP premium for:
  - Surviving children until they lose eligibility.
  - Surviving spouses for up to 3 years from the sponsor's date of death
- Family members are responsible for TDP cost-shares.
- Surviving family members who are enrolled in the TDP are automatically disenrolled and enrolled in the TDP Survivor Benefit. 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 don't qualify for the TDP Survivor Benefit—for specifics, check with the TRDP contractor.

Enrollment Methods

- **Online:**
  - Go to the Beneficiary Web Enrollment website at http://dmdc.osd.mil/appj/bwe (A DS Logon,DFAS (myPay) account, or Common Access Card (CAC) is needed)
  - Select the "Dental" tab to enroll and complete the necessary information
  - Payment must be made by credit card.

Note: This option isn't available overseas.

- **By Phone:**
  - CONUS: 1-855-MET-TDP1 (1-855-638-8371)
    OCONUS: 1-855-MET-TDP2 (1-855-638-8372)
    TDD/TTY: 1-855-MET-TDP3 (1-855-638-8373)
  - First monthly payment must be made by credit card.
- **By Mail:** Complete the *TDP Enrollment/Change Authorization* (available on www.tricare.mil/forms) form and mail it with the first monthly premium to the TDP contractor. Payment must be made with a check or money order

Exceptions to Disenrolling Before Completing the Initial 12-month Commitment Period

Situation	Description
Loss of eligibility	Sponsor or family member loses eligibility due to death, divorce, marriage, age, or end of entitlement.
Sponsor and family relocate to the OCONUS service area	TDP enrollees may disenroll within 90 calendar days of the transfer. The date of the relocation must be on the disenrollment request. The disenrollment date is based on the date the contractor gets the *TDP Enrollment/Change Authorization*.
ADSM gets permanent change of station orders	If an ADSM transfers with TDP-enrolled family members to a duty station where space-available dental care is available at the local DTF, the sponsor may choose to disenroll his or her family within 90 calendar days of the transfer. The disenrollment date is based on the date the TDP contractor receives the *TDP Enrollment/Change Authorization*.
Guard or Reserve sponsor deactivation (sponsor was on active duty for more than 30 days in a row)	Family members can disenroll before the end of the initial 12-month commitment period if they had enrolled within 30 days of sponsor's 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 initial 12-month commitment 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 the *TDP Enrollment/Change Authorization*.
- TDP enrollees who don't pay their monthly premiums are disenrolled and can't re-enroll ("locked out") for 12 months from the date the last premium payment covered.

TDP Claims: Finding and Submitting Forms

CONUS

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

OCONUS

- The TDP claim submission document is 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:
  - 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
- If enrollees need help with their overseas claim, they can send an e-mail to OCONUSDentalClaims@metlife.com

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 appeal.

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

Eligibility

- Eligible family members of certain non-enrolled retirees may enroll in the TRDP if they have documented proof that the retiree:
  - Is eligible to get ongoing comprehensive dental care from the Department of Veterans Affairs
  - Is enrolled in a dental plan through employment but the plan isn't available to family members
  - Can't get TRDP because of a current and enduring medical or dental condition

Note: Those not eligible for TRDP 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

- The sponsor or surviving dependent must authorize the enrollment
  - 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 (POA); the spouse must include copy of POA with the enrollment form.
- To enroll:
  - Online:
    - Go to the Beneficiary Web Enrollment website at http://dmdc.osd.mil/appj/bwe (A DS Logon,DFAS (myPay) account, or Common Access Card (CAC) is needed)
    - Select the "Dental" tab to enroll and complete the necessary information
  - By Mail : Download application from http://trdp.org/downloads/enrollment-application.pdf and mail to:

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

TRDP Claims

- TRDP claim forms are available at http://www.trdp.org/downloads/claim-form-trdp.pdf
- Mail claims to:

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

- Mail overseas claims to:

Delta Dental of California
Federal Government Programs
P.O. Box 537006
Sacramento, CA 95853-7006

- Enrollees who live overseas may also file their claims online.
- Beneficiaries 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 registering for a Consumer Toolkit account (https://www.ddfgptoolkits.com/ipWeb/appmanager/ct/desktop).

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 an appeal.

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/tma/greatlakes
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 on active service for 30 days or less, Guard/Reserve members are covered by 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 for more information.)	Guard/Reserve family members aren't TRICARE-eligible at this time, and 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 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.)	Sponsors may purchase TDP coverage for eligible family members.

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 LOD/NOE care, to include when traveling directly to or from their place of duty. They don't show as eligible in DEERS, but 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 an 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 Defense Health Agency – Great Lakes (DHA-GL) (formerly known as the Military Medical Support Office [MMSO]).

- DHA-GL authorizes LOD/NOE care with a civilian provider for Guard/Reserve members **not** in a PSA.
  - The unit medical representative submits the LOD/NOE determination, a copy of orders or drill attendance sheet, and a DHA-GL *Medical Eligibility Verification* form, which can be found at http://www.health.mil/GreatLakes.
  - DHA-GL reviews the documentation, and issues an authorization determination.
- The member doesn't need prior authorization for an initial emergency room visit. If admitted to a hospital/facility, the member must get a DHA-GL or MTF authorization before or as soon as possible after admission. After leaving the hospital/facility, prior-authorization is required before getting an appointment for ongoing care.
- Overseas Guard/Reserve members must use their service's procedures for LOD/NOE care. DHA-GL isn't involved in LOD/NOE care overseas other than the U.S. Virgin Islands.
  - For LOD/NOE care in the U.S. Virgin Islands, call DHA-GL at 1-888-647-6676

?	Two days after SGT Wilson's arrival, a canister falls on her foot while she's unloading a military transport vehicle. What needs to happen to get her care covered? Can she be seen 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 service if the condition needs continued treatment and ongoing care is authorized.

Members should make sure they and their command or medical unit keep the official LOD/NOE document before release from active service in case they need follow-up care later. For more information, visit the DHA-GL website at http://www.health.mil/GreatLakes.

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 DHA-GL 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: Defense Health Agency-GL Attn: RC Retail Pharmacy Reimbursement Suite 304 2834 Green Bay Road North Chicago, IL 60064-3091 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	DHA-GL reviews the documents and verifies eligibility. They send 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 to the member.	The overseas contractor's claims processor mails the reimbursement check 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 service, whichever is later. This 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 at an MTF if living in a PSA
  - Seek covered primary care from a TRICARE-authorized provider if living in a remote location (referrals and authorizations for non-routine care must be coordinated through the regional contractor and DHA-GL or the overseas contractor)
- Family members:
  - Are automatically covered under TRICARE Standard/Extra when showing as eligible in DEERS
  - May be able to enroll in a TRICARE Prime option, including Prime, 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 March 1, a Guard/Reserve member receives delayed-effective-date orders to active service for 180 consecutive days, with a reporting date of September 1. On March 5, TRICARE coverage begins for the Guard/Reserve member and eligible family members.

Scenario 2: On March 1, a Guard/Reserve member receives delayed-effective-date orders to active service for 180 consecutive days, with a reporting date of September 1. On March 5, TRICARE coverage begins for the Guard/Reserve member and eligible family members. On April 1, the Guard/Reserve member's orders are amended. As a result, the member and their family's TRICARE coverage ends on April 15.

?	On March 1, SGT Wilson receives orders to active service for 90 consecutive days, starting September 1. Does SGT Wilson qualify for early eligibility? If so, when is she TRICARE-eligible? Can she enroll in TRICARE Prime?

4.0 Coverage 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 qualify to enroll in a TRICARE Prime option.
Dental Coverage	• If enrolled, TDP coverage automatically ends. • ADSMs get dental care at military dental treatment facilities or through the Active Duty Dental Program (ADDP).	• If enrolled, TDP coverage continues with lower premiums. • Eligible family members can purchase new TDP coverage at the lower 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 TAMP information.) ● 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 coverage.	● TAMP provides 180 days of transitional TRICARE coverage for eligible family members. ● Family members are automatically covered under TRICARE Standard/ Extra and may enroll or reenroll in TRICARE Prime, if available. (TPRADFM and TOP Prime Remote aren't 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 start when 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 eligibility (e.g., active duty, TAMP).	● Eligible family members may get TRS member-and-family coverage, but only if the sponsor is also covered.
Continued Health Care Benefit Program (CHCBP)	● CHCBP provides up to 18 months of premium-based health coverage. (See the *Transitional Benefits* module for more 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 60 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 individuals 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 active service are automatically reenrolled. ● Sponsors who aren't TAMP eligible and weren't enrolled before they served may purchase TDP sponsor coverage.	● Family members may purchase or continue TDP family coverage. ● If already enrolled in TDP, premiums increase to the appropriate family-member rate.

* *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 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 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 get full retiree benefits. (See Section 7.0 of this module for more on TRR.)	● Eligible family members may get TRR member-and-family coverage if purchased by their sponsor. ● 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. They are then entitled to TRICARE retired family member benefits.
TRICARE Retiree Dental Program (TRDP)	● Eligible sponsors may purchase coverage under the TRDP. (See the *Dental* module for more information.)	● Eligible family members may purchase coverage. ● 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 offer the TRICARE Standard/Extra or TRICARE Overseas Program (TOP) Standard benefit.
- 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.
- 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 determine whether a member is qualified to purchase TRS or TRR.
  - To qualify, Guard/Reserve members must be in the Selected Reserve of the Ready Reserve.
  - Certain members of the Selected Reserve who are involuntarily separated under other than adverse conditions may qualify for an additional 180 days of TRICARE Standard coverage for themselves and their family members after separation. Coverage requires continuing TRS purchase.
    - Member must be enrolled in TRS on the last day of his or her Selected Reserve service for continued 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 isn't in the Selected Reserve.
    - Those who don't pay their premiums or choose to stop purchasing TRS coverage won't be reinstated.
  - To qualify for TRR, retired Guard/Reserve members must be under age 60 and a member of the Retired Reserve of a reserve component who qualifies for non-regular retirement under 10 USC, Chapter 1223
- To purchase TRS or TRR, members **must not** be enrolled or eligible to enroll in the Federal Employees Health Benefits (FEHB) Program under their own employment.

?	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 see if they qualify for 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 get the application
  - Members can get 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 send 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 is based on how and when members purchase coverage.

7.4.1 General Enrollment

- Qualified members may purchase TRS or TRR coverage any time during 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's 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 period 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 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, divorce, or death, their TRS or TRR coverage (member-only or member-and-family) may need to change. They have to send in 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 for coverage to begin on the date of the qualifying life event or premiums adjusted. 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 **isn't** postmarked or received within the 60 days following the qualifying life event, claims are denied until the family member is enrolled. Coverage then starts on the date the application is received and processed.

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:
  - 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 changes coverage to TRS or TRR survivor coverage. (Advise beneficiaries to report and 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 end on the day after the sponsor's death. Contractors refund premiums if there were no claims submitted during those 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 mirrors TRICARE Standard/Extra or TOP Standard.
- Pharmacy benefits are through the pharmacy contractor stateside and in U.S. territories and the overseas contractor in all other countries.

7.6 TRS and TRR Costs

- TRS: TRICARE Standard/Extra cost-shares, deductibles, and catastrophic caps for **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 for **regular retirees** apply to all TRR-covered individuals.
- See the *TRICARE Options* Module for more on Standard/Extra.

7.6.1 TRS and TRR Monthly Premiums

- TRS and TRR premiums may change on an annual basis, effective January 1.
- Visit www.tricare.mil/costs for current TRS and TRR premiums.
- The first 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 first payment, all premiums must be paid by monthly electronic funds transfers (EFTs) or credit/debit card.
  - The contractor processes 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.) ● 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.) ● 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 disenrolling to make sure they have no break in health care coverage

7.7.2 Voluntary Disenrollment

- To disenroll, TRS and TRR members and families must:
  - 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 last month a premium was paid.

7.7.4 Purchase Suspension

- TRS/TRR members who voluntarily disenroll or stop automatic payments and don't disenroll are subject to a 12-month purchase suspension from the date coverage ended.
- These members may request reinstatement from the regional contractor within the first three months of suspension.
  - Requests must include payment of all overdue and current premiums, as well as information needed to set up electronic premium payments.
  - If the request meets the above criteria, the regional contractor reinstates coverage back to the day after the premiums were last paid.
- Members may request re-enrollment after three and up to 12 months following the suspension.
  - Requests must include two months' worth of premiums, as well as information needed for recurring electronic premium payments.
  - Coverage goes into effect the first of the month after the request is made.
- 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.)
  - 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 turned down the civilian job because she and her fiance decided 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 ends her TRS coverage. One month later, her husband loses his job and benefits. Can SGT Wilson still get TRS? If so, what does she need to do?

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 CHCBP information.)

7.9 Distinguishing 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 hasn't reached age 60 ● Must not be eligible for or enrolled in the FEHB program
Cost-Shares	● ADFM rate	● Retiree rate
Premiums	● Monthly premium ● Minimum two-month initial premium payment required ● Premiums are adjusted every calendar year, effective January 1 ○ Visit www.tricare.mil/costs for premium rates	● Monthly premium ● Minimum two-month initial premium payment required ● Premiums are adjusted every calendar year, effective January 1 ○ Visit www.tricare.mil/costs for 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

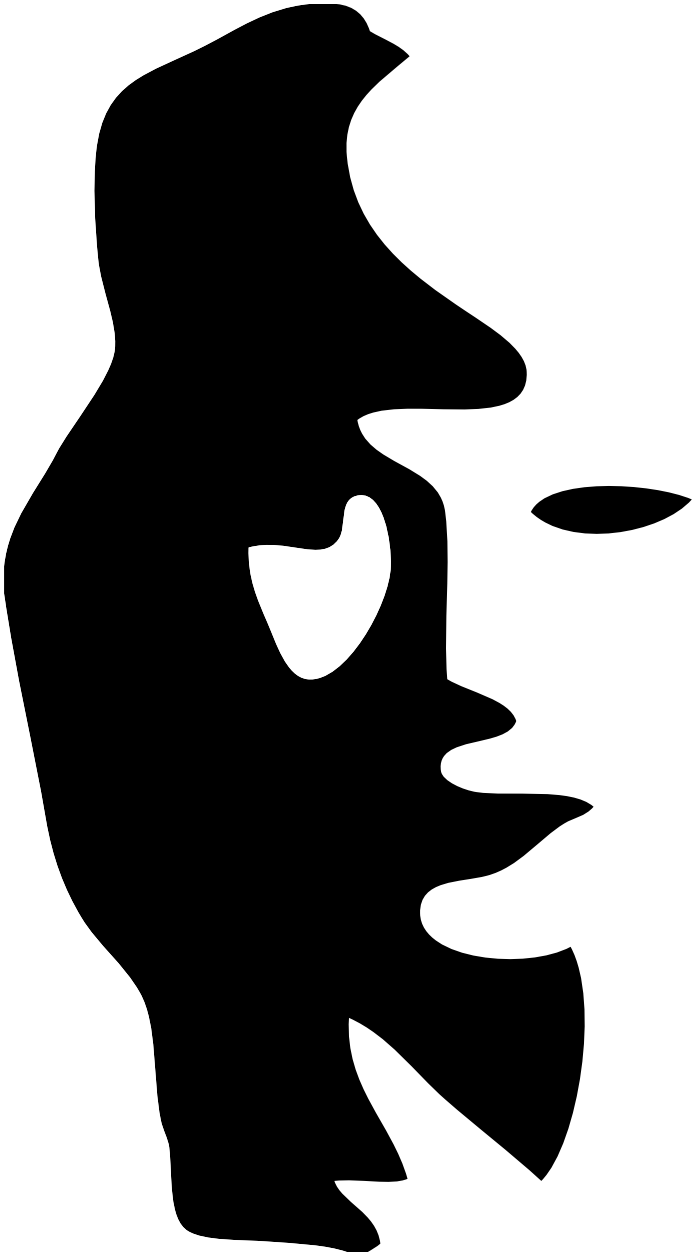
Participant Guide

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 the TRICARE Young Adult (TYA) program**
- **State the purpose of TRICARE Plus**
- **Describe the Extended Care Health Option (ECHO)**

Key Terms

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

1.0 TRICARE Young Adult Program (TYA)

The premium-based TRICARE Young Adult (TYA) program offers for purchase TRICARE Standard or Prime coverage stateside and overseas 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, otherwise they are TYA Standard. (See the *TRICARE Options* and *Prime Remote Options* modules for more on command sponsorship.)
- Young adult dependents of TRICARE For Life (TFL) sponsors can purchase TYA Standard, or may qualify to purchase a TYA Prime option if they meet TYA and TRICARE Prime criteria.
- 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 purchase or continue TYA coverage:
    - TYA coverage ends six months after the sponsor's death, or when the 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 under age 26 on the date the sponsor would've retired, the young adult can purchase TYA as a dependent of a retiree.

- TYA coverage ends when:
  - The young adult submits a *TRICARE Young Adult Application* (DD Form 2947) 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 contractor, along with an initial two-month premium payment.

- Young adult dependents who lose TRICARE eligibility (e.g., age out of TRICARE at 21) may avoid a break in coverage by making sure their DD Form 2947 is postmarked within 30 days of losing eligibility; claims are denied until their TYA status shows in DEERs. Coverage begins:
  - TRICARE Standard: the first day of the 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
- Continuous coverage requires an electronic payment from a checking or savings account or an automatic recurring credit/debit charge.
- Once the contractor completes the enrollment, it sends a notice to the young adult. The enrollee then logs on to milConnect to download his or her enrollment card and find out who's their PCM (if Prime).
- Once DEERs shows their enrollment, the young adult and sponsor should have the young adult present a sponsor-notarized Application for Identification Card/DEERs Enrollment (DD Form 1172-2) at the nearest service ID-card issuing facility so the young adult can get a new ID card to show when seeking care.
- Qualified young adults may purchase TYA coverage anytime unless locked out after failing to pay TYA premiums or because the sponsor failed to pay 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 there was an administrative error with their enrollment or premium payment or he or she proves they have an extraordinary need to continue TYA coverage.
    - Young adults should send reinstatement requests to the contractor within 90 days of the last full premium payment.
    - The TRICARE Regional Office (TRO), TRICARE Area Office (TAO), or USFHP decide if TYA coverage can resume.

?	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 she purchase TYA coverage since the rest of the Cooper family is TRICARE Prime. What does Rachel have to do to get TYA coverage? How does she pay her premiums? Can she still use her old ID card?

1.3 TYA Portability

To switch regions, or from TRICARE to USFHP or vice versa, the young adult must send a new *DD Form 2947* to the new contractor.

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 premiums, visit www.tricare.mil/costs.
- Options and 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 based on the sponsor's status (active duty, Guard/Reserve, retiree, etc.)
- TRICARE Standard deductibles and cost-shares apply if the young adult is TYA Standard; TRICARE Prime copays and cost-shares apply if TYA Prime.
- Deductibles, cost-shares, and copays for TRICARE-covered services apply to the individual/family's catastrophic cap; TYA premiums don't.
- Pharmacy copays and cost-shares apply.

2.0 TRICARE Plus

- TRICARE Plus is a primary care program offered at select military treatment facilities (MTFs) stateside and overseas.
  - TRICARE Plus isn't a TRICARE option; it offers primary care at an MTF with an assigned primary care manager (PCM).
  - MTF commanders may limit the number of enrollees; 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's no enrollment fees or cards 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 contractor.
- Once the contractor enters the TRICARE Plus enrollment into the Defense Online Enrollment System (DOES) the beneficiary shows as TRICARE Plus in DEERS, with an assigned PCM.
- Once the TRICARE Plus enrollment shows in the MTF's appointment system, enrollees can make appointments with their PCM.

2.3 TRICARE Plus Disenrollment

- TRICARE Plus enrollees may disenroll any time by giving the MTF a *TRICARE Plus Disenrollment Request* (DD Form 2854).
- The MTF sends the request to the contractor to record in DEERS.

2.4 TRICARE Plus—Not Portable

Unlike TRICARE Prime, TRICARE Plus isn't portable. TRICARE Plus at one MTF doesn't carry over to another MTF.

2.5 Specialty Care

- MTFs may see TRICARE Plus enrollees for specialty care on a "space-available basis." Otherwise, TRICARE Plus enrollees must seek specialty care from a civilian TRICARE-authorized provider if they're still TRICARE eligible (i.e., Standard/Extra, TFL) or use Medicare or other health insurance (OHI).
- The MTF isn't responsible for costs for 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 is a financial resource to help pay for services and supplies that reduce the disabling effects of an active duty family member's (ADFM's) qualifying condition.
- Services may include medical and rehabilitative services, institutional care, and respite care. (See Appendix A for more 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 for ECHO eligibility information.)
- 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 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, National Oceanic and Atmospheric Administration), the family member is a transitional survivor, or the family member lives with a custodial parent, not the active duty sponsor.
  - For more information on EFMP, have the beneficiary contact their Service EFMP Office or visit www.militaryonesource.mil/EFMP. (See Appendix A for some additional information.).
- Regional contractors, TAOs, or USFHP determine if a family member is eligible for ECHO. If they determine the family member isn't eligible, the decision is a factual determination and **isn't** appealable.

3.2 ECHO Registration

- The sponsor, or other authorized persons acting for the family member, must send the regional contractor, TAO, or USFHP:
  - Proof the sponsor is on active service in one of the uniformed services
  - Medical records of qualifying conditions (See Appendix A for information on ECHO qualifying conditions.)
- If there is a delay in the EFMP enrollment process, the regional contractor, TAO, or USFHP system may grant provisional ECHO status for 90 days so the family member can get ECHO services.

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

3.3 ECHO Benefit Authorization

- ECHO benefits must be authorized before the family member receives any services, supplies, or equipment.
  - The regional contractor, ECHO case manager, TAO, or USFHP serve as the family member's POC for prior authorization.
- If the family member wants to change providers, they must get a new referral and authorization.
- Beneficiaries may appeal denial of ECHO services and supplies.

3.4 ECHO Costs

- ECHO has no deductibles or enrollment fees.
- Families must pay a cost-share (based on the sponsor's pay grade) for the months registered family members receive ECHO benefits. ECHO cost-shares don't count towards the family's catastrophic cap. (See Appendix A for cost-share amounts.)
- Families may have to pay cost-shares for 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 filing claims for ECHO-authorized care, the family or 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 send claims to the TRICARE or USFHP claims processor based on where the family member lives or 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, non-emergency specialty care for a documented combat-related condition.
  - The primary care provider writes a referral for the needed service(s).
- The CRSC travel benefit isn't 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 “minimum 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)
- Individuals who are **only** direct-care eligible and those with line of duty care don’t have MEC.

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 for more information.)

Module Objectives

- **Identify who may be eligible for 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 assigned duty stations.
- Enrollment in EFMP helps Services station families in areas where family members' needs can be met. This is especially important when family members are 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 http://www.militaryonesource.mil/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 a 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 specific mental or physical disabilities and enrollment in EFMP, when applicable.
- The family member needs his or her assigned MTF/civilian PCM, USFHP Primary Care Provider, or a TRICARE-authorized provider to confirm and document the qualifying condition(s) and need for ECHO 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 the family member has to live in a controlled setting
- Travel costs for institutionalized family members receiving authorized ECHO benefits (to and from the institution)
- In-home medical services
- ECHO respite care: ECHO family members may get 16 hours of respite care per month in any month the family member receives other authorized ECHO benefits

Note: All ECHO benefits require prior-authorization.

Services Not Available Under ECHO

- Inpatient care for treatment of an acute illness or an acute worsening of the qualifying condition
- Structural changes to living space and permanent fixtures
- Dental care and orthodontic treatment (covered under adjunctive dental care or purchase of dental program coverage)
- 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

- 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 information 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 that occurred while on active duty.

CAP Services

- Assistive technology to increase access to computer and telecommunications environments
- 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
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 relationship 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 beneficiaries with TRICARE and Medicare.

?	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 have Medicare Part B, no matter how old they are or where they live.
- TFL coverage starts the first day Medicare Part A **and** Part B start.
- Those under age 65 may enroll in TRICARE Prime (if they live in a Prime Service Area).
  - They don't have to pay the Prime enrollment fee as long as they have Medicare Part B.

2.1 Defense Enrollment Eligibility Reporting System (DEERS)

- TRICARE and Medicare share files to make sure beneficiaries have Part A and Part B.
  - TFL status shows as pending until their Medicare status is known.
- 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 federal health insurance program for:
  - People who are 65 or older
  - Certain people under age 65 with disabilities
  - People with end-stage renal disease (ESRD) (permanent kidney failure requiring dialysis or a transplant)
  - People with amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease

3.1 What Does Medicare Cover?

- Medicare Part A (hospital insurance), helps cover inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care.
- Medicare Part B (medical insurance) helps cover services from doctors and other health care providers, outpatient care, home health services, some preventive health services, durable medical equipment, and other medical services.

3.2 Signing Up for Medicare Part A and B

- Individuals already getting benefits from Social Security or the Railroad Retirement Board (RRB) automatically get Part A and Part B starting the first day of the month they turn 65. (If their birthday is on the first day of the month, Part A and Part B starts the first day of the month before.)
  - Those living in Puerto Rico automatically get Part A; Part B isn't automatic so they'll need to sign up.
  - Disabled individuals under age 65 automatically get Part A; Part B only starts after they get disability benefits from Social Security for 24 months or certain disability benefits from the RRB for 24 months.
  - Individuals with ALS automatically get Part A and Part B the month their disability benefits begin.
  - Individuals close to age 65, but not getting Social Security or RRB benefits need to sign up by contacting Social Security or the RRB 3 months before they turn 65.

- Those not eligible for premium-free Part A based on their own work history should contact the Social Security to find out if they qualify under their spouse's or divorced spouse's Social Security number (SSN). (See Appendix B for more information.)
- Individuals with ESRD need to sign up by visiting their local Social Security office.
- Those who are automatically enrolled will get their Medicare card in the mail 3 months before their 65th birthday or on their 25th month of disability benefits.

3.3 Medicare Part A and B Costs

- Most people don't pay a monthly premium for Part A coverage if they or their spouse paid Medicare taxes while working; this is called premium-free Part A.
- Individuals must pay the Part B premium each month. The amount individuals pay can change each year depending on their income.
  - Beneficiaries who don't sign up for Part B when they're first eligible may have to pay a late enrollment penalty. Their monthly premium for Part B may go up 10% for each full 12-month period they could have had Part B, but didn't sign up for it.

4.0 TRICARE For Life

4.1 Medicare Part B Enrollment Is Required

- Under federal law, TRICARE beneficiaries eligible for premium-free Medicare Part A must have Medicare Part B to keep TRICARE. Beneficiaries lose their TRICARE benefits and claims are denied if they don't have Medicare Part B.
  - 3 months before their 65th birthday or on their 25th month of disability benefits, DMDC notifies TRICARE beneficiaries of the need to sign up for Part B.

4.2 Exceptions to Medicare Part B Requirement

- The following beneficiaries with Part A don't have to sign up for Part B to keep TRICARE.
  - Active duty service members (ADSMs) and active duty family members (ADFMs) whose sponsor is on active duty.
    - Medicare Part B **must** be in place on or before the sponsor's retirement date (medical or regular) so there's no break in TRICARE coverage.
    - If they sign up after the sponsor's retirement date, there may be a break in TRICARE coverage until Part B starts.
  - TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) members.

?	Sergeant Major Gill turns 65 in two months and will have Medicare Part A. What happens to SgtMaj Gill's TRICARE eligibility if he doesn't sign up for 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 sign up for Part B, but still be TRICARE-eligible?

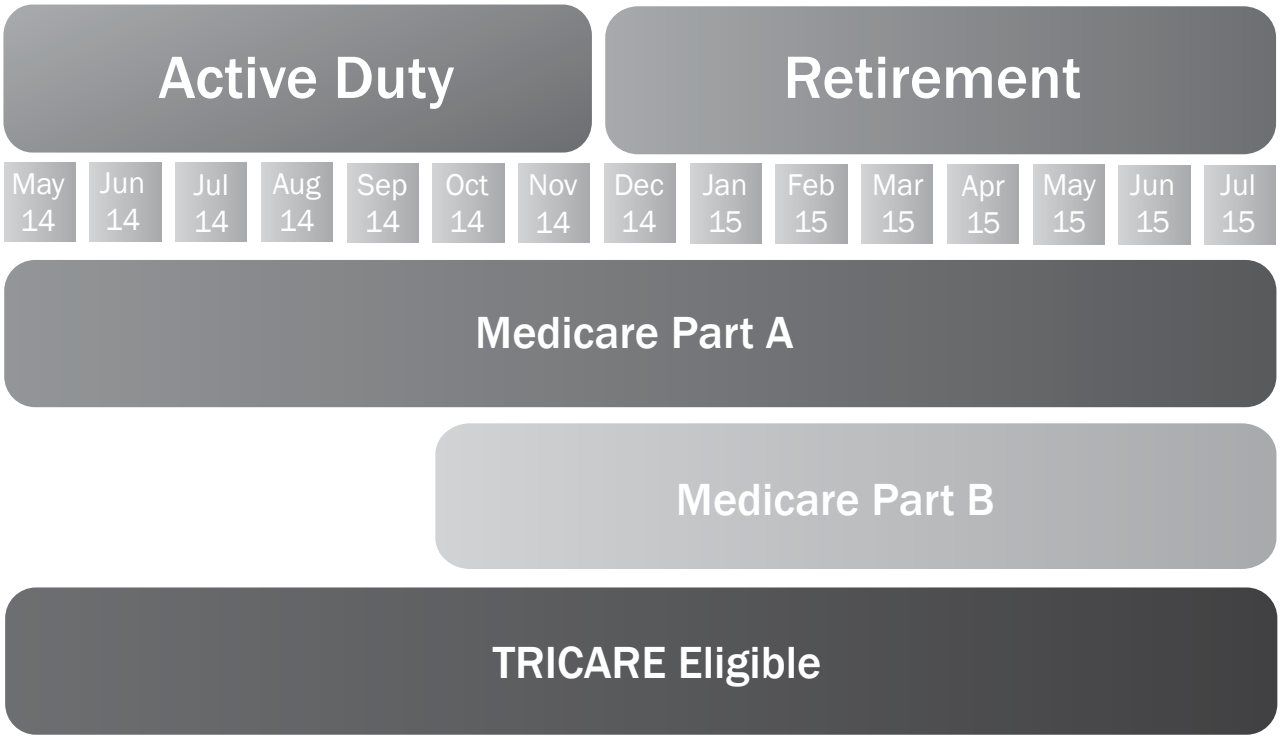
4.3 Scenarios

4.3.1 Scenario 1

Sergeant Williams is a combat-wounded ADSM getting Social Security disability benefits. He gets notice that his Medicare Part A and Part B start May 2014. He drops Part B because he's on active duty. His service notifies him that his medical retirement date is December 1st, 2014. He decides to sign up for Part B while on active duty. His Part B starts October 1, 2014. Though he dropped Part B when he was first eligible, he signed up before he retired. Does he have a break in coverage? When does his TRICARE eligibility start?

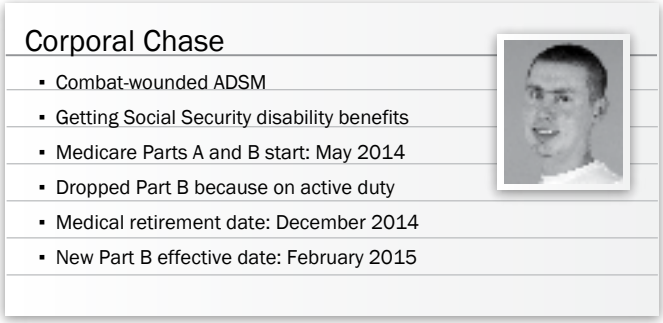
Scenario 1

No break in TRICARE eligibility because he signed up for Medicare Part B before he retired.



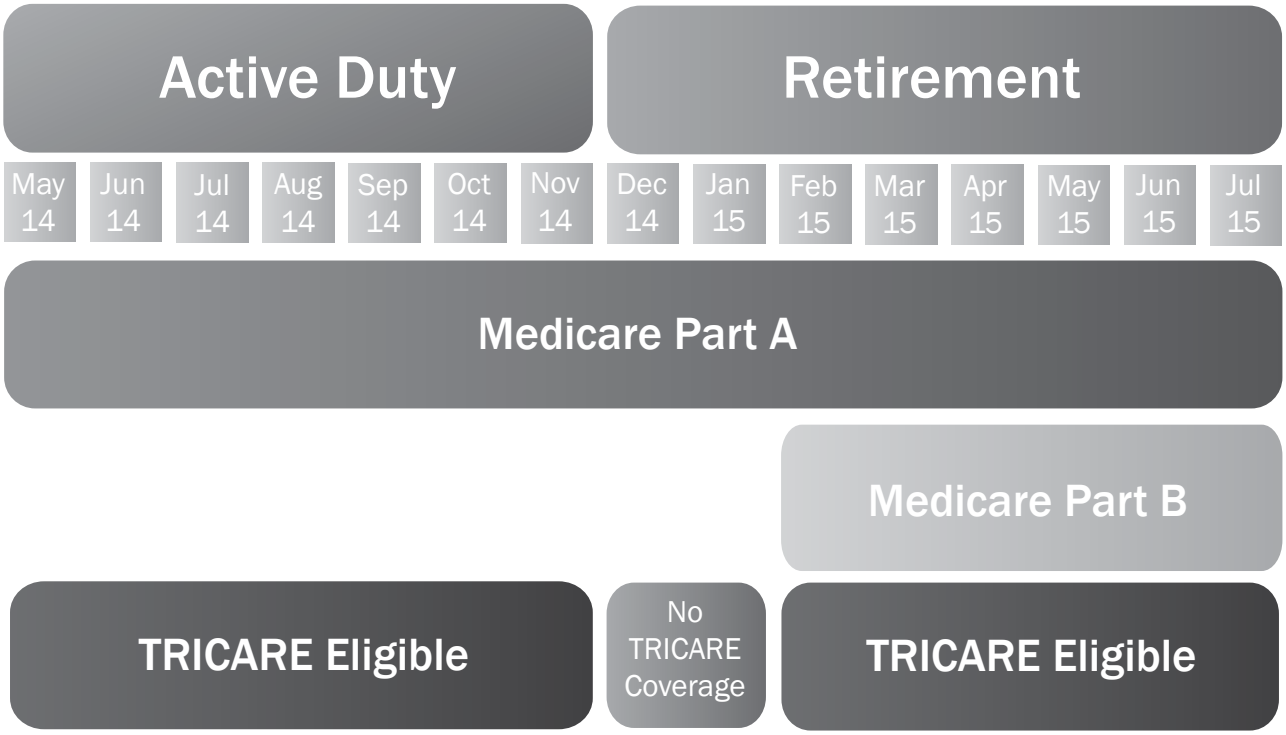
4.3.2 Scenario 2

Corporal Chase is a combat-wounded ADSM getting Social Security disability benefits. He gets notice that his Medicare Part A and Part B start May 2014. He drops Part B because he's on active duty. His service notifies him that his medical retirement date is December 1st, 2014. Corporal Chase decides to sign up for Part B on January 1, 2015. Does he have a break in coverage? When does his TRICARE eligibility start?



Scenario 2

Break in TRICARE eligibility because he signed up for Medicare Part B after he retired.



5.0 How TFL Works with Medicare

5.1 Services Covered by Both Medicare and TRICARE:

- Medicare pays first; TRICARE pays second and usually covers the beneficiary's Medicare deductible and cost-shares.
- Medicare Part B pays 80% and TRICARE usually pays the remaining 20%.

5.2 Services Covered by Medicare, But Not by TRICARE:

Medicare pays first; TRICARE doesn't pay. 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 doesn't pay; TRICARE is the first payer. The beneficiary pays TRICARE's deductible and cost-shares (Standard/Extra rates or Prime copays). (Example: compression stockings.)

5.4 Services Not Covered by TRICARE or Medicare:

The beneficiary is responsible for all costs. (Examples: Cosmetic surgery, beneficiary doesn't follow Medicare rules)

5.5 Payer Table

	✓ Medi ICARE	✓ Medi ICARE	✓ TRICARE ✗ Medi	ICARE ✗ Medi
Medicare	Pays First	Pays First	Does Not Pay	Does Not Pay
TRICARE	Pays Second	Doesn't Pay	Pays First	Doesn't Pay
Beneficiary	No Out-of-Pocket Expenses	Pays Medicare Deductible, Cost-Share, or Both	Pays TRICARE Deductible, Cost-Share, or Both	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 overseas host nation insurance.

- If the beneficiary has group health plan coverage through his or her current employer, the employer group/ OHI processes the claim first, Medicare processes the claim second, and TRICARE processes the claim last. (A few exceptions apply, per Medicare policy)
- If a beneficiary has OHI, such as a Medicare supplement, Medicare processes the claim first, OHI processes the claim second, and TRICARE processes the claim last.
  - When OHI processes the claim after Medicare, the beneficiary must file a claim with the TFL claims processor since the claim isn't automatically sent to TRICARE.
- If the beneficiary goes to a VA facility for care not related to a service-connected disability: Medicare won't pay for the services, even if it's a Medicare-covered service; TRICARE can only pay up to 20% of the TRICARE-allowed charge. The beneficiary may be responsible for paying the VA the remainder of the TRICARE allowable charge.

7.0 Working Beneficiaries Age 65 and Older

- Medicare lets individuals wait to sign up for Part B when they're first eligible if they're covered under a group health plan based on current employment (their own, a spouse's). These individuals can sign up for Part B:
  - Anytime they're still covered by the group health plan
  - During the 8-month period that starts the month after the employment ends or the coverage ends, whichever happens first.
- Though they can sign up for Part B later, they won't have TRICARE coverage if they don't have Medicare Part B.
  - If they wait and sign up for Part B two months into their special enrollment period, they won't have TRICARE coverage for those two months.
  - TFL coverage starts the day both Medicare Part A **and** Medicare Part B are active.

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

8.0 TFL Claims Processing

When a beneficiary has Medicare and TRICARE:

- The TFL claims processor handles all claims for TFL beneficiaries, except those who live or get services overseas where Medicare isn't accepted—those claims 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 electronically forwards the claim to TRICARE (as long as the beneficiary told his or her provider that he or she has TFL and no OHI).
- Beneficiaries get a Medicare Summary Notice (MSN) in the mail every 3 months that lists all the services and/or supplies billed to Medicare. The notice shows what Medicare paid and what the beneficiary may owe the provider. This notice isn't a bill.
- Beneficiaries also get a monthly TFL explanation of benefits (EOB) that lists all the services and/or supplies billed to TFL, what TFL paid, and what the beneficiary may owe the provider. The EOB isn't a bill.
    - Instead of getting monthly EOBs, beneficiaries may register at www.TRICARE4U.com to get an e-mail notification when their claim processed. Once registered, they can log in to see their EOB.
- If Medicare doesn't pay because it determines the care wasn't medically necessary, TFL also doesn't pay.
    - The beneficiary may appeal Medicare's decision, and if Medicare reconsiders and provides coverage, TFL also reconsiders coverage and payment. (See the *Appeals* module for more information).
- When TRICARE is primary payer and denies for medical necessity, the TRICARE appeal process applies.

9.0 Using TFL While Overseas

The same Part B requirement and exceptions that apply to beneficiaries living in the United States and its territories also apply to beneficiaries living overseas.

- 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 first billing Medicare. 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).
    - Overseas beneficiaries should be prepared to pay the total billed charges up front and 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), a copy of the provider's itemized bill, and proof of payment by credit/debit card or an ATM withdrawal, to the overseas claims processor.

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 sign up for Medicare Part D at a later date, he or she doesn't pay a penalty for late enrollment. The TRICARE Pharmacy Program is seen by Medicare as 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.
- See section 9.0 of the *Pharmacy* module for more information on pharmacy benefits and TFL.

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 is primary payer. True or False? Why?

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

Scenario 3
Sergeant Jones was an ADSM getting social security disability benefits. She is now retired. Before her retirement, she signed up for 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 has Medicare Part A and 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 relationship 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)
  - Helps cover inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care
  - The Social Security Administration (SSA) determines eligibility for premium-free Medicare Part A based on an individual's/spouse's payment of Medicare taxes while working.
- Medicare Part B (Medical insurance)
  - Helps cover medically-necessary doctor's services, outpatient care, home health services, some preventive services, durable medical equipment, and other outpatient medical services
  - Individuals sign up for Medicare Part B and pay a monthly premium; premiums may change on an annual basis
    - Most people pay the standard premium amount, while others pay based 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 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 https://www.medicare.gov/sign-up-changes-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html

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

- Medicare Part D (Medicare Prescription Drug Coverage) helps cover the cost of prescription drugs and is run by Medicare-approved private insurance companies. Medicare considers the TRICARE Pharmacy Program as creditable coverage.

Medicare Part B Enrollment Periods

Initial Enrollment Period

- This is a seven-month period that starts 3 months before the month the beneficiary turns 65, includes the birthday month, and ends 3 months after the month the beneficiary turns 65.
  - Individuals with a birthday on the first day of the month are eligible for Medicare the month before their 65th birthday.
  - Individuals with a birthday other than on the first day of the month are eligible for Medicare the first day of the month they turn 65.

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 they were covered under a group health plan based on current employment (their own or a spouse's). This includes active duty service members and active duty family members.

They can sign up:

- Anytime they're covered by the group health plan
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first
  - Beneficiaries don't pay a Medicare Part B late enrollment penalty for late enrollment if they sign up during a SEP.
  - Medicare Part B coverage starts the month following enrollment.
  - This SEP doesn't apply to people with ESRD.

Medicare Part B Premium Penalty

Individuals who don't sign up for Medicare Part B when first eligible, may have to pay a Medicare late enrollment penalty for as long as they don't have Part B. The monthly premium for Part B may go up 10% for each full 12-month period they could have had Part B, but didn't.

Medicare Prescription Drug Benefit — Medicare Part D

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

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 begins on January 1 of the following year.
- Penalty: Individuals may owe a late enrollment penalty if at any time after their Initial Enrollment Period is over, there's a period of 63 or more days in a row when they don't have Part D or other creditable prescription drug coverage. (TRICARE is creditable prescription drug coverage.)
- TRICARE beneficiaries may disenroll from Part D anytime and use their TRICARE Pharmacy Program coverage as primary payer.

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?"

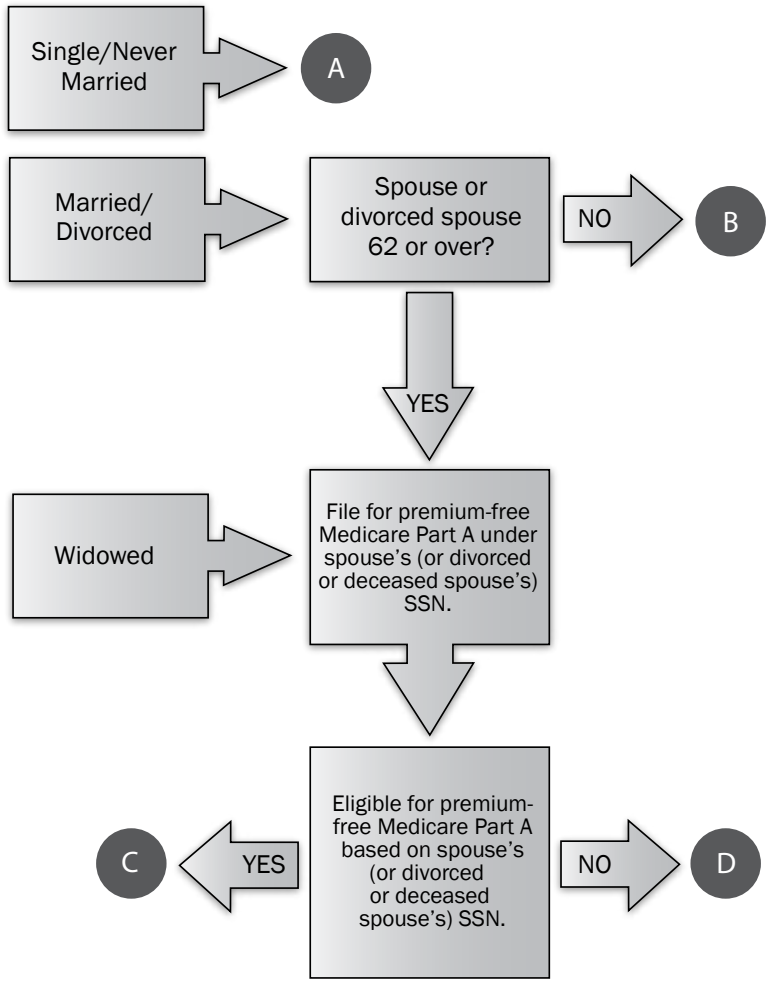
Share the following with the beneficiary in response to this question:

The Social Security Administration sends you a Notice of Award, a Disapproved Claim, or both, after you apply for Medicare.

- A *Notice of Award* is an official letter that states you're eligible for premium-free Part A and enrolled in Part B, eligible for premium-free Part A and not enrolled in Part B, or only enrolled in Part B.
- A *Notice of Disapproved Claim* is an official letter stating you're not eligible for premium-free Medicare Part A.

If you don't sign up for Medicare Part B when you're first eligible, you may have to pay a late enrollment penalty if you decide to or have to sign up later.

Use the diagram below to find out what you need to do to keep your TRICARE coverage. Even if you're not eligible for premium-free Medicare Part A at age 65, you can still sign up for Part B.



To Remain TRICARE Eligible

A. Take your Notice of Award and/or Disapproved Claim, or both, to your local ID card office to update your DEERS record and to get a new ID card. You continue to be eligible for TRICARE Prime and TRICARE Standard past your 65th birthday.

B. Follow instructions for A and sign up for Part B. Then, 3 months before your spouse (or divorced spouse) turns 62, sign up for 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'll get a Notice of Award from the Social Security Administration. Sign up for Part B. Your record in DEERS automatically updates to show your Part A and Part B coverage. Your TRICARE For Life coverage begins on the date you have both Part A and Part B.

D. You'll get a Notice of Award, Disapproved Claim, or both, from the Social Security Administration. This notice is based on your spouse's (or divorced spouse's) SSN. Take the Notice of Award, Disapproved Claim, or both, received based on your and your spouse's (or divorced spouse's) record to your local ID card office to update your DEERS record and to get a new ID card. You continue to be eligible for TRICARE Prime and TRICARE Standard 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 them**
- **Describe how other health insurance (OHI) works with TRICARE**
- **Describe how to resolve claims issues**
- **Identify three reasons for a delay in claims processing or getting an Explanation of Benefits (EOB)**

Key Terms

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

This and the next module (Appeals) applies to health care services, not to pharmacy or dental. See the appendix in the Pharmacy and Dental modules for claims and appeals information. 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 so TRICARE only pays for covered services or supplies from authorized civilian sources of medical care.
- Professional providers include physicians (independent providers or group practice), physical therapists, and other types of providers who meet certain criteria.
- 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 authorized providers may file claims. However, **the beneficiary is ultimately responsible for making sure claims are timely filed**.
- The spouse, parent, or legal guardian of a minor (under age 18) or an incompetent beneficiary may submit claims for dependent family members (certain restrictions apply).

2.1 Filing Deadlines

- Beneficiaries should file claims as soon as possible after getting care.
- Claims have to be filed.

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

Note: There are no filing deadlines for active duty service members' (ADSMs') claims.

- If a claim is denied for lack of timely filing, the beneficiary needs to follow the instructions on how to file an appeal. These come with the denial.

3.0 Submitting Claims

- Providers/beneficiaries submit claims to the claims processor based on the beneficiary's address or Prime enrollment region, except overseas and TFL.
- The overseas contractor's claims processor handles all overseas claims.
- The TRICARE for Life (TFL) contractor processes claims for beneficiaries with Medicare and TRICARE, even if they are Prime enrollees.

- There are two major TRICARE claims processors:

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

- Network providers file claims for beneficiaries.
  - The beneficiary has to make sure a claim is timely filed.
  - If a network provider doesn't meet the claims filing deadline, the network provider can't bill the beneficiary for services.
- Non-network providers don't have to file claims, but may do so.
  - The beneficiary has to make sure the claim is timely filed.
  - The beneficiary pays all costs if the provider doesn't meet filing deadlines.
- If a claim goes to the regional contractor instead of the claims processor, the contractor forwards the claim.
- If sent to the wrong claims processor, the claims processor forwards the claim to the right claims processor or returns it to the sender.
- Beneficiaries need to give providers up-to-date contact information so claims go to the right claims processor and so beneficiaries get payments, explanations, instructions, or other information.

Note: For US Family Health Plan (USFHP) claims information, see the *TRICARE Options* module. 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 civilian care and prescription drugs. If a provider uses this form, the contractor sends the claim back. (See Section 4.2 for more information.)

- *DD Form 2642* is available for download at:
  - TRICARE website: www.tricare.mil/forms
  - PGBA website: www.myTRICARE.com
  - WPS website: www.TRICARE4u.com
- Beneficiaries call the regional contractor to get a *DD Form 2642*.
- Beneficiaries must submit a separate claim for:
  - Each episode of care
  - Services from different providers
  - Each family member, even if 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 be for more than one medication.

4.2 Providers

- Stateside:
  - Professional providers use the current CMS 1500, *Health Insurance Claim Form*.
  - Institutional providers use the current CMS 1450, *Health Insurance Claim Form*.
- Overseas providers are asked, not required, to submit a CMS form.

4.3 Items That Accompany a Claim

Beneficiaries need to attach the following to their claim form:

- An itemized bill from the provider with diagnosis and procedure codes for billed services/supplies. This must be on the provider's letterhead or on a standard form with the provider's tax ID number.
- A list of pharmacy charges written on the pharmacy's letterhead or bill.
- Proof of payment 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 information, which may include a payment determination, denial statement, or Explanation of Benefits (EOB) (See Section 8.0)
- *Statement of Personal Injury—Possible Third-Party Liability, TRICARE Management Activity* (DD Form 2527)
  - Required when it appear's a beneficiary's care is possibly accident related, work related, or both, and when certain procedure or diagnostic codes show a third-party may be responsible for payment.
  - Beneficiaries must submit the *DD Form 2527* with the initial claim within 35 days after getting the form from the claims processor.
  - If the *DD Form 2527* isn't submitted on time, the claim may be suspended and not processed until the claims processor gets the form.

?	Emily was referred to a non-network specialist. He told the Stewarts that his office doesn't file claims, meaning the Stewarts have to file the claim. What must the Stewart's send to the claims processor?

5.0 Claims Processing Considerations

There are claims processing standards and the claims processor is only to pay for covered services, per law and regulation.

5.1 Processing Criteria

Claims processors reviews claims using the following payment criteria (in the order given):

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 an approved clinical preventive service.
6. The beneficiary has to pay his or her portion 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 when the contractor checks for eligibility; ***and***
  - The sponsor is/was TRICARE eligible on the date(s) of service on the newborn's claim
- 366 days after the date of birth, claims are denied until the child is registered in DEERS.
- 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) 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.
  - If the family submits the form on day 61 or later, TRS/TRR coverage starts the month after the application is received, so some newborn claims would be denied.
- See Appendix A of the *Key TRICARE Concepts and Terms* module for more on newborn eligibility.

6.0 TRICARE Overseas Program (TOP) Prime Remote Claims

The following table describes some unique processes for TOP claims.

TOP Prime Remote Claims

● The overseas contractor's Call Centers serve as Primary Care Managers (PCMs). They arrange and authorize care with qualified purchased care/host nation providers.
● When authorized, the provider submits the claim to the overseas claims processor and it's processed as "cashless-claimless" for TOP enrollees.
  ○ When TOP Prime Remote-enrolled ADSMs seek care without an authorization, their claims are denied. In these cases, reimbursement should come through the ADSM's service-specific fund.
  ○ When enrollees get authorized care from other than the contractor-identified provider, enrollees pay up front and file their own claims for reimbursement.
● The TOP Prime Remote procedure for overseas claims coordinated through a TOP Prime Remote Point of Contact (POC):
  ○ The POC helps complete and submit claims, but they can't sign forms for enrollees.
  ▪ The overseas contractor sets up 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 to give 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 the 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 pays 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, attaching a copy of the OHI plan's EOB and the itemized bill to the claim form.
- Beneficiaries are to let MTF staff, contractors, or claims processors know they have OHI and when their OHI changes. The claims processor may delay processing or later recoup payment if it appears the beneficiary has OHI.
- When the OHI doesn't cover a procedure or service TRICARE covers, the claim has to include a copy of 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; TRICARE pays last.
  - Beneficiaries submit the 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 a claim processes, the beneficiary and provider each receive a TRICARE EOB 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 most 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 claims are timely filed. If the provider says a claim was sent, the beneficiary and provider 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 (hospitals and ambulance companies don't share insurance information).

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 submitted the claim late
- Diagnosis is missing or doesn't match 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
- No authorization on file
- Provider's unique Provider Identification Number or National Provider Identification is missing
- Eligibility is questioned or DEERS information isn't correct

8.3 Importance of Reviewing EOBs

- Beneficiaries should carefully compare each EOB with services they received and their bills, checking the provider's name, services received, the services, dates, etc and TRICARE payment or denial.
  - Beneficiaries should call 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 may indicate fraud.
- Beneficiaries may contact the regional contractor or claims processor by phone or secure e-mail.
- Beneficiaries may also get help from a military treatment facility (MTF) or regional Beneficiary Counseling and Assistance Coordinator (BCAC) or Debt Collection Assistance Officer (DCAO).

8.4 Components of an EOB

- **Claims Processor:** Self-explanatory. This may be important. Example: A claim could be denied or process as POS if sent to the wrong processor.
- **Date of Notice:** The EOB date.
- **Mail to Name and Address:** The beneficiary's (or beneficiary's parent's or guardian's) address as noted on the provider's claim form. The claims processor mails the EOB to this address.
- **Claim Number:** Unique claim number; used for claims 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. Only the last four digits of the SSN appear on the EOB.
- **Beneficiary Name:** The person the provider treated.
- **Service Provided By:** Provider (person, practice, facility) name.
- **Services Provided:** Procedure code(s) and brief description.
- **Date of Services:** Dates the provider saw/treated the beneficiary.
- **Amount Billed:** What the provider charged for a particular service(s).
- **TRICARE Allowed:** This is the amount TRICARE pays based on date and location of service and provider status (network vs. non-network).
- **See Remarks:** Number or code for a claim action; look at the "Remarks" section for the description and explanation.
- **Claim Summary/Beneficiary's Name:** A summary of claims costs. It includes the following: amount billed, amount allowed by TRICARE, non-covered amount (if any), amount OHI/Medicare paid (if applicable), what TRICARE paid, cost-share/copay (if any), what the deductible is (if any), beneficiary responsibility (e.g., deductible+cost-share/copay+costs for non-covered services [if any]).
- **Out-of-Pocket Expense:** Shows how much the beneficiary/family has paid for health care services as of the EOB date and how much has gone towards the catastrophic cap (the most the beneficiary/family pays for out of their own pockets per fiscal year). Claims processors and the pharmacy contractor determine, track, and report beneficiaries' out of pocket costs to DEERS.
- **Remarks:** Explains the numbers or codes listed in "See Remarks" section
- **Paid To:** Indicates who the claims processor sent the check to. This can be the provider, or beneficiary, based on the provider's status and how the claim was filed. If a network provider, the check goes to the provider; if a participating provider, the check goes to the provider; if a non-participating provider, the check goes to the beneficiary who then pays the provider; if the beneficiary paid up front, the check goes to the beneficiary.
- **Amount Paid:** What TRICARE paid.
- **Check Number:** Self-explanatory.

8.5 Application Exercises

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

Answer the questions below based on the fictional EOB provided.

1. What's the EOB date?

2. Who's the sponsor?

3. Who got care?

4. Who saw the beneficiary and what happened during the visit?

5. How much did the provider bill?

6. How much does TRICARE pay for these services and what is the term for this amount?

7. What do the remark codes show?

8. How much did the government pay?

9. What's the deductible?

10. What's 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. Mrs. Smith filed her claim and received her EOB, along with a check for $60. She is upset because she didn't get back the full $200. Mrs. Smith wants this taken care of now!.

Based on her EOB and your knowledge, 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. If TRICARE doesn't pay, the EOB shows no beneficiary liability because the claim/item was actually 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, 2015
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.	11/29/2014	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, 2014	Met To Date	Limit	Beginning October 1, 2014	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 solve claims problems, beneficiaries should call their claims processor or regional contractor.
- The beneficiary may contact an MTF or TRICARE Regional Office (TRO)/TRICARE Area Office (TAO) BCAC to review his or her case and get help if possible.
- If a beneficiary gets sent to collection, he or she should first contact the regional contractor to find out why he or she owes the provider and if anything can be done to fix the claim, 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 claims for their region.

9.1 Helping the Beneficiary with Claims Issues

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

- What was the date of service? What was the beneficiary's eligibility or category on that date?
- What care did the beneficiary get (e.g., appointment, hospitalization, medications given in a provider's office, supplies)?
- Was this inpatient or outpatient?
- Did the beneficiary contact the claims processor to get answers to questions (e.g., regional, dental, pharmacy)? If yes, what did they learn?
- Did the beneficiary bring his/her EOB, summary payment voucher, or bill?
- If there's an EOB, study the notes to see 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 you have access) or call the claims processor. If a provider didn't file a claim, tell the beneficiary to ask the provider's office to do so or send an itemized bill (with a diagnosis code listed) to the beneficiary to file a claim. If the claim processor didn't receive the claim, the beneficiary or the provider may resubmit the claim.

- 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 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:
  - Investigates certain cases for the DHA
  - Manages the DHA anti-fraud program
  - Coordinates and controls national cases, working 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.
- Fraud may be:
  - Submitting claims for services not delivered or used
  - Filing false claims or medical records
  - Showing incorrect dates, frequency, duration, or description of services
  - Billing at a higher rate than needed for a less costly service
  - Seeking unnecessary 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, or exclusion (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 usually 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 isn't 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 to submit them**
- **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 details for the stateside regional contractor's explanation of benefits (EOB). A sample EOB for each regional contractor is on the following pages. Use the information listed below as an aid when looking at 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).
3. **Mail-to Name and Address:** The TRICARE EOB is mailed directly to the person (or parent or guardian for minors) at this address and noted on the provider's claim form.
4. **Date of Notice:** The date PGBA prepared the EOB.
5. **Insured ID:** The ID of the individual (active duty, retired, or deceased).
   The 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 ID appear on the EOB.
6. **Patient Name:** Self-explanatory.
7. **Claims Processed From:** The date range for claims shown in the EOB.
8. **Provider of Service:** Name of the provider.
9. **Total Paid This Reporting Period:** What TRICARE paid the provider.
10. **Total Patient Responsibility:** What the beneficiary owes the provider.
11. **Benefit Period Summary:** Shows the individual and family annual deductible and maximum out-of-pocket expense (catastrophic cap) 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:** Self-explanatory.
13. **Patient Name:** Self-explanatory.
14. **Insured ID:** The last four digits of the ID.
15. **Provider:** The person/facility who treated the beneficiary.
16. **Amount Other Insurance Paid:** The amount the primary/other health insurance paid (if there is also coverage from another health plan).

    Amount You Paid: What the beneficiary paid the provider, as noted on the claim.
17. **Amount Your Provider May Bill You:** What the beneficiary owes (deductible, co-pay, cost share).

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

    Amount Paid To You: What TRICARE paid the beneficiary.
18. **Claim Number:** A unique number 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. 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 contains one or more grouped procedure codes.
22. **Remarks:** If there is a code or number here, refer to the "Remarks" section of the EOB for the code description 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:** A beneficiary's payment due and history. It includes the beneficiary's/family's annual deductible and any copayment or cost-share the beneficiary owes. 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 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, 2015

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 05/12/15 to 06/10/15**

(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 2014.

As of June 7, 2015, 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	End	(20) Service Provided	(21) APC #	Remarks (22)	Your Provider Charged	Allowed Amount (23)	Amount Not Covered	Deductible	Copayment (24)	Cost Share
05/22/15	05/22/15	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
05/23/15	05/23/15	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)

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, 2015

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 05/12/15 to 06/10/15**

(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 2014.

As of June 7, 2015, 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
05/22/15	05/22/15	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
05/23/15	05/23/15	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 | T I

(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, 2015

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 05/12/15 to 06/10/15**

(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 2014.

As of June 7, 2015, 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
05/22/15	05/22/15	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
05/23/15	05/23/15	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

Overseas Region Sample EOB

TRICARE EXPLANATION OF BENEFITS

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

PATIENT NAME
STREET ADDRESS
CITY STATE ZIP

Date of Notice	03/16/2015
Sponsor SSN	XXX-XX-1234
Sponsor Name	Sponsor Name
Patient Name	Patient Name
Claim Number	2015001 1234567
Provider #	Provider Number
Provider Name	Provider Name

If you have questions about this notice, please call
1-877-451-8659 or visit us online at
www.TRICARE-overseas.com

Explanation of Benefits (EOB) **THIS IS NOT A BILL** Explanation of Benefits (EOB)

SERVICES PROVIDED BY	DATE OF SERVICE	AMOUNT BILLED	TRICARE ALLOWED	REMARKS
Provider Name	02/02/15 – 02/19/15	$89292.44	$89292.44	003
Total		$89292.44	$89292.44	

CLAIM SUMMARY		BENEFICIARY SHARE	
TRICARE Amount Billed	$89292.44	Cost Share/Copay	$0.00
TRICARE Allowed	$89292.44	Deductible	$0.00
TRICARE Paid	$89292.44		
Medicare/Other Ins. Paid	$0.00		

OUT OF POCKET EXPENSE:

	Beginning October 1, 2013		Beginning October 1, 2012		Beginning October 1, 2011	
	Limit	Met to Date	Limit	Met to Date	Limit	Met to Date
Catastrophic Cap	$3,000.00	$0.00	$3,000.00	$3000.00	$3,000.00	$3000.00

Remark Codes:

Payment has been made to the beneficiary.

003: If you are not satisfied with our determination, you have the right to request a review within 90 days of the date of this notice. Please send your request and a copy of this notice to the following address: TRICARE Overseas P.O. Box 7992, Madison, WI 53708. You can also submit your request for review on our website, www.TRICARE-overseas.com.

PAID TO	AMOUNT PAID	AMOUNT YOU OWE
Payee Name	$89292.44	$0.00

TRICARE Fundamentals Course

Appeals

11

Participant Guide

References

2008 TRICARE Operations Manual, Chapters 12–13

Module Objectives

- **Explain who can file an appeal**
- **Separate 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 denials and appeal notices tell how, where, and by when to file the next appeal.

1.0.1 Provider Sanction

A sanctioned provider is a provider who is denied approval as a TRICARE-authorized provider or whose status as an authorized provider is ended, limited, or suspended.

- Providers may be sanctioned by TRICARE for:
  - Failure to maintain credentials
  - Provider fraud
  - Abuse
  - Conflict of interest
  - Other reasons
- Only the provider or his/her representative can appeal the sanction.
- If appealed, 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?

- A TRICARE eligible beneficiary, including:
  - A parent or guardian of a beneficiary under age 18
  - The guardian of a beneficiary who can't act on his or her own behalf
- A health care provider who was:
  - Denied approval
  - Suspended, limited, or is no longer a TRICARE-authorized provider
- TRICARE-participating providers (except network providers who appeal to the contractor they have a contract with or a state court)
  - Non-network providers are considered participating when appealing pre-admission/pre-procedure denials (before services are delivered)
  - Non-network, non-participating providers can't file appeals
- A representative, as noted in a written document from a beneficiary or provider
  - While a provider can't file an appeal for a beneficiary, a beneficiary can appoint a provider as a representative. The beneficiary has to complete and send in 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's an immediate family member)

1.2 What May Be Appealed?

- Facts that may be appealed:
  - Diagnosis
  - The need for inpatient care
  - Pre-authorization denials
  - TRICARE payment denials
  - Denial/ending of TRICARE coverage/payment for services, treatments, or supplies authorized in the past
  - 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 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 work valid eligibility denial determinations through the sponsor's branch of service.)

2.0 Appeals Process

- When filing an appeal, the appealing party sends a package to the contractor, asking for reconsideration. The package must include a cover letter with case information, a copy of the denial letter, Explanation of Benefits (EOBs), claims, bills, clinical notes, medical history, and/or documents the appealing party thinks support reversing the denial decision.
  - Not including a copy of the denial letter may delay the review or result in the appeal going to the wrong location.
  - If appealing parties can't get all supporting documents in on time, they should send in the appeal anyway and in the cover letter state they plan to send additional information.
  - The appealing party should keep originals of all appeal paperwork.
- See the chart on the following page for more on medical necessity and factual determination appeals.

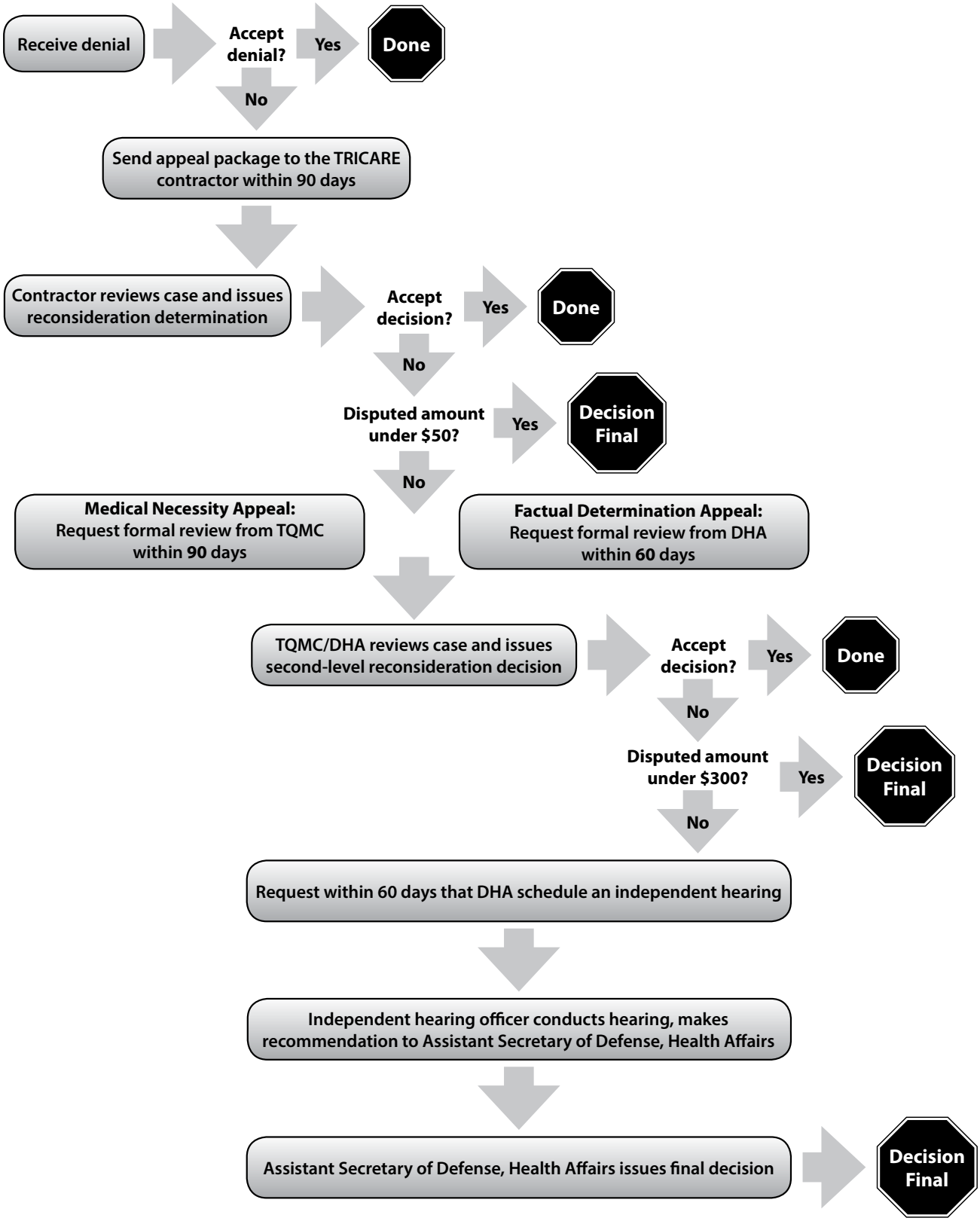
2.1 Appeals of Medical Necessity

- Appeals of medical necessity address whether care is appropriate, reasonable, and adequate for the beneficiary's condition, including inpatient, outpatient, specialty, custodial care, and mental health services.
- The TRICARE Quality Management Contractor (TQMC) reviews appeals of medical necessity and issues second-level reconsideration decisions.

2.2 Appeals of Factual Determination

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

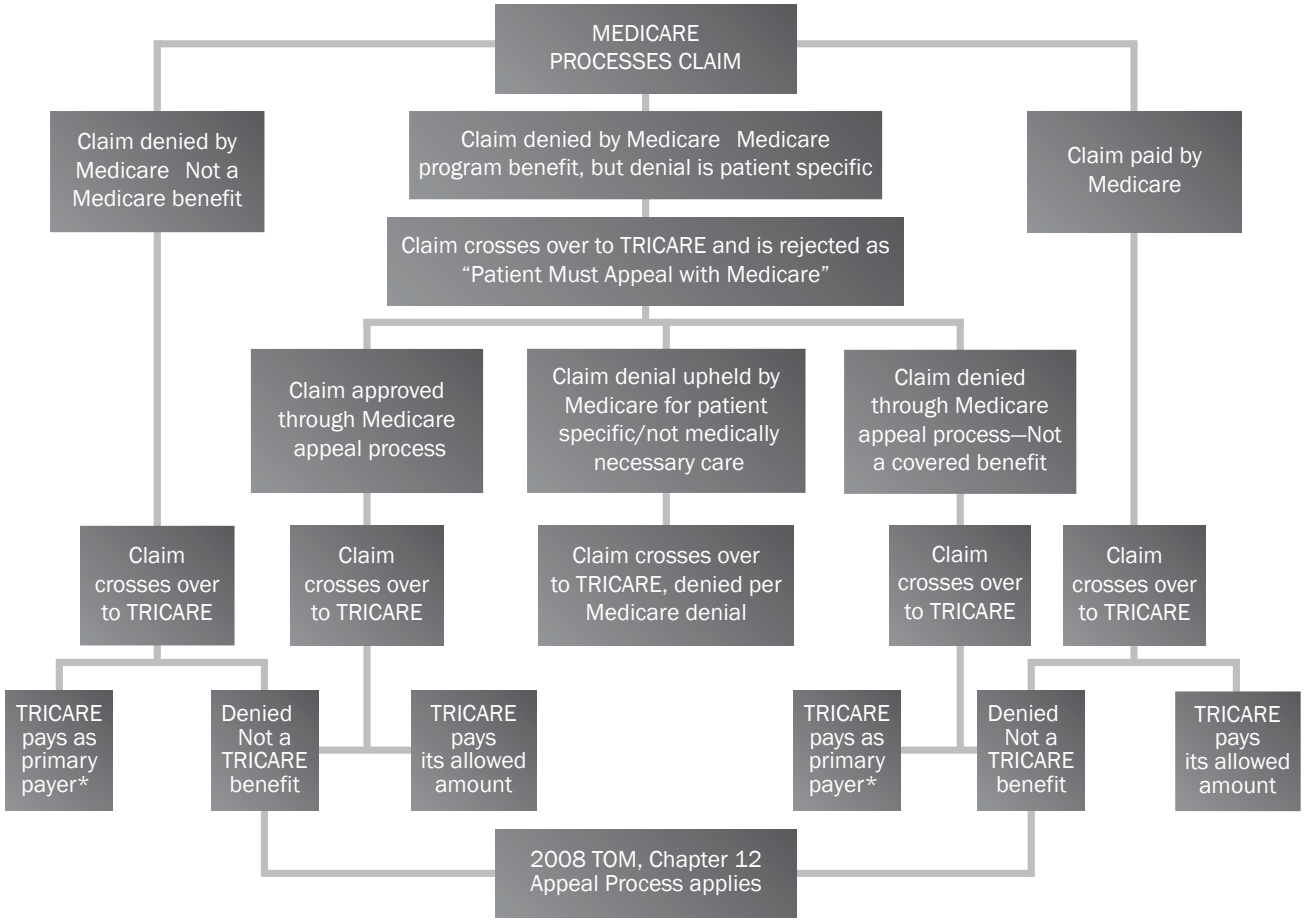
TRICARE Appeals Process*



* *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 beneficiary can file an appeal with Medicare.
  - If Medicare decides to pay based on the appeal, TRICARE then reviews for payment consideration.
  - TRICARE considers payment 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 TPR location (stateside or overseas) doesn't get prior authorization before getting specialty care, his or her claim may be denied.
  - The ADSM may appeal by first contacting:
    - The Defense Health Agency – Great Lakes (DHA-GL) (formerly known as the Military Medical Support Office [MMSO]) if the member received care in the United States or the U.S. Virgin Islands or under TRICARE Prime Remote.
    - MTF staff if care was based on an MTF referral or the ADSM shows as an MTF Prime enrollee 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

      Defense Health Agency-GL
      Suite 304
      2834 Green Bay Road
      North Chicago, IL 60064-3091

    - 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 appeal is denied, ADSMs may then appeal to their service Surgeon General or the senior medical officer of their respective service. The address for this second level appeal is in the first appeal denial letter.

5.0 Summary

5.1 Where to Get Additional Claims and Appeals Information for Beneficiaries

Direct beneficiaries to the:

- TRICARE contractor or claims processor
- DHA-GL (stateside and Virgin Island TPR ADSMs only)

5.2 Beneficiary Appeals Checklist

When helping beneficiaries with an appeal, tell them they must:

- Meet filing deadlines
- Send the appeal in writing with signatures
- Include copies of all supporting documents with the appeal (If all paperwork isn't available, send the cover letter and as many documents as possible by the deadline and note more information will be sent; then send it in a timely manner.)
- Keep originals or copies of everything (e.g., EOB, letter denying prior authorization)
- Include a copy of the most recent denial letter with 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

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Participant Guide

1.0 Important TRICARE Resources

1.1 Important Websites for Customer Service Staff

TRICARE Website	www.tricare.mil
DHA and MHS Website	http://www.health.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	https://www.express-scripts.com/static/formularySearch/2.0/#/formularySearch/drugSearch
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
TRICARE Resources	http://www.tricare.mil/Resources.aspx

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.HumanaMilitary.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 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 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 Toll-free: 1-888-777-8343 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

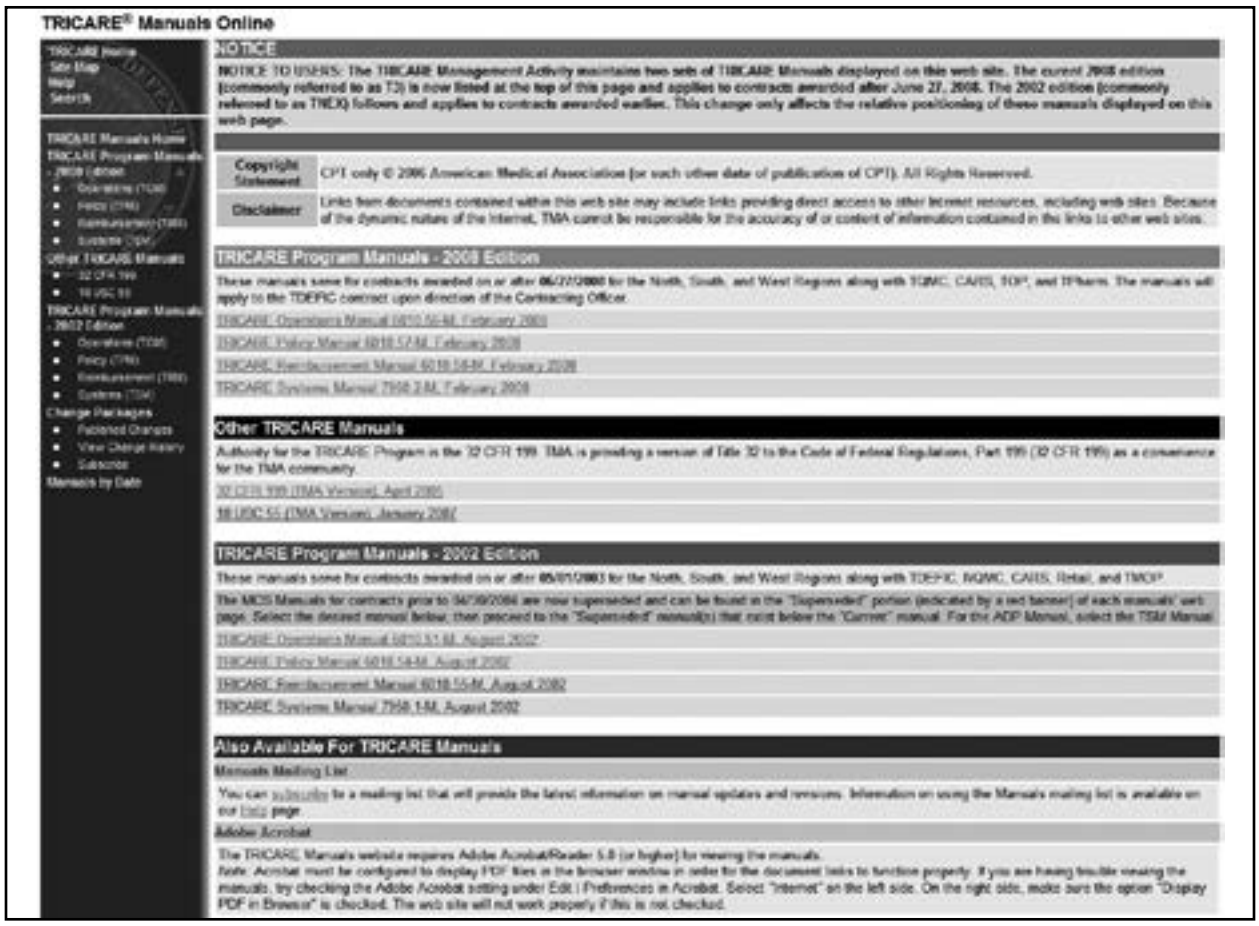
1.5 TRICARE For Life

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 TRICARE benefit information. Manuals are found at http://manuals.tricare.osd.mil and are kept up to date on published changes. Contractor's can't carry out changes until directed by their 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.



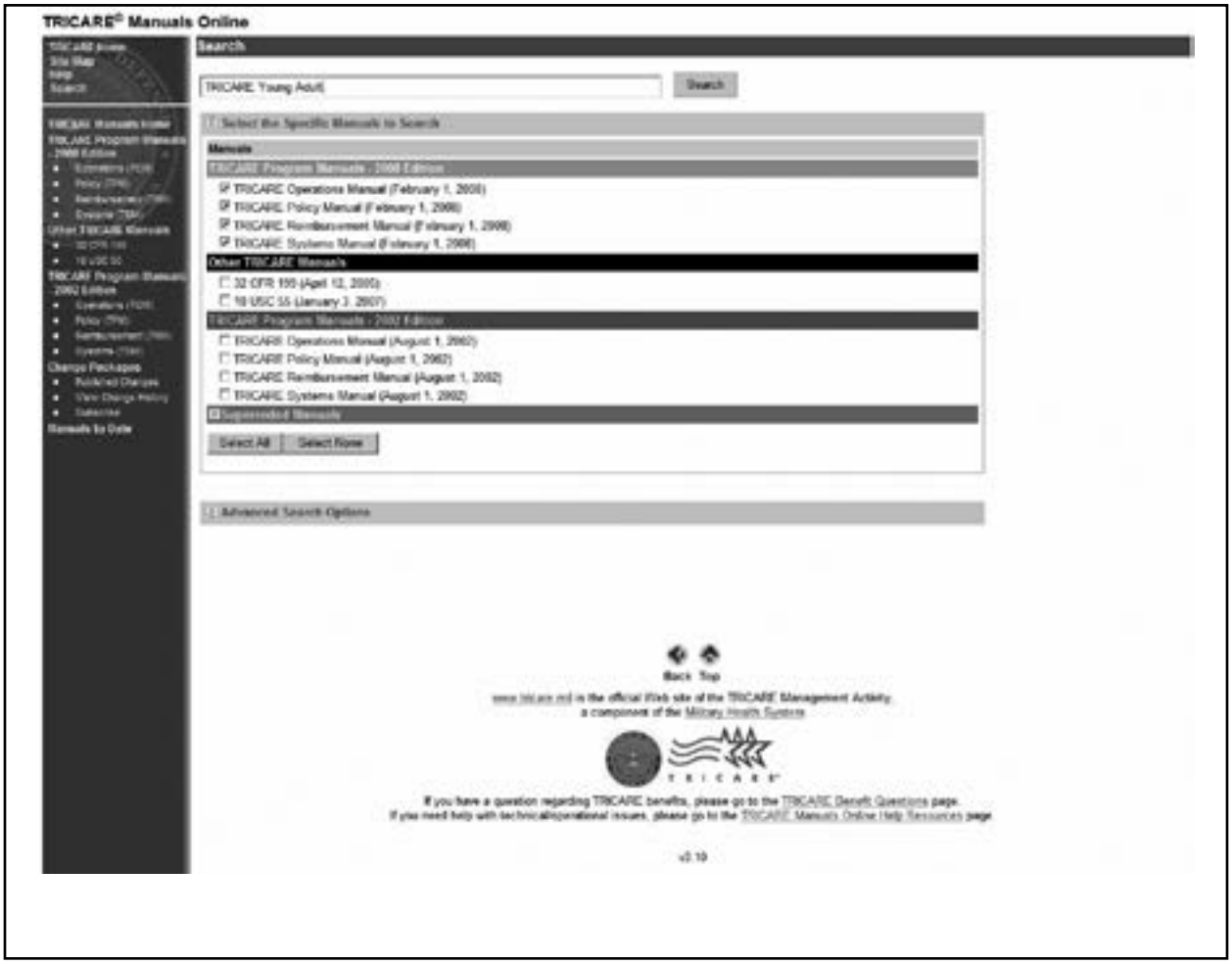
2.1 Basic Search

The TRICARE Manuals website lets you search for benefit information.

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

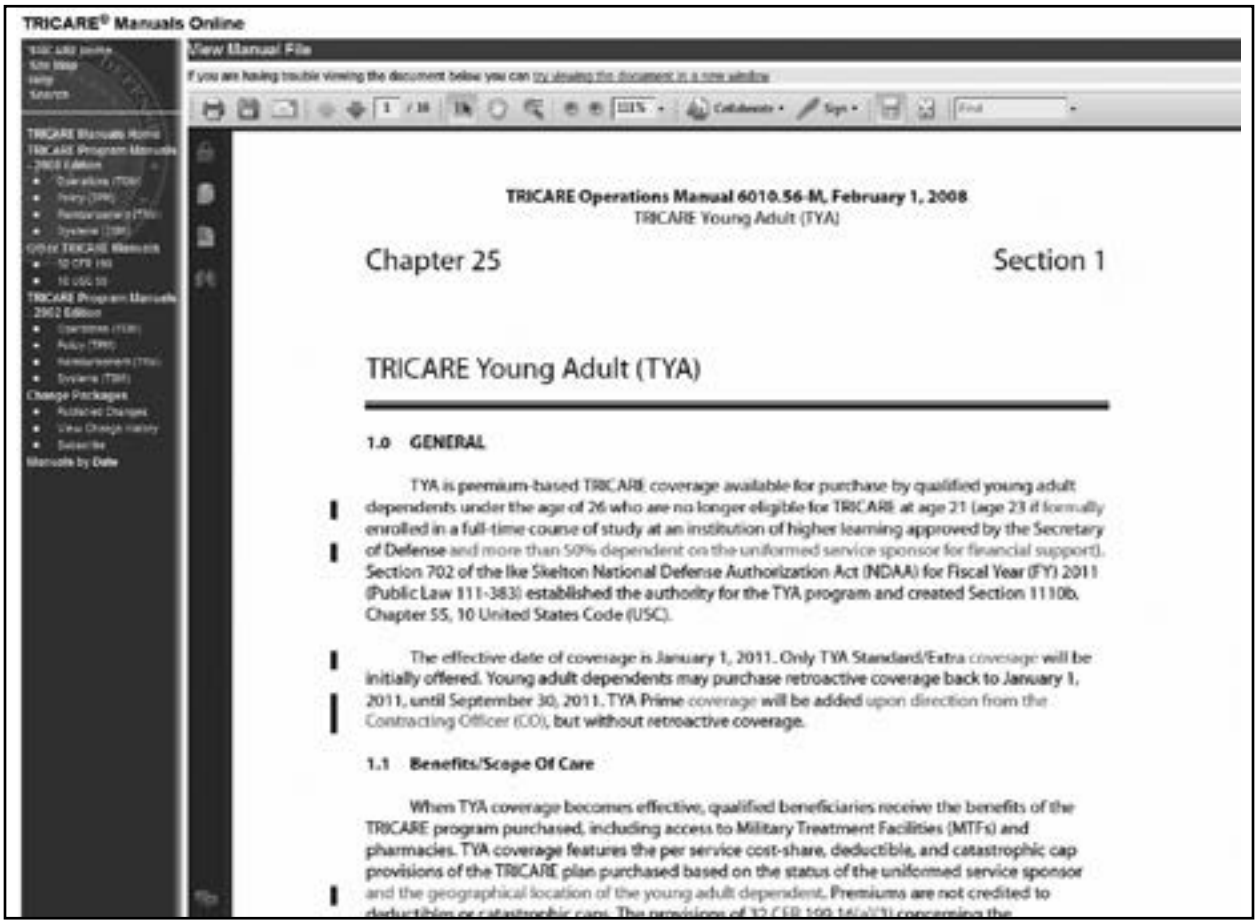
2.1.1 Enter a search string (e.g., TYA) and select the manual(s) you want to search

- To find current benefit information, use the default search setting “Search most recent version of the selected manuals” located in the Advanced Search Options drop down.
- Try to make the search string as specific and simple as possible. The more words you use, the less likely you are to find what you’re looking for (the search engine looks for the string of words you entered). You’re more likely to find what you’re looking for by using short entries and unique words.



2.1.2 The website displays a list of manual content containing terms from the search string

2.1.3 The website displays the selected manual section



2.2 Subscribing to Manual Updates

To register for manual updates, visit 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

Some mobile applications (may not be available on all devices):

- milConnect Mobile, provided by DMDC
- Express Scripts

3.3 Defense Health Agency (DHA) – Great Lakes (DHA-GL) (formerly known as MMSO)

Army, Air Force, Navy, Marine Corps, and Coast Guard	1-888-647-6676 http://www.health.mil/About-MHS/Defense-Health-Agency/Healthcare-Operations/TRICARE-Health-Plan-Division/Defense-Health-Agency-Great-Lakes [Insert branch of Service] Point of Contact Defense Health Agency-GL Suite 304 2834 Green Bay Road North Chicago, IL 60064-3091
United States Public Health Service (USPHS)	1-800-368-2777, opt. 2

DHA-GL Medical Eligibility Verification Reserve Component Form
http://www.health.mil/About-MHS/Defense-Health-Agency/Healthcare-Operations/TRICARE-Health-Plan-Division/Defense-Health-Agency-Great-Lakes

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	https://www.express-scripts.com/static/formularySearch/2.0/#/formularySearch/drugSearch
Pharmacy Operations Division	http://www.health.mil/pod 1-210-295-1271 (DSN: 421-1271)

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
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 2606 Virginia Beach, VA 23450-2606	Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 9530 Virginia Beach, VA 23450-9530
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	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 16041 E. Centretech Parkway Aurora, CO 80011-9066 Fax: (303)-676-3981 http://www.health.mil/fraud	
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

Proof of TRICARE Coverage	
MilConnect website: http://milconnect.dmdc.mil 1-800-538-9552 (say “proof of insurance”) Fax: 1-831-655-8317, TYY/TDD: 1-866-363-2883	Written Requests: Defense Manpower Data Center Support Office (DSO) 400 Gigling Rd Seaside, CA 93955-6771

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)	http://health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties E-mail: PrivacyOfficerMail@dha.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
ACA	Affordable Care Act
ACD	Autism Care Demonstration
ACN	Appointment Control Number
ADA	American Dental Association
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
ALS	Advanced Life Support
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 and Assistance Coordinator
BLS	Basic Life Support
BMI	Body Mass Index
BRAC	Base Realignment and Closure
BWE	Beneficiary Web Enrollment
CAC	Common Access Card
CACD	Comprehensive Autism Care Demonstration
CAP	Computer/Electronics Accommodation Program
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 (now known as TRICARE)
CHCBP	Continued Health Care Benefits Program
CMAC	CHAMPUS Maximum Allowable Charge
CMS	Center for Medicare and Medicaid Services
CO	Contracting Officer
COBRA	Consolidated Omnibus Budget Reconciliation Act
CONUS	Continental United States
COR	Contracting Officer’s Representative
CRSC	Combat-Related Special Compensation
CPT	Current Procedural Terminology
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
DHA-GL	Defense Health Agency, Great Lakes
DHHQ	Defense Health Headquarters
DHP	Defense Health Program
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 Transfer
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
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
HMO	Health Maintenance Organization
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)
MEC	Minimum Essential Coverage
MHS	Military Health System
MOH	Medal of Honor
MSN	Medicare Summary Notice
MTF	Military Treatment Facility
NAL	Nurse Advice Line
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
PHI	Personal Health Information
PHS	Public Health Service
PII	Personal Identifying Information
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
RAPIDS	Real-Time Automated Processing Identification System
RC	Reserve Component
RCPTA	Reserve Component Purchased TRICARE Application
RD	Regional Director
RTC	Residential Treatment Center
RVU	Relative Value Unit
SAS	Specified Authorization Specialist
SELRES	Selected Reserve
SF	Standard Form
SG	Surgeon General
SNF	Skilled Nursing Facility
SOFA	Status of Forces Agreement
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)
TLAC	TRICARE Latin America and Canada
TMA	TRICARE Management Activity (abolished October 1, 2013)
TMAC	TRICARE Maximum Allowable Charge
TMOP	TRICARE Mail Order Pharmacy
TOL	TRICARE Online
TOM	TRICARE Operations Manual
TOP	TRICARE Overseas Program
TOPD	TRICARE OCONUS Preferred Dentists
TOP POC	TRICARE Overseas Program Point of Contact
TPL	Third Party Liability
TPM	TRICARE Policy Manual
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TQMC	TRICARE Quality Monitoring Contract
TRDP	TRICARE Retiree Dental Program
TRM	TRICARE Reimbursement Manual
TRO	TRICARE Regional Office
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy Benefit
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TSM	TRICARE Systems Manual
TTY	Teletypewriter
TYA	TRICARE Young Adult
UCCI	United Concordia Companies, Inc.
URFS	Unremarried Former Spouse
USERRA	Uniformed Services Employment and Reemployment Rights Act
USFHP	US Family Health Plan
USMTF	Uniformed Services Military Treatment Facility

USPHS	United States Public Health Service
VA	Veterans Affairs/Administration
VHA	Veterans Health Administration
WIC	Women, Infants, and Children Overseas Program
WPS	Wisconsin Physicians Service
WSM	Wounded Service Member
WTU	Warrior Transition Unit
WWR	Wounded Warrior Regiment

TRICARE Fundamentals Course

Definitions

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Participant Guide

References

2008 TRICARE Operations Manual, Appendix B

The following glossary lists and defines common terms used when working with TRICARE beneficiaries. It doesn't include any and all definitions. For additional terms, you may need to check the TRICARE manuals at http://manuals.tricare.osd.mil.

20th-of-the-Month Rule

The 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 after the contractor received the form.

Note: The form must be received and in processing by the 20th of the month, not postmarked by the 20th.

Access Standards

Set standards for accessing care 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, a Prime enrollee's primary care manager should be within a 30-minute drive of the enrollee's home (under normal driving conditions); specialty care should be available within one hour drive time.

Active Duty Service Member (ADSM)

An individual serving in one of the seven uniformed services of the United States under a call or order that isn't for 30 days or less.

Adjunctive Dental Care

Medically necessary dental care to treat a covered medical (not dental) condition; is part of the treatment of the condition, or is needed for or, as the result of, dental trauma that may be or is due to treatment of an injury or disease.

Appeal

A formal written request by a beneficiary, a participating provider, a provider denied TRICARE authorized provider status, or a designated representative, to make a decision about denied coverage, payment, or status.

Authorization for Care

The determination that a 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 licensed by a state, accredited by a national organization, or meets other standards of the medical community, and certified to deliver TRICARE-covered services. The beneficiary is responsible for finding out whether a provider is TRICARE-authorized. Regional contractors verify a provider's authorized/certified (overseas) status before they pay on a claim.

Balance Billing

Occurs when a provider bills the difference between billed charges and what TRICARE, other health insurance, and the beneficiary paid. 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 eligible by the respective uniformed services. Family members include spouses and children (biological, adopted, or step) up to age 23, depending on the child's eligibility.

Benefit

The TRICARE benefit consists of those services, to also include payment amounts, cost-shares, and copayments, authorized by Title 10 and carried out through 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 diagnosing and treating an illness or injury, including maternity care and well-baby care. Benefits include specific medical services and supplies 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 to answer questions and help solve TRICARE-related problems

Billed Charge

The total cost of care from a provider, without discounts or reduced fees.

Beneficiary Liability

The legal requirement of a beneficiary, his or her estate, or family member to pay for TRICARE-covered services. Beneficiary liability includes deductibles, copayments, cost-shares, amounts above the TRICARE-allowable charge when a beneficiary uses a non-participating provider, and costs for services and supplies TRICARE doesn't cover.

Cashless-Claimless

TRICARE Overseas Program (TOP) Prime/TOP Prime Remote experience when enrollees get prior-authorized care from an identified, certified host nation provider. The provider files the claim and the TOP contractor pays the provider. The enrollee doesn't have to pay up front/out-of-pocket or file a claim. (The enrollee **is** responsible for making sure a claim is filed and processed, as per his or her EOB).

Catastrophic Cap

The most a TRICARE beneficiary pays out of pocket for TRICARE-covered services per fiscal year (October 1–September 30). The following aren't included in the catastrophic cap:

- Point-of-service cost-shares and deductibles
- The additional 15 percent above the TRICARE-allowable charge to non-participating providers
- TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult premiums
- Costs for services 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 eligible under the Department of Veterans Affairs.

Claim

A document requesting payment from a beneficiary, a beneficiary's representative, or provider for health care services, prescription medications, and medical equipment and supply items.

Clinical Preventive Services

Services, such as health screenings and examinations, meant to keep individuals healthy or to discover health problems in a timely manner. Preventive services include pap smears, mammograms, colorectal cancer exams, prostate cancer exams, cholesterol tests, and vaccinations

Confidentiality Requirements

The procedures and controls protect the confidentiality/privacy of medical information as required by 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, by law, activates or retains members of the uniformed services 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 offering health coverage for 18 to 36 months after TRICARE eligibility or premium-based program coverage ends for certain former beneficiaries.

Contractor

An organization the Defense Health Agency contracts with for delivery and payment for services and administrative support, such as enrollment/application processing, quality monitoring, or customer service.

Coordination of Benefits

The process in which TRICARE waits until all other coverage plans (other health insurance, Medicare) complete their claims' process before taking action as secondary coverage and payer. Exceptions where TRICARE is first payer: 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 from civilian providers and beneficiaries pay for prescription drugs.

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 a reconsideration determination, formal review determination, or hearing final decision is made.

Debt Collection Assistance Officer (DCAO)

Individuals 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 per fiscal year for outpatient services before TRICARE begins cost-sharing (doesn't apply to Prime options).

Defense Enrollment Eligibility Reporting System (DEERS)

A DMDC system that reflects personnel, eligibility, enrollment, and catastrophic cap information. Beneficiaries are responsible for making sure DEERS records are correct.

Defense Health Agency (DHA)

A Department of Defense Combat Support Agency, established October 1, 2013, responsible for shared services, functions, and activities of the Military Health System (MHS) and other common clinical and business processes.

Defense Health Agency, Great Lakes (DHA-GL)

The 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. DHA-GL also authorizes care for a line of duty injury, illness, or condition for inactive Guard/Reserve.

DMDC

The office responsible for the Defense Enrollment Eligibility Reporting System (DEERS) and TRICARE eligibility. DMDC also notifies beneficiaries about their health care plan status, as well as loss of eligibility.

Demonstration

A study or test project looking at other methods of delivery and payment for proposed health care services. After the demonstration ends, TRICARE decides whether the proposed change becomes a TRICARE benefit.

Dental Treatment Facility (DTF)

Uniformed service facility that provides dental care, primarily to active duty service members. DTFs may see other beneficiaries based on capacity and capability.

DoD Benefit Number (DBN)

A unique 11-digit family member identifier that ties a family member to a sponsor and identifies the ID 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 of identifying a specific individual.

Double Coverage

Coverage of a TRICARE beneficiary by another insurance, medical service, or health plan that may also cover 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 without 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 covered under a TRICARE Prime option (including the US Family Health Plan).

Enrollment Fees

The amount paid by some 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 address, 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 for family members 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, showing the actions taken on a claim.

Exclusion

Exclusion means TRICARE can't pay on non-covered items, services, and/or supplies.

Extended Care Health Option (ECHO)

ECHO is a supplemental program to the TRICARE basic program. ECHO serves as an additional financial resource for qualified active duty family members for select services and supplies designed to address 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 of a home bound family member.

Fee for Service (FFS)

A method in which doctors and other health care providers are paid for each service. Beneficiaries may have to pay out of pocket and file for reimbursement.

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, that gives individuals the right to access information from the federal government. TRICARE and its contractors have to follow this law.

Grievance

A written complaint by a beneficiary 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 were not actually eligible on the dates of service. (The ineligible person usually possesses an erroneous or illegal identification card.) To receive a good faith payment, the civilian provider must show he or she used reasonable measures to identify a person as eligible (e.g., copy of ID card, online inquiry) and bill the former beneficiary for services.

Health Benefits Advisors (HBAs)

Individuals at military treatment facilities (on occasion at other locations) who provide general information on availability and access to care in the uniformed services, direct medical care system, and information on TRICARE benefits. May also be the MTF BCAC

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 type of health plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care, unless authorized or for emergency care. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. The TRICARE Prime options are similar to HMOs. .

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 facility to receive necessary medical care, with the patient remaining 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 in any format (e.g., letter, memorandum, note attached to a claim). Allowable charge complaints, grievances, and appeals aren't included in this definition.

Managed Care Support Contractor (MCSC)

Regional contractors supporting the Military Health System. The contractor's required to provide health, medical, and administrative support services.

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 as to its 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 limited 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 non-formulary drug shouldn't be used because it may be harmful to the person (based on other drugs being taken, medical condition(s), etc.).
- The beneficiary experiences, or is likely to experience, significant harmful effects from the formulary alternative, and is likely to be able to take the non-formulary drug without side effects.
- The formulary alternative doesn't provide the expected clinical results, 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 pose unacceptable clinical risk
- There is no formulary alternative

Medicare-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 for 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 has 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 doesn't 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 need care the MTF doesn't offer, the MTF refers the enrollee out for civilian care; the regional contractor then reviews the referral and authorizes or denies care.

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 payment 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. The agreements for health care delivery made between the contractor and military treatment facilities are included in this definition.

Network Pharmacies

Retail pharmacies who sign contracts with the pharmacy contractor for prescription drug services.

Network Provider

A professional or institutional provider who signs a contract with a TRICARE contractor to provide covered services at a negotiated rate. A network provider agrees to follow TRICARE program requirements, file claims, and handle other paperwork for TRICARE beneficiaries. 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 institution, a physician or other authorized individual professional provider, or other authorized provider that 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 for payment, not TRICARE. In such cases, TRICARE pays the beneficiary, who is then to pay the non-participating provider. The provider can only 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 organization offering health care benefits. OHI is gained through an employer, entitlement program, or other source.

Out-of-Pocket Costs

What a beneficiary pays for services. This includes enrollment fees, cost-shares, deductibles, copayments, and personal costs 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 been made.

Point of Service (POS)

This option allows Prime option enrollees to self-refer for non-emergency care to any TRICARE-authorized provider. The enrollee pays 50% of the TRICARE-allowable amount charge.

Preferred Provider Organization (PPO)

A health plan that provides services to people at a lower cost if they use the doctors, hospitals, etc. that are contracted with or belong to the plan. TRICARE Extra is a PPO-like option for Standard beneficiaries who use network providers.

Preventive Care

Periodic screening and testing that focuses on maintaining one's personal health.

Primary Care

The standard, usual, and customary services provided as routine health care. Services include 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). It also refers to medically necessary diagnostic laboratory and x-ray procedures and tests.

Primary Care Manager (PCM)

A military treatment facility provider, team of providers, or a civilian network provider or practice that sees Prime-option enrollees for primary care services. Enrollees agree to seek all non-emergency, non-mental health care services from their assigned PCMs.

Prime Service Area (PSA)

A geographic area where TRICARE Prime is offered. TRICARE defines the Prime Service Areas around military treatment facilities and at Base Realignment and Closure locations.

Prior Authorization

A process of reviewing medical necessity, appropriateness, and TRICARE coverage and then approving or denying the care before services are received (or within 24 hours of an emergency admission). Some drugs and certain dental treatments may also require this review. Services requiring prior authorization may vary from region to region.

Privacy Act, 5 USC 552a

A law that protects personal privacy and lets an individual to know what records are collected, maintained, used, or shared; to see and get copies of records (at the individual's request); and to correct or add to those records. It requires Government activities which collect, maintain, use, or share any record with personal identifying information can show those actions are 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 safeguards are in place to prevent misuse or unauthorized release of such information.

Professional Fees

Charges for services from individual medical professionals (e.g. doctor, anesthetist, nurse practitioner, therapist, etc.). Hospitals or third-party payers require these fees to be broken down on an inpatient claim. Professional providers then bill for their own services.

Provider

A hospital or other facility offering medical care or services, a physician or other individual professional provider, or other organization or individual delivering services or supplies (as defined in 32 CFR or TRICARE manuals).

Provider Termination

When a provider's status as a TRICARE-authorized provider ends because the provider doesn't qualify to be a TRICARE-authorized provider.

Reconsideration

A written appeal to a contractor following an initial denial determination

Referral

The process used to send a Prime enrollee to another professional provider for consultation or a health care service the referring provider believes is necessary but can't provide.

Region

A geographic area defined by the U.S. Government for contracting medical care and other services for TRICARE-eligible beneficiaries.

Regional Contractor

A contracted civilian health care organization who provides health, medical, and administrative support services in a specific TRICARE region. The regional contractors help combine the services of uniformed service treatment facilities with their network of civilian 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 stateside regions and directing the TRICARE Regional Offices.

Residence

For TRICARE purposes, "residence" is a beneficiary's place for day-to-day living. Temporary lodging or housing 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 residence of the custodial parent(s) or legal guardian's. An incompetent adult beneficiary's residence is that of the legal guardian. Under split enrollment, when a Prime enrolled family member lives 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 so primary caregivers who care for the beneficiary at home can get a needed rest or break. Respite care consists of skilled and non-skilled services so the beneficiary's qualifying condition and safety needs are met.

Retiree

A member or former member of a uniformed service who is entitled to retired, retainer, or equal uniformed-service pay.

Routine Care

Includes general office visits for the treatment of symptoms, chronic or acute illnesses, diseases or follow-up care and preventive care. Also known as primary care.

Specified Authorization Staff (SAS)

There are service-designated SAS assigned to DHA-GL. For care in a TPR-designated area or in the Virgin Islands, the SAS coordinates civilian health care for service members. This includes issuing prior authorizations and notifying the nearest same service MTF of routine and emergency hospital admissions so the service can oversee the care. (Overseas, SAS functions are performed by the TRICARE Area Office on an as needed basis).

Secondary Payer

The plan or program whose benefits are payable 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 fitness for duty care 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 Defense Health Agency - Great Lakes (DHA-GL).

Specialty Care

Specialized medical/surgical diagnosis, treatment, or services a primary care provider 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 isn't yet 23, is enrolled as a full-time student in an accredited institution of higher learning, and depends 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, as long as approved by the uniformed service's clinic/hospital commander or the Director, Defense Health Agency.

Survivor

A spouse's status three years after his or her active duty sponsor's death, as noted by the sponsor's service. Survivors pay 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 legally requiring a third person to pay damages to the government for care. The Government seeks repayment under the Federal Medical Care Recovery Act.

Third Party Payer

An insurance, medical service, or health plan that pays for or covers 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 defined 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 a DoD physician validates the condition. Family members aren't 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 receive the same health care benefits as active duty family members, to include Prime enrollment, as long as they maintain TRICARE eligibility. Spouses are considered transitional survivors for three years from the date of the sponsor's death. Eligible dependent children remain transitional survivors as long as they are 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 most 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 overseeing health care support services 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 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 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

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 Prime benefits in overseas locations near uniformed service clinics and hospitals. TOP Prime is only available to active duty service members and command-sponsored family members; enrollment is required.

TRICARE Overseas Program Prime Remote (TOP Prime Remote)

A TRICARE option that offers Prime benefits to active duty service members permanently assigned to designated remote overseas locations, and to their eligible command-sponsored family members. The TOP contractor acts as the enrollee's primary care manager and authorizes care from host-nation providers; enrollment is required.

TRICARE Plus

A primary care enrollment program at select military treatment facilities (MTFs). Beneficiaries eligible for MTF care (except those enrolled in TRICARE Prime or a health maintenance organization [HMO]) may submit an enrollment request; approval is based on the MTF Commander's guidance.

TRICARE Prime

A health management organization (HMO)-like option where beneficiaries living in Prime Service Areas voluntarily enroll in a program offering TRICARE Standard benefits and enhanced primary and preventive benefits with set copayments. TRICARE Prime enrollees are assigned a primary care manager (PCM) at a military treatment facility (uniformed service clinic or hospital) or the regional contractor's network and must 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 offering 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; enrollment required.

TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

A TRICARE Prime option offering health care coverage through civilian network or TRICARE-authorized providers for family members of uniformed live AND work 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)

An office within the Defense Health Agency that oversees the health care delivery 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 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 for retired service members and their family members.

TRICARE Standard

A fee-for-service like option in which beneficiaries seek TRICARE-covered services from any TRICARE-authorized provider. Beneficiaries pay an annual deductible and cost-shares, and may be responsible for other costs; no enrollment required.

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: 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.

Uniformed Services Headquarters POCs/Service Project Officers

The uniformed services office or individual responsible for submitting waiver requests to the Defense Health Agency for active duty service members referred for non-covered services.

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 hasn't been given
- The device is a FDA Category A Investigational Device Exemption (IDE)
- There is no reliable evidence showing the treatment or procedure was the subject of well-controlled studies that looked at its maximum tolerated dose, its toxicity, its safety, and its desired outcomes as compared with the standard means of treatment or diagnosis
- The reliable evidence shows that experts on the treatment or procedure agree that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard 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 professional attention and may lead to disability/death 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 enrolled 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 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.