TRICARE® For Life

HANDBOOK

Learn how TRICARE and Medicare work together.

Important Information

TRICARE	www.tricare.mil
TRICARE For Life Contractor	
WPS Government Services	866-773-0404 www.TRICARE4u.com
TRICARE Pharmacy Program	
Express Scripts, Inc.	877-363-1303 https://militaryrx.express-scripts.com www.tricare.mil/pharmacy
Accredo (specialty pharmacy)	877-882-3324
TRICARE Overseas Program	
International SOS Government Services, LLC	Country-specific toll-free contact information www.tricare-overseas.com/contact-us www.tricare-overseas.com
TRICARE East Region Contractor	
(For pre-authorization only) Humana Military	800-444-5445 www.tricare.mil/east
TRICARE West Region Contractor	
(For pre-authorization only) TriWest Healthcare Alliance	888-TRIWEST (888-874-9378) www.tricare.mil/west
Medicare	800-MEDICARE (800-633-4227)
Social Security Administration	800-772-1213

TRICARE For Life Handbooks are available in hard copy. To order, call WPS at 866-773-0404.

An Important Note About TRICARE Program Information

At the time of publication, this information is current. It's important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. Military hospital and clinic guidelines and policies may be different than those outlined in this publication. For the most recent information, contact the TRICARE For Life contractor or your local military hospital or clinic. More information regarding TRICARE, including the Health Insurance Portability and Accountability Act Notice of Privacy Practices, can be found online at **www.health.mil**. As a TRICARE beneficiary, you have the rights concerning your health care. To learn more about your rights and responsibilities in the Military Health System, visit **www.tricare.mil/rights**.

Keep Your DEERS Information Up To Date!

It's essential to keep information in the Defense Enrollment Eligibility Reporting System current for you and your family. Failure to update DEERS to accurately reflect the sponsor's or family member's residential address and/or the ineligibility of a former family member could be considered fraud and a basis for administrative, disciplinary, or other appropriate action. To confirm or update your contact information, go to **https://milconnect.dmdc.osd.mil**.

TRICARE and the Affordable Care Act

Most TRICARE plans meet the Affordable Care Act requirement for minimum essential coverage. To learn more about the Affordable Care Act, go to **www.tricare.mil/aca**.

Important Contact Information

TRICARE FOR LIFE CONTRACTOR

WPS Government Services administers the TRICARE For Life benefit. WPS is your primary contact for TRICARE-related customer service needs in the U.S. and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands). International SOS Government Services, LLC administers the TFL benefit overseas.

GENERAL CONTACT INFORMATION	GRIEVANCES
Phone: **866-773-0404** **866-773-0405 (TDD)** Online: **www.TRICARE4u.com** By mail: WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707	Email: **reportit@wpsic.com** By mail: WPS/TRICARE For Life ATTN: Grievances P.O. Box 8974 Madison, WI 53708

CLAIMS	
WPS/TRICARE For Life (stateside) P.O. Box 7890 Madison, WI 53707	TRICARE Overseas Program (Latin America and Canada) P.O. Box 7985 Madison, WI 53707 USA
TRICARE Overseas Program (Eurasia-Africa) P.O. Box 8976 Madison, WI 53708 USA	TRICARE Overseas Program (Pacific) P.O. Box 7985 Madison, WI 53707 USA

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM

DEERS is a database of uniformed service members (active duty and retired), their family members, and others who are eligible for military benefits, including TRICARE. Current DEERS registration is key to getting timely, effective TFL benefits. You have several options for updating and verifying DEERS information:

In person (Add a family member or update contact information)	Visit a local Uniformed Services ID card office. Find an office near you at **https://idco.dmdc.osd.mil/idco**. Call to confirm location and business hours.
Phone or fax (Update contact information)	**800-538-9552** (phone) **866-363-2883** (TDD/TTY) **800-336-4416** (fax)
Online (Update contact information)	milConnect: **https://milconnect.dmdc.osd.mil**
Mail (Update contact information)	DMDC/DEERS Support Office 400 Gigling Rd. Seaside, CA 93955

TRICARE REGIONAL CONTRACTORS

Regional contractors provide health care services and support in the TRICARE regions. They can help TFL beneficiaries with pre-authorizations, but they don't provide referrals for TFL beneficiaries. You can go to **www.medicare.gov** for help finding providers, hospitals, home health agencies, or suppliers of durable medical equipment in your area. See the following table for contact information for the two U.S. regional contractors. If you're overseas, the TRICARE Overseas Program contractor is International SOS. Contact your TOP Regional Call Center listed below or visit **www.tricare-overseas.com**.

Regional Contractors (Stateside)

TRICARE East Region
Humana Military 800-444-5445 www.tricare.mil/east
TRICARE West Region
TriWest Healthcare Alliance 888-TRIWEST (888-874-9378) www.tricare.mil/west

TOP Regional Call Centers (Overseas)

TRICARE Eurasia-Africa
+44-20-8762-8384 (overseas) 877-678-1207 (stateside) tricarelon@internationalsos.com
TRICARE Latin America and Canada
+1-215-942-8393 (overseas) 877-451-8659 (stateside) tricarephl@internationalsos.com
TRICARE Pacific
+65-6339-2676 (overseas) 877-678-1208 (stateside) sin.tricare@internationalsos.com

FOR MORE INFORMATION	RESOURCE NUMBERS	WEBSITES
Medicare	800-633-4227	www.medicare.gov
Social Security Administration	800-772-1213	www.ssa.gov
TRICARE Pharmacy Program	877-363-1303	https://militaryrx.express-scripts.com
Federal Employees Dental and Vision Insurance Program	See website	www.BENEFEDS.gov
TRICARE Dental Program	844-653-4061 (CONUS) 844-653-4060 (OCONUS) 711 (TDD/TTY)	www.uccitdp.com
TRICARE Customer Service Community Directory (Find a Beneficiary Counseling and Assistance Coordinator or a Debt Collection Assistance Officer)	See website	www.tricare.mil/bcacdcao
Find a military hospital or clinic	See website	www.tricare.mil/mtf
MHS GENESIS Patient Portal	800-600-9332	https://my.mhsgenesis.health.mil
Get benefit correspondence by email	See website	https://milconnect.dmdc.osd.mil

Welcome to TRICARE For Life

LEARN HOW TRICARE AND MEDICARE WORK TOGETHER.

TRICARE For Life is Medicare-wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B, regardless of age or where you live.

TRICARE For Life provides comprehensive health care coverage worldwide. You have the freedom to seek care from any Medicare-participating or Medicare non-participating provider, or military hospital or clinic if space is available.

The information in this handbook will help you make the most of your TFL coverage. You'll find information about eligibility requirements, getting care, and claims. It also provides details about your pharmacy and dental coverage options.

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How TRICARE For Life Works

ELIGIBILITY

TRICARE For Life is available to TRICARE beneficiaries, regardless of age or where you live, if you have Medicare Part A and Medicare Part B. You're eligible for TFL on the first date you have both Medicare Part A and Medicare Part B.

TRICARE Eligibility Requirements

When you're eligible for premium-free Medicare Part A:

- Medicare Part B coverage is required to remain TRICARE-eligible if you're:
  - A retired service member (including retired National Guard and Reserve members drawing retirement pay)
  - A family member of a retired service member
  - A Medal of Honor recipient or eligible family member
  - A survivor of a deceased sponsor
  - An eligible former spouse
- Medicare Part B coverage **isn't** required to remain TRICARE-eligible if:
  - You're an active duty service member or active duty family member. ADSMs remain eligible for TRICARE Prime or TRICARE Prime Remote. ADFMs remain eligible for TRICARE Prime, TRICARE Prime Remote, or TRICARE Select options while the sponsor is on active duty. However, when the sponsor retires, you must have Medicare Part B to remain TRICARE-eligible. See "Medicare Part B (Medical Insurance)" later in this section for information about the Medicare Part B Special Enrollment Period for ADSMs and ADFMs.
  - You're enrolled in TRICARE Reserve Select, TRICARE Retired Reserve, TRICARE Young Adult, or the US Family Health Plan. While you aren't required to have Medicare Part B to remain eligible for TRS, TRR, TYA, or USFHP, you're strongly encouraged to sign up for Medicare Part B when first eligible to avoid paying monthly late-enrollment premium penalties.

Note: Regardless of age, ADFMs who have Medicare Part A may enroll in TRICARE Prime if they live in a Prime Service Area, or with a drive-time waiver, within 100 miles of an available primary care manager. A PSA is a geographic area where TRICARE Prime is available. It's typically an area near a military hospital or clinic. The TRICARE Prime enrollment fee is waived for TRICARE Prime beneficiaries with Medicare Part B, in some cases, regardless of age. Learn more at **www.tricare.mil/medicare**.

UNDERSTANDING MEDICARE

TFL is managed by the Defense Health Agency. Medicare is managed by the Centers for Medicare & Medicaid Services. The two agencies work together to coordinate benefits.

Medicare is a federal health insurance program for people:

- Age 65 or older
- Under age 65 with certain disabilities
- Any age with end-stage renal disease

There are two ways to get Medicare: through Original Medicare, which includes Medicare Part A and Part B, or by enrolling in a Medicare Advantage plan (also known as Medicare Part C). TRICARE For Life is Medicare-wraparound coverage for TRICARE beneficiaries who have both Medicare Part A and Part B.

See Figure 1.1 on the next page to learn about the difference between Original Medicare and Medicare Advantage.

Medicare Part A (Hospital Insurance)

Medicare Part A covers inpatient hospital care, hospice care, inpatient skilled nursing facility care, and some home health care. The Social Security Administration determines your eligibility for Medicare Part A based on your work history or your spouse's work history. (This includes divorced spouses and deceased spouses.) You're eligible for premium-free Medicare Part A at age 65 if you or your spouse has 40 quarters or 10 years of Social Security-covered employment.

If you aren't eligible for premium-free Medicare Part A when you turn age 65 under your own Social Security number, you must file for benefits under your spouse's SSN if they're age 62 or older. (This includes divorced spouses and deceased spouses.) If your spouse isn't yet age 62, and you anticipate that they'll be eligible for premium-free Medicare Part A at age 65, you should sign up for Medicare Part B when first eligible at age 65 to avoid paying a late-enrollment premium penalty. You should then file for Part A benefits under your spouse's record two months before they turn age 62.

Note: If neither spouse will be eligible for premium-free Medicare Part A, neither will need Medicare Part B to remain TRICARE-eligible.

Medicare Part B (Medical Insurance)

Medicare Part B covers provider services, outpatient care, home health care, durable medical equipment, and some preventive services. Medicare Part B has a monthly premium, which may change yearly and varies based on income. If you sign up after your Initial Enrollment Period for Medicare Part B, you may have to pay a late-enrollment premium penalty (10% for each 12-month period that you were eligible to enroll in Medicare Part B but didn't) for as long as you have Medicare Part B. For specific information about your Part B premium or penalty amount, call the SSA at **800-772-1213**.

Medicare allows ADSMs and ADFMs who are eligible for Medicare based on age or disability (except those with ESRD) to delay Part B enrollment and sign up during a Special Enrollment Period, which waives the late-enrollment premium penalty. The Special Enrollment Period for ADSMs and ADFMs is available anytime the sponsor is on active duty

Figure 1.1 *Original Medicare and Medicare Advantage*

ORIGINAL MEDICARE	MEDICARE ADVANTAGE
• When using Original Medicare, you can get health care services from any Medicare participating or Medicare non-participating provider, regardless of their specialty. • Medicare Part A is hospital insurance, which is financed by payroll deductions when you are or were working. • Medicare Part B is medical insurance, which primarily covers outpatient services. You pay a premium each month, which is based on your level of income. • If you're eligible for TRICARE and have Medicare Part A and Part B, TRICARE For Life provides wraparound coverage, which pays your out-of-pocket costs in Original Medicare for TRICARE-covered services. Medicare and TRICARE coordinate benefits. This eliminates the need for you to file claims. • Medicare Supplement Insurance (Medigap) coverage is optional. You pay a premium each month. Medigap pays your out-of-pocket costs in Original Medicare.	• Medicare Part C refers to Medicare Advantage plans, which are offered by private companies that contract with Medicare. A Medicare Advantage plan provides all of your Part A and Part B services—and usually Part D pharmacy coverage. • You may pay a plan premium each month in addition to your Medicare Part B premium. • You must get all your health care services from the Medicare Advantage plan's network of providers. This doesn't apply to emergency services. • If you enroll in a Medicare Advantage plan, you may have to pay copayments at the time of service. • TRICARE For Life can reimburse you for copayments you paid for TRICARE-covered services, when you file a paper claim.

or within eight months following either (1) the month your sponsor retires (2) the month TRICARE coverage ends, whichever comes first. To avoid a break in TRICARE coverage, ADSMs and ADFMs must sign up for Medicare Part B before their sponsor's active duty status ends. **Note:** ADSMs and ADFMs with ESRD don't have a Special Enrollment Period and should enroll in Medicare Part A and Part B when first eligible.

USFHP and Medicare Eligibility

If you're a USFHP beneficiary under age 65 and eligible for premium-free Medicare Part A, you're strongly encouraged to have Medicare Part B (except for disabled ADFMs). If you're enrolled in USFHP and eligible for Medicare based on disability or age, you aren't required to have Medicare Part B. As of Oct. 1, 2012, Medicare-eligible beneficiaries ages 65 and older can no longer enroll in USFHP. Anyone whose enrollment was effective Oct. 1, 2012 or later and becomes Medicare-eligible based on age, is disenrolled from USFHP and transferred to TFL.

Medicare Eligibility Based on a Disability

If you receive Social Security disability benefits, you're eligible for Medicare in the 25th month of receiving disability payments. Medicare will notify you of your Medicare entitlement date.

If you return to work and your Social Security disability payments are suspended, your Medicare eligibility continues for up to eight years and six months. When your disability payments are suspended, you'll get a bill every three months for your Medicare Part B premiums. You must continue to pay your Medicare Part B premiums to remain eligible for TRICARE coverage.

Note: If you have Medicare due to a disability, you can continue your TRICARE Prime enrollment (if you qualify). If you're under age 65 and choose not to enroll in TRICARE Prime or USFHP, you'll automatically be covered by TFL.

Medicare Eligibility Based on ESRD

If you're eligible for Medicare benefits based on ESRD, enroll in Medicare Part A and Part B when you're first eligible to remain TRICARE-eligible. ADSMs and ADFMs with ESRD don't have a Special Enrollment Period and should enroll in Part B when first eligible to avoid the Part B late-enrollment premium penalty.

Medicare Eligibility Based on Lou Gehrig's Disease

If you have Lou Gehrig's disease (also called amyotrophic lateral sclerosis or ALS), you automatically get Medicare Part A and Part B the month your disability begins.

Medicare Eligibility Based on Age

The Medicare eligibility age is 65. If you already get retirement benefits from the SSA or the U.S. Railroad Retirement Board, you're automatically eligible for Medicare Part A and Part B the month you turn age 65 or the month prior if your birthday falls on the first of the month.

If you don't receive Social Security or U.S. Railroad Retirement Board benefits before age 65, you must apply for Medicare benefits. Your Medicare Initial Enrollment Period is a seven-month period.

- If your birthday falls on the first of the month, your Initial Enrollment Period begins four months before the month you turn age 65. Enroll no later than two months before the month you turn age 65 to avoid a break in TRICARE coverage. You're eligible for Medicare coverage on the first day of the month before you turn age 65.
- If your birthday falls on any day other than the first of the month, your Initial Enrollment Period begins three months before the month you turn age 65. Enroll no later than one month before your birth month to avoid a break in TRICARE coverage. You're eligible for Medicare on the first day of the month you turn age 65.

Enroll in Medicare Part B when first eligible to avoid a break in TRICARE coverage. If you sign up after your Initial Enrollment Period, you may have to pay a late-enrollment premium penalty for as long as you have Part B. The Medicare Part B penalty is 10% for each 12-month period that you were eligible to enroll in Part B but didn't.

Frequently Asked Questions:

Medicare

I'll be 65 soon and will be eligible for Medicare. I work full time and have employer-sponsored group health plan coverage. I don't plan on retiring for a few more years. Medicare says I can delay my Part B enrollment if I have employer-sponsored coverage. How does this affect my TRICARE benefit?

If you're eligible for premium-free Medicare Part A, you must also have Part B to remain TRICARE-eligible, even if you have employer-sponsored coverage. Medicare allows individuals with employer-sponsored coverage to delay Part B enrollment and sign up during a Special Enrollment Period, which waives the late-enrollment premium penalty. If you or your spouse still works and has employer-sponsored coverage, you may sign up for Medicare Part B during a Special Enrollment Period, which is available anytime you or your spouse is currently working and covered by employer-sponsored coverage, or within the eight months following either (1) loss of employment or (2) loss of group health plan coverage, whichever comes first.

If you choose to delay enrollment in Medicare Part B and rely solely on your employer-sponsored coverage, sign up for Part B before you retire or lose employer-sponsored coverage to ensure your TRICARE coverage under TFL begins immediately following the end of your employer-sponsored coverage. Your TFL coverage begins on the first day you have both Medicare Part A and Part B coverage.

If I'm not eligible for premium-free Medicare Part A when I turn age 65, can I still use TFL?

Because you aren't eligible for premium-free Medicare Part A, you don't need Medicare Part B to keep your TRICARE benefit. You don't transition to TFL. You may continue enrollment in TRICARE Prime if you live in a PSA, or if qualified, you may enroll in TRICARE Select. For information about TRICARE program options, visit **www.tricare.mil**.

If you aren't eligible for premium-free Medicare Part A under your own SSN when you turn age 65, you must file for benefits under your spouse's (this includes divorced or deceased spouses) SSN if they're age 62 or older. If your spouse isn't yet age 62, you must file for benefits under their SSN two months before they turn age 62.

If you'll be eligible under your spouse's SSN in the future, you should sign up for Medicare Part B during your Initial Enrollment Period to avoid paying a Part B late-enrollment premium penalty. Even if you aren't eligible for premium-free Medicare Part A, you're eligible for Medicare Part B at age 65. See "Medicare Eligibility Based on Age" earlier in this section for more information.

If you sign up for Medicare and aren't eligible for premium-free Part A under your or your spouse's (this includes divorced or deceased spouses) SSN, you'll get a "Notice of Award" or "Notice of Disapproved Claim" from SSA. To keep your TRICARE coverage, take the "Notice(s) of Award" or "Notice(s) of Disapproved Claim" to a Uniformed Services ID card office to have your Defense Enrollment Eligibility Reporting System record updated and get a new ID card. This allows you to keep your eligibility for TRICARE Prime or TRICARE Select after you turn age 65.

Note: Uniformed Services ID card offices won't accept an SSA *Report of Confidential Social Security Benefit Information* form (SSA-2458) as proof of ineligibility for premium-free Part A to keep your TRICARE eligibility.

Your Part B premiums are automatically taken out of your Social Security or U.S. Railroad Retirement Board monthly payments. If you don't get these types of payments, Medicare bills you every three months for Part B premiums. **Note:** If you live in Puerto Rico and already get SSA or U.S. Railroad Retirement Board benefits, you automatically get Medicare Part A; however, you must sign up for Part B.

Medicare Eligibility Based on an Asbestos-Related Disease

If you've been diagnosed with an asbestos-related disease (for example, mesothelioma) and lived in Lincoln County, Montana, for a total of at least six months during a period ending 10 years or more before the diagnosis, you're eligible for Medicare. Your Medicare coverage is effective the month after you sign up.

HOW TRICARE FOR LIFE WORKS WITH MEDICARE

Medicare and TFL work together to minimize your out-of-pocket expenses. However, there are instances when some health care costs may not be covered by Medicare or TRICARE.

See Figure 1.2 shows TFL out-of-pocket costs.

Health Care Services Covered by Medicare and TRICARE

When you see a Medicare participating or Medicare non-participating provider, you have no out-of-pocket costs for services covered by both Medicare and TFL. Most health care services fall into this category. After Medicare pays its portion of the claim, TRICARE pays the remaining amount, and you pay nothing.

Figure 1.2 ***TRICARE For Life Out-of-Pocket Costs***

TYPE OF SERVICE	MEDICARE PAYS	TRICARE PAYS	YOU PAY
Covered by TRICARE and Medicare	Medicare-allowed amount	Remaining amount	Nothing
Covered by Medicare only	Medicare-allowed amount	Nothing	Medicare deductible and cost-share
Covered by TRICARE only	Nothing	TRICARE-allowable amount	TRICARE deductible and cost-share
Not covered by TRICARE or Medicare	Nothing	Nothing	Billed charges (which may exceed the Medicare or TRICARE-allowable amount)

As the primary payer, Medicare approves health care services for payment. If Medicare doesn't pay because it determines that the care isn't medically necessary, TRICARE also doesn't pay. You can appeal Medicare's decision and, if Medicare reconsiders and provides coverage, TRICARE also reconsiders coverage.

If a health care service is covered by both Medicare and TRICARE, but Medicare doesn't pay because you've used up your Medicare benefit, TRICARE becomes the primary payer. In this case, you're responsible for your TRICARE deductible and cost-shares.

If a health care service is normally covered by both Medicare and TRICARE, but you get the service from a provider who has opted out of Medicare, the provider can't bill Medicare and Medicare pays nothing. When you see an opt-out provider, TFL processes the claim as the second payer, unless you have other health insurance. TRICARE pays the amount it would have paid if Medicare had processed the claim (normally TRICARE pays up to 20% of the TRICARE-allowable charge), and you may be responsible for the remainder of the billed charges.

Similarly, U.S. Department of Veterans Affairs providers can't bill Medicare and Medicare pays nothing. When you see a VA provider for health care not related to service-connected injuries or illnesses, TFL processes the claim as the second payer. TRICARE pays up to 20% of the TRICARE-allowable charge.

Opt-out providers establish private contracts with patients. Under a private contract, there are no limits on what the provider can charge for health care services.

Medical Services Covered by Medicare but Not by TRICARE

When you get care that's covered by Medicare only (for example, chiropractic care), Medicare processes the claim as the primary payer. TRICARE pays nothing, regardless of any action Medicare takes. You're responsible for the Medicare deductible and cost-shares.

Medical Services Covered by TRICARE but Not by Medicare

When you get care that's covered only by TRICARE (for example, TRICARE-covered services received overseas), TFL processes the claim as the primary payer. You're responsible for the applicable TRICARE deductible, cost-shares, and remaining billed charges. Outside the U.S. and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands), there may be no limit to the amount that nonparticipating non-network providers can bill. You're responsible for paying any amount that exceeds the TRICARE-allowable charge, in addition to your deductible and cost-shares. Learn more at **www.tricare.mil/TFLOverseas**.

TFL claims are normally filed with Medicare first; however, when Medicare doesn't cover a health care service, your provider can file the claim directly with WPS Government Services, unless you have OHI. See the *Claims* section for more information.

Medical Services Not Covered by Medicare or TRICARE

When you get care that isn't covered by Medicare or TRICARE (for example, most cosmetic surgery), neither makes a payment on the claim. You're responsible for the entire bill. To learn more, visit **www.medicare.gov** or **www.tricare.mil/coveredservices** or contact WPS.

Coordinating TRICARE For Life with Other Health Insurance

How Medicare coordinates with OHI depends on whether or not the OHI is based on current employment. In either case, TRICARE pays last.

OHI Not Based on Current Employment

If you have OHI that isn't based on your or a family member's current employment, Medicare pays first, your OHI pays second, and TRICARE pays last.

OHI Based on Current Employment

Generally, if you have an employer-sponsored health plan based on current employment, that health plan pays first, Medicare pays second, and TRICARE pays last. If there are fewer than 20 employees in the employer-sponsored plan, Medicare pays first, your OHI pays second, and TRICARE pays last.

When your OHI processes the claim after Medicare, you need to submit a claim to WPS for any remaining balance. See the *Claims* section for more information. **Note:** TRICARE pays after most insurance plans with the exception of Medicaid, TRICARE supplements, the Indian Health Service, and other programs and plans as identified by the Defense Health Agency.

How TRICARE For Life Works Overseas

TRICARE is the only payer overseas. Medicare provides coverage in the U.S. and U.S. territories. Medicare also covers health care services received aboard ships in U.S. territorial waters. In these locations, TFL works exactly as it does in the U.S. Unless you have OHI, TRICARE is the second payer after Medicare for most health care services. Your provider files the claim with Medicare first. Medicare pays its portion and automatically forwards the claim to WPS.

Medicare doesn't provide coverage outside the U.S., U.S. territories, or aboard ships outside U.S. territorial waters. Therefore, TRICARE is your primary payer for health care received in all other overseas locations, unless you have OHI.

Eligible TFL beneficiaries may receive covered services and supplies from a network provider or any authorized-TRICARE provider. You'll be subject to the applicable catastrophic cap, deductibles, and cost-shares. If you receive covered services from a network provider, your out-of-pocket costs will generally be lower. Pre-authorization may be required (except for emergency care). Area- or country-specific requirements may also apply. For requirements about getting care in the Philippines, see "Overseas Providers" in the *Getting Care* section.

Be prepared to pay up front for services and submit a claim to the TRICARE Overseas claims processor. See the *Claims* section for more information.

FAQs

Frequently Asked Questions:

How TRICARE For Life Works

Does TFL pay for the Medicare Part B premium and deductible?

The Medicare Part B monthly premium is your responsibility. TFL covers the Medicare Part B deductible as long as the health care service is covered by both Medicare and TRICARE.

Using TFL seems so easy. Should I cancel my Medicare supplement, Medicare Advantage Plan, or OHI?

Carefully evaluate your health insurance needs to determine if you should continue Medicare supplements, Medicare Advantage Plans, or OHI. You may contact your local State Health Insurance Assistance Program for free health insurance counseling and assistance.

Note: If you drop your OHI coverage, you must notify WPS.

I'm a TFL beneficiary and a retired federal employee. Can I suspend my Federal Employees Health Benefits Program coverage to use TFL?

Yes. You may suspend your FEHB coverage and premium payments at any time. Visit **www.opm.gov/forms** to get a *Health Benefits Cancellation/Suspension Confirmation* form (RI 79-9). Be sure to complete the "Suspension" section of the form. If you suspend FEHB and later decide you want it again, you can re-enroll during FEHB Open Season. If you cancel FEHB, you can never get it back. Eligible former spouses who haven't remarried can get the form from the employing offices or retirement system maintaining their enrollments.

Is a referral or TRICARE pre-authorization required for health care services?

A referral or TRICARE pre-authorization isn't required under TFL when Medicare is the primary payer. However, when TRICARE becomes the primary payer, TRICARE pre-authorization requirements apply.

I was enrolled in TRICARE Prime at a military hospital. I received a letter from the military hospital telling me I'm no longer eligible for enrollment in TRICARE Prime. What does that mean?

Once you become eligible for premium-free Medicare Part A because you're age 65, you're eligible for TFL when you also have Medicare Part B. You're no longer eligible for enrollment in TRICARE Prime, unless you have an active duty sponsor.

You may continue to seek care at a military hospital or clinic if space is available, but you'll likely need to seek care from civilian Medicare providers. Contact Medicare for assistance with finding Medicare providers.

You may be able to sign up for TRICARE Plus. TRICARE Plus is a program that allows beneficiaries who normally are only able to get military hospital and clinic care if space is available, to enroll and get primary care appointments at the military hospital or clinic. TRICARE Plus offers the same primary care access standards as beneficiaries enrolled in a TRICARE Prime option. Beneficiaries should contact their local military hospital or clinic to determine if TRICARE Plus is available and whether they may participate in it.

Enrollment in TRICARE Plus at one military hospital or clinic doesn't automatically extend TRICARE Plus enrollment to another military hospital or clinic. The military hospital or clinic isn't responsible for any costs when a beneficiary enrolled in TRICARE Plus seeks care outside the military hospital or clinic.

Getting Care

FINDING A PROVIDER

You can get health care services from Medicare participating and Medicare non-participating providers, as well as from providers who have opted out of Medicare. If TRICARE For Life is the primary payer, you must visit TRICARE-authorized providers and facilities. You'll have significant out-of-pocket expenses when you get care from opt-out providers, or when seeing a U.S. Department of Veterans Affairs provider for health care not related to a service-connected injury or illness. Costs vary according to the type of provider you see (for example, opt-out or VA).

Medicare Participating Providers

Medicare participating providers agree to accept the Medicare-allowed amount as payment in full.

Medicare Non-Participating Providers

Medicare non-participating providers don't accept the Medicare-allowed amount as payment in full. They may charge up to 15% above the Medicare-allowed amount, a cost that's covered by TRICARE.

Opt-Out Providers

Providers who opt out of Medicare enter into private contracts with patients and aren't allowed to bill Medicare. Therefore, Medicare doesn't pay for health care services you get from opt-out providers. When you see an opt-out provider, TRICARE pays the amount it would have paid (normally up to 20% of the allowable charge) if Medicare had processed the claim, and you may be responsible for paying the remainder of the billed charges. In cases where access to medical care is limited (e.g., underserved areas), TRICARE may waive the second-payer status for Medicare opt-out providers and pay the claim as the primary payer.

Veterans Affairs Providers

VA providers can't bill Medicare and Medicare can't pay for services received from the VA. If you're eligible for both TFL and VA benefits, you'll have significant out-of-pocket expenses when seeing a VA provider for health care not related to a service-connected injury or illness. If you get care at a VA facility, you may be responsible for 80% of the bill. By law, TRICARE can only pay up to 20% of the TRICARE-allowable amount for these services. When using your TFL benefit, your least expensive options are to see a Medicare participating or Medicare non-participating provider.

If you want to seek care from a VA provider, check with WPS by calling **866-773-0404** to confirm coverage details and determine what's covered by TRICARE.

Military Hospitals and Clinics

A military hospital or clinic is usually located on or near a military base. You can get care at a military hospital or clinic if space is available. See Figure 2.1 for military hospital and clinic appointment priorities.

Figure 2.1 ***Military Hospital and Clinic Appointment Priorities***

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

Overseas Providers

With TFL overseas, you can generally use any civilian provider, and get care at military hospitals and clinics if space is available. If you're in the Philippines, however, you must see a certified provider for care. Additionally, TRICARE Select Overseas beneficiaries who live in the Philippines and who seek care within designated Philippine locations are encouraged to see a TRICARE-preferred provider. Visit **www.tricare-overseas.com/beneficiaries/philippines** for more information.

When seeking care from a civilian provider, be prepared to pay up front for services and submit a claim to the TRICARE Overseas Program claims processor. Outside the U.S. and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands), there may be no limit to the amount that nonparticipating non-network providers may bill, and you're responsible for paying any amount that exceeds the TRICARE-allowable charge, in addition to your deductible and cost-shares.

For information on overseas proof-of-payment requirements for submitting claims, see "Health Care Claims Overseas" in the *Claims* section.

For more information about getting care overseas, call your TOP Regional Call Center or visit **www.tricare-overseas.com**.

EMERGENCY CARE

TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a person to reasonably believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others. The TRICARE health care benefit covers adjunctive dental care (for example, dental care that's medically necessary to treat a

covered medical—not a dental—condition). The TRICARE health care benefit doesn't cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontal, or emergency dental care that isn't related to a medical condition. Eligible TRICARE beneficiaries may receive non-adjunctive dental services, if enrolled in the TRICARE Dental Program or the Federal Employees Dental and Vision Insurance Program.

If you need emergency care in the U.S. or U.S. territories, call 911 or go to the nearest emergency room. Make sure you present your Medicare card so your claim is filed with Medicare.

If traveling or living overseas, first attempt to seek care from the nearest military hospital or clinic. If a military hospital or clinic isn't available, seek care from the nearest emergency care facility. You can contact the TOP Regional Call Center for your area or visit **www.tricare-overseas.com** for help finding a civilian provider. Contact the TOP Regional Call Center within 24 hours if you're admitted to coordinate follow-on care.

URGENT CARE

Urgent care services are medically necessary services required for an illness or injury that wouldn't result in further disability or death if not treated immediately but does require professional attention within 24 hours. You could require urgent care for conditions such as a sprain or rising fever, as both of these conditions have the potential to develop into an emergency if treatment is delayed longer than 24 hours.

MHS GENESIS Patient Portal

If you get care at military hospitals or clinics, you may access your Military Health System health care records through the MHS GENESIS Patient Portal.

The portal is a secure way to manage the health care you get at military hospital or clinics online 24/7.

Through the MHS GENESIS Patient Portal, you may be able to:

- Book and cancel appointments at a military hospital or clinic
- Request prescription refills and renewals at a military pharmacy
- View military hospital or clinic notes and certain laboratory/test results
- Exchange secure messages with your military hospital or clinic health care team

Log into the MHS GENESIS Patient Portal at **https://my.mhsgenesis.health.mil**. Learn more at **www.tricare.mil/mhsgenesis**. Get one-on-one support from the MHS GENESIS Help Desk at **800-600-9332**.

VIRTUAL HEALTH CARE

Virtual health is medical or health care services you receive using secure communication technology instead of seeing your health care provider in-person. Virtual health appointments include phone and video conferencing.

Medicare Part B covers certain virtual health (telehealth) services. If virtual health services aren't payable by Medicare, TRICARE is the first payer. For more information and to see what virtual health services Medicare covers, go to **www.medicare.gov/coverage/telehealth**.

MENTAL HEALTH CARE

Medicare helps cover visits with the following types of health care providers:

- A psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician's assistant

Medicare only covers these visits when they're provided by health care providers who accept Medicare payment. To help lower your costs, ask your health care providers if they accept assignment, which means they accept the Medicare-approved amount as payment in full, before you schedule an appointment.

NURSE ADVICE LINE

Military Health System

Your health, our priority 24/7

If it's after hours or you aren't sure if you need to see a health care provider, contact the Military Health System Nurse Advice Line 24/7.

Visit **www.mhsnurseadviceline.com** to chat with a nurse or to find country-specific numbers. In the U.S., call **800-TRICARE (800-874-2273)**, option 1. You can talk to a registered nurse who can:

- Answer your urgent care questions
- Help you determine whether you need to see a health care provider
- Help you find the closest urgent care center or emergency room
- Help you schedule appointments at military hospitals or clinics, if available

The MHS Nurse Advice Line isn't intended for emergencies and isn't a substitute for emergency treatment. Emergency care means care for an illness or injury that threatens your life, limb, sight, or safety. If you reasonably believe you have an emergency, always call 911 or your international emergency number, or go to the nearest emergency room.

For more information on Medicare's mental health care coverage, visit **www.medicare.gov**.

PRE-AUTHORIZATION FOR CARE

When TRICARE becomes the primary payer (for example, if your Medicare benefits run out), TRICARE pre-authorization requirements apply.

Pre-authorization is a review of the requested health care service to determine if it's medically necessary at the requested level of care. If you have a pre-authorization from a TRICARE regional contractor (Humana Military; TriWest Healthcare Alliance; or International SOS Government Services, LLC) that covers the dates on your claim, WPS honors that pre-authorization and no TRICARE pre-authorization is required.

For requests for pre-authorization, providers should fill out the specific request form and submit it for review. Pre-authorization request forms and instructions on how to submit forms are available online at **www.TRICARE4u.com**.

If you have questions about pre-authorization requirements, contact WPS.

The following services require pre-authorization:

- Adjunctive dental services (dental care that's medically necessary in the treatment of an otherwise covered medical—not dental—condition)*
- Extended Care Health Option services (active duty family members only)
- Home health care services
- Home infusion therapy
- Hospice care
- Transplants—all solid organ and stem cell
- Some prescription medications (for example, brand-name drugs or those with quantity limitations)

Note: This list **isn't** all-inclusive. For details about pre-authorization requirements, contact WPS.

* *For more information on TRICARE dental coverage, see "Dental Coverage" in the* TRICARE For Life Coverage *section.*

TRICARE For Life Coverage

MEDICAL COVERAGE

TRICARE For Life and Medicare cover services that are medically necessary and considered proven. TRICARE has special rules and limitations for certain types of care, and some types of care aren't covered at all. TRICARE policies are very specific about which services are covered and which aren't. It's in your best interest to take an active role in verifying coverage.

Note: Medicare also has limits on the amount of care it covers. In some cases, TRICARE may cover these health care services after your Medicare benefits run out.

To learn if Medicare covers a specific service or benefit, visit **www.medicare.gov** or call **800-633-4227**. To determine if TRICARE covers the service or benefit, visit **www.tricare.mil/coveredservices** or call WPS Government Services at **866-773-0404**. See Figure 1.2 in the *How TRICARE For Life Works* section for more information on your out-of-pocket costs.

Examples of services that are generally **not** reimbursable by TRICARE or Medicare include:

- Acupuncture
- Experimental or investigational services
- Eye exams (routine)
- Hearing aids*

Note: This list **isn't** all-inclusive.

* *If you're a retired sponsor, you may be eligible for the Retiree-At-Cost Hearing Aid Program. It's available at some military hospitals and clinics. Visit* ***www.tricare.mil/hearingaids*** *for more information.*

DENTAL COVERAGE

You may qualify for one of two voluntary dental care programs: the TRICARE Dental Program or the Federal Employees Dental and Vision Insurance Program.

Federal Employees Dental and Vision Insurance Program

FEDVIP, offered by the U.S. Office of Personnel Management, is available to retired service members and their eligible family members, including certain retired National Guard and Reserve members and their family members.

FEDVIP is also available to certain surviving family members of deceased active duty sponsors, Medal of Honor recipients, and their immediate family members and survivors.

Former spouses and remarried surviving spouses don't qualify to purchase dental coverage. However, if enrolled in a TRICARE health plan, they may qualifty to purchase vision coverage. For information about FEDVIP, visit **www.benefeds.gov**.

TRICARE Dental Program

The TDP provides worldwide dental coverage for eligible family members of active duty service members, survivors, certain National Guard and Reserve members and their families, and Individual Ready Reserve members and their families. Former spouses and remarried surviving spouses don't qualify to purchase coverage. For more information about the TDP, visit **www.uccitdp.com** or call United Concordia at **844-653-4061 (CONUS)** or **844-653-4060 (OCONUS)**.

VISION COVERAGE

You and other eligible family members enrolled in a TRICARE health plan may qualify to purchase vision coverage through FEDVIP. For information about FEDVIP, visit **www.benefeds.gov**.

Frequently Asked Questions:
TRICARE For Life Coverage

Does TRICARE cover long-term care?

No. Long-term care (or custodial care) isn't a covered benefit. However, you may qualify to purchase long-term care insurance through commercial insurance programs or through the Federal Long Term Care Insurance Program.

For more information about the Federal Long Term Care Insurance Program, visit **www.opm.gov** or call **800-582-3337**.

Does TRICARE cover skilled nursing care?

TRICARE covers skilled nursing services; meals (including special diets); physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Skilled nursing care is typically provided in a skilled nursing facility.

For TRICARE and Medicare to cover SNF admission, you must have had a medical condition that was treated in a hospital for at least three consecutive days, and you must be admitted to a Medicare-certified, TRICARE-participating SNF within 30 days of discharge from the hospital (with some exceptions for medical reasons). Your health care provider's plan of care must demonstrate your need for skilled nursing services.

TRICARE is the primary payer for SNF care beyond Medicare's 100-day limit, as long as the patient continues to require skilled nursing services and no other health insurance is involved. SNF care requires pre-authorization on day 101, when TRICARE is the primary payer. TRICARE covers an unlimited number of days as medically necessary.

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

Pharmacy

PRESCRIPTION DRUG COVERAGE

TRICARE offers comprehensive prescription drug coverage and several options for filling your covered prescriptions. To fill a prescription, you need a prescription and a valid Uniformed Services ID card or Common Access Card. Your options for filling your prescriptions depend on the type of drug your provider prescribes. For more information, visit **https://militaryrx.express-scripts.com** or call **877-363-1303**. Express Scripts, Inc. administers the TRICARE pharmacy benefit.

When traveling overseas, be prepared to pay up front for medications and file a claim to be reimbursed for non-military hospital or clinic and non-network pharmacy services. TRICARE recommends that you fill all of your prescriptions before traveling overseas.

If you live or travel in the Philippines, you're required to use a certified pharmacy. For more information, visit **www.tricare-overseas.com/beneficiaries/philippines**.

Over-the-counter drugs aren't covered overseas (except in U.S. territories). This includes drugs that are considered OTC in the U.S., even when they require a prescription in a foreign country.

Note: You **don't** need a Medicare Part D prescription drug plan to keep your TRICARE prescription drug coverage.

FILLING PRESCRIPTIONS

Military Pharmacies

Military pharmacies are usually located within military hospitals and clinics. At a military pharmacy, you can get up to a 90-day supply of most medications at no cost. Most military pharmacies accept prescriptions from both civilian and military providers, regardless of whether or not you're enrolled at the military hospital or clinic.

Electronic prescribing is accepted at many military pharmacies in the U.S., Puerto Rico, and Guam. This allows your civilian providers to send prescriptions electronically to military pharmacies near you. E-prescribing from a health care provider to a pharmacy reduces medication errors and offers more convenience. You can ask your provider to look for your local military pharmacy in the e-prescribing database/network.

Non-formulary drugs are generally not available at military pharmacies. To check the availability of a particular drug, contact the nearest military pharmacy.

TRICARE Pharmacy Home Delivery

There's no cost for TRICARE Pharmacy Home Delivery for active duty service members. For all other beneficiaries, copayments apply for all covered drugs. You'll get up to a 90-day supply of your

prescription drugs with free standard shipping. You can easily order refills online, by phone, or by mail. Home delivery also provides you with convenient notifications about your order status, refill reminders, and assistance in renewing expired prescriptions. If you have questions about your prescriptions, pharmacists are available 24/7 to speak confidentially with you.

For faster processing of your home delivery prescriptions, register before placing your first order. Once you're registered, your provider can send prescriptions electronically or by phone. Express Scripts sends your medications directly to your home within about 14 days of receiving your prescription. Register for TRICARE Pharmacy Home Delivery using any of the options listed in Figure 4.1.

Note: Overseas beneficiaries must have an Army/Air Post Office, Fleet Post Office, or Diplomatic Post Office address or be assigned to a U.S. Embassy or Consulate and have a prescription from a U.S.-licensed provider to use home delivery. Refrigerated medications can't be shipped to APO/FPO/DPO addresses. Home delivery is available overseas with APO/FPO/DPO addresses (not available in Germany, Norway, or Saudi Arabia) and with certain restrictions. If you live in Germany, Norway, or Saudi Arabia, fill prescriptions at military or overseas pharmacies when possible.

You aren't eligible to use TRICARE Pharmacy Home Delivery if you have other health insurance with a prescription plan, including a Medicare Part D prescription program, **unless** you meet one of the following requirements:

- Your OHI doesn't include pharmacy benefits.
- Your OHI doesn't cover the drug you need.
- You've met your OHI's benefit cap (for example, you've met your benefit's maximum coverage limit).
- You have a supplemental pharmacy benefit that is managed by Express Scripts.

To ensure you have your prescription refill when you need it, Express Scripts offers an automatic refill program. To learn more, call **877-363-1303**. You can sign up for the refill program at **https://militaryrx.express-scripts.com/automatic-refills**.

Learn more about TRICARE Pharmacy Home Delivery at **www.tricare.mil/homedelivery**.

Figure 4.1 *TRICARE Pharmacy Home Delivery Registration Methods*

ONLINE	Visit **www.esrx.com/mhd**
PHONE	Call **877-363-1303** or **877-540-6261** (TDD/TTY)
MAIL	Download the registration form from **https://militaryrx.express-scripts.com/forms** and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85082

TRICARE Retail Network Pharmacies

Another option for filling your prescriptions is through TRICARE retail network pharmacies. To fill prescriptions, present your prescription and Uniformed Services ID card to the pharmacist. All beneficiaries (except active duty service members) pay one copayment for 30-day supply of covered drugs.

This option allows you to fill your prescriptions at TRICARE retail network pharmacies throughout the U.S. without having to submit a claim. You have access to TRICARE retail network pharmacies in the U.S. and the U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. There are no TRICARE retail network pharmacies in American Samoa.

To find a pharmacy nearby, visit **www.esrx.com/findpharmacy** or call **877-363-1303** for customer service, including finding the nearest TRICARE retail network pharmacy.

Non-Network Pharmacies

At non-network pharmacies, you pay the full price of your medication up front and file a claim for reimbursement. Claims are subject to deductibles, out-of-network cost-shares, and copayments. You must meet all deductibles before TRICARE can reimburse you. For details about filing a claim, see the *Claims* section.

PHARMACY POLICY

Quantity Limits

TRICARE has established quantity limits on certain medications, which means the Department of Defense pays for a specified, limited amount of medication each time you fill a prescription. Quantity limits are often applied to ensure medications are used safely and appropriately.

Exceptions to established quantity limits may be made if the prescribing provider can justify medical necessity, or in cases of natural disasters, as approved by TRICARE.

Prior Authorization

Some drugs require prior authorization, also known as pre-authorization, from Express Scripts. Drugs requiring prior authorization may include, but aren't limited to, prescription drugs specified by the DOD Pharmacy and Therapeutics Committee, brand-name drugs with generic equivalents, drugs with age limitations, and drugs prescribed for quantities exceeding normal limits. Search for your drug to see if it's covered under TRICARE, requires prior authorization, or has quantity limits by going to **https://militaryrx.express-scripts.com**, hovering over "Benefits" on the page menu, and clicking on "Covered Medications." You can also call **877-363-1303** for information about your prescription drug.

Generic Formulary and Brand-Name Formulary Drugs

Generic drugs are medications approved by the U.S. Food and Drug Administration that are clinically the same as brand-name drugs. Generic drugs provide the same safe, effective treatment as brand-name drugs. It's generally DOD policy to use generic formulary drugs instead of brand-name drugs whenever possible. Generally, a

generic equivalent of a brand-name drug will be dispensed. To receive a brand-name drug, your prescribing provider must complete a clinical assessment, which confirms a brand-name is medically necessary. Express Scripts must grant approval. Prescribers can call **866-684-4488** to submit a request for a brand-name drug to be dispensed instead of a generic, or fax a completed form to **866-684-4477**. Find the *Brand over Generic Prior Authorization Request Form* at **https://militaryrx.express-scripts.com/forms**. Log in to your account to find and print out the form. To see if your brand-name drug has a generic equivalent, go to **www.esrx.com/tform**. If a generic-equivalent drug doesn't exist or isn't on the formulary, the brand-name drug is dispensed at the brand-name copayment. If you fill a prescription for a brand-name drug that isn't considered medically necessary and when a generic equivalent is available, you're responsible for paying the entire cost of the prescription.

Non-Formulary Drugs

The DOD P&T Committee may recommend that certain drugs be placed in the non-formulary category. These medications include any drug in a therapeutic class determined to be less clinically effective or less cost-effective than other drugs in the same class. Non-formulary drugs are available through the TRICARE Pharmacy Program at an additional cost. You may be able to fill non-formulary prescriptions at formulary costs if your provider can establish medical necessity by completing and submitting the appropriate TRICARE pharmacy medical-necessity form for the non-formulary medication. For forms and medical-necessity criteria, search for the non-formulary medication by either going to **https://militaryrx.express-scripts.com** hovering over "Benefits" on the page menu, and clicking on "Covered Medications" or calling Express Scripts at **877-363-1303**.

Note: Some non-formulary drugs are only covered through home delivery. Check with Express Scripts before filling prescriptions for non-formulary drugs at a TRICARE retail network pharmacy.

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

Non-Covered Drugs

Non-covered prescription drugs are excluded from TRICARE coverage. If your drug falls into the non-covered category, you'll have to pay the full cost of the prescription drug.

Compound Drugs

A pharmacist makes compound drugs by mixing multiple ingredients together to create a prescription drug that's specific to a beneficiary's needs. TRICARE screens all prescriptions for compound drugs to ensure each ingredient of the drug is safe, effective, and covered by TRICARE.

If your compound drug doesn't pass the initial screening, you have three options:

1. Your pharmacist may be able to use a different, approved ingredient.
2. Your health care provider may prescribe a different drug.

3. Your health care provider may request a prior authorization. If the prior authorization is denied, you can appeal that decision.

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

Specialty Drugs

Specialty prescription drugs are used to treat chronic, complex conditions. Examples of these conditions include multiple sclerosis, rheumatoid arthritis, and hepatitis. Specialty drugs include drugs that can be injected, infused, or inhaled. Specialty drugs are usually self-administered. Some specialty drugs require special storage and handling, such as refrigeration. Many specialty drugs are high cost and aren't readily available at your local pharmacy. Specialty drugs may also have side effects that require nurse or pharmacist monitoring.

Visit the TRICARE Formulary Search Tool or view the specialty drug list to see if you're taking a specialty medication. You can find the Formulary Search Tool at **https://express-scripts.com/tform**. Find the specialty drug list at **www.tricare.mil/specialtydrugs**.

FILLING SPECIALTY PRESCRIPTION DRUGS

The TRICARE pharmacy network* where you may fill specialty drug prescriptions includes:

- TRICARE Pharmacy Home Delivery
- TRICARE retail network pharmacies†
- Military pharmacies

Call first to see if your specialty prescription drug is available. To find and compare copayments for specialty drugs, go to **www.esrx.com/tform**.

* *Unless your specialty drug is a Limited Distribution Drug.*

† *Unless your specialty drug is required to be filled through TRICARE Pharmacy Home Delivery or a military pharmacy.*

TRICARE Pharmacy Home Delivery

When you fill specialty drug prescriptions through TRICARE Pharmacy Home Delivery, you'll receive specialty pharmacy services from Accredo.

Accredo is an accredited specialty pharmacy serving patients with complex and long-term health conditions.

Accredo specialty pharmacy services include scheduled prescription drug delivery and refill reminder calls. You can also get advice from staff trained in your condition. This service continues as long as you're taking the specialty medication. With Accredo, you won't pay anything more beyond your TRICARE copayment.

To get started, call **877-882-3324**. An Accredo patient care advocate is available to work with you. They can also connect you with your military or civilian prescriber, as needed. To learn more about Accredo, go to **www.tricare.mil/specialtydrug**s.

Specialty drugs you get through home delivery are subject to applicable copayments. To view copayments for covered drugs, visit **www.esrx.com/tform.**

If your specialty drugs aren't available through TRICARE Pharmacy Home Delivery or Accredo, you may be able to fill

them through a TRICARE retail network pharmacy. You may also be able to fill them at a military pharmacy.

TRICARE Retail Network Pharmacies

You may be able to fill your specialty drug prescription at TRICARE retail network pharmacies, including Accredo.

Accredo is the primary retail specialty pharmacy for TRICARE. However, other retail network pharmacies may be able to fill your specialty drug prescriptions.

To find a TRICARE retail network pharmacy that can fill your specialty drug prescription, go to **www.esrx.com/findpharmacy**. Contact your pharmacy to confirm they carry the drug you need.

When you fill a specialty drug prescription at a TRICARE retail network pharmacy, you'll pay the applicable copayment.

In some cases, you must fill certain specialty drugs prescriptions through TRICARE Pharmacy Home Delivery. This includes certain maintenance drugs and specialty drugs that require medication monitoring. In these cases, you can get two courtesy refills at a TRICARE retail network pharmacy. After that, you'll pay full price. To avoid paying more at retail pharmacies, transfer your specialty drug prescriptions to TRICARE Pharmacy Home Delivery or to a military pharmacy.

Military Pharmacies

Some military pharmacies may stock your specialty drug. You should call your local military pharmacy first to see if your specialty drug is available. There's no cost to fill covered specialty drug prescriptions at a military pharmacy. To find a military pharmacy near you, go to **www.tricare.mil/mtf**.

Non-Network Retail Pharmacies

If you choose to fill your specialty prescription at a non-network pharmacy, you pay the full price for a covered drug up front and file a claim for reimbursement. Reimbursements are subject to applicable deductibles, cost-shares, copayments, and other charges. All deductibles must be met before you can be reimbursed. Overseas, most pharmacies are non-network pharmacies.

Limited Distribution Drugs

A limited distribution drug is created when a drug manufacturer limits the number of pharmacies that have access to a particular specialty drug. To find out if you're taking a LDD and where you can fill it, visit **https://express-scripts.com/tform**.

PHARMACY CLAIMS

You don't need to file pharmacy claims for prescriptions filled at military pharmacies, through TRICARE Pharmacy Home Delivery or at TRICARE retail network harmacies. However, if you fill a prescription at a non-network pharmacy in the U.S. or U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands), you must pay the full price of your prescription up front and file a claim to get money back.

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

To file a paper claim:

1. Download the *TRICARE DoD/ CHAMPUS Medical Claim—Patient's Request for Medical Payment* form (DD Form 2642) by visiting **www.tricare.mil/pharmacyclaims**.
2. Complete the form and attach the required paperwork as described on the form.
3. Mail the form and paperwork to:

   Express Scripts, Inc.
   TRICARE Claims
   P.O. Box 52132
   Phoenix, AZ 85082

Prescription claims require the following information for each drug:

- Patient's name
- Drug name, strength, date filled, days' supply, quantity dispensed, and price
- National Drug Code, if available
- Prescription number
- Name and address of the pharmacy
- Name and address of the prescribing provider
- Shipping invoice from OHI mail order pharmacy, if applicable
- Explanation of benefits from OHI, if applicable

If you have OHI with pharmacy benefits and have questions about filing OHI-related pharmacy claims, call Express Scripts at **877-363-1303**.

Pharmacy Claims Overseas

Overseas, you can fill prescriptions at military pharmacies or through home delivery, if available. Otherwise, you'll need to fill prescriptions at overseas pharmacies by paying the full cost up front and filing a claim with the TRICARE Overseas Program claims processor to get money back. You must submit proof of payment with all overseas pharmacy claims, including an itemized bill or invoice. For more information about how to file claims for prescriptions filled overseas, visit **www.tricare.mil/pharmacyclaims**.

Pharmacy Claims Appeals

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

Your signed, written request must state the specific matter you disagree with. Send your request to:

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

Your request for reconsideration must have a postmark or be received within 90 calendar days from the date of the decision. There shouldn't be a delay while additional documentation is forthcoming. If you're going to send additional documentation, you must state in your letter requesting reconsideration that you're sending additional documentation by a specific date.

Claims

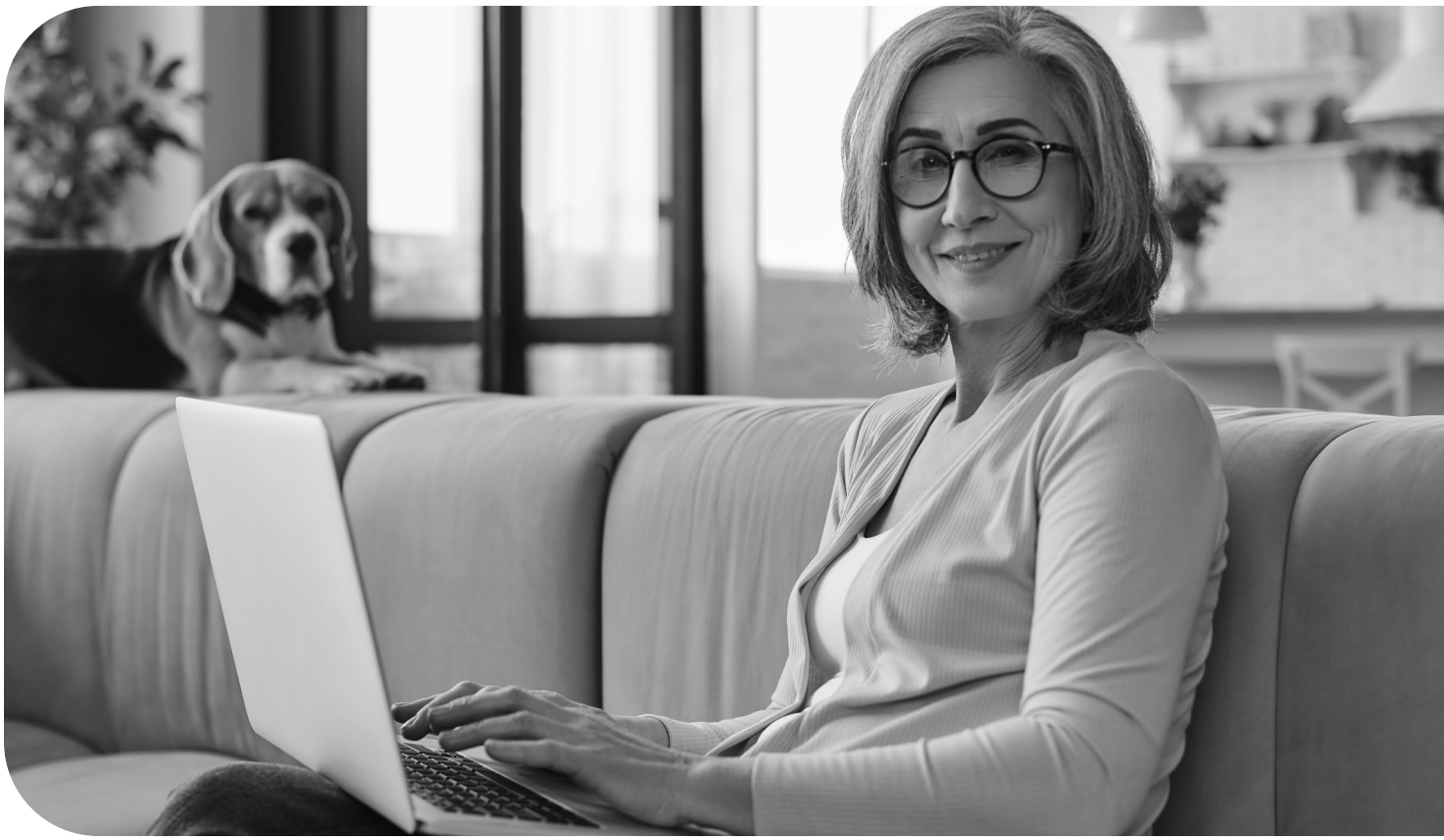
HEALTH CARE CLAIMS IN THE U.S. AND U.S. TERRITORIES

In most cases, your provider files your health care claims with Medicare first. Medicare pays its portion and, unless you have other health insurance, forwards the claim to WPS/TFL for for processing.

Note: If you have TRICARE Prime and Medicare, your claims will process as described above. Your claims won't process through your regional contractor.

However, when TRICARE is the primary payer (for example, if Medicare doesn't cover the health care service), your provider may be required to file your claim directly with WPS/TFL. If you have OHI, you must file the claim with your OHI before filing with WPS/TFL.

You must file your claims within one year of either the date of service or the date of an inpatient discharge. To file a claim with WPS/TFL, fill out a *TRICARE DoD/ CHAMPUS Medical Claim—Patient's Request for Medical Payment* form (DD Form 2642). You can download forms and instructions from TRICARE at **www.tricare.mil/claims** or the WPS website at **www.TRICARE4u.com**.



When filing a claim with TFL, include your *Medicare Summary Notice* and OHI explanation of benefits, if applicable.

Attach a readable copy of the provider's bill to the claim form, making sure it includes the following:

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

For care received in the U.S. or U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands), claims must be filed within three years of either the date of service or the date of an inpatient discharge. Send claims to the WPS/TFL mailing address provided in the *Important Contact Information* section.

HEALTH CARE CLAIMS OVERSEAS

TRICARE is the primary payer for care overseas—unless you have OHI—and Medicare pays nothing. You're required to submit proof of payment with all claims for care received overseas. Proof of payment may include a credit card receipt, canceled check, credit card statement, or invoice from the provider that clearly states payment was received. For more information, contact your TRICARE Overseas Program Regional Call Center and choose option 2 for claims assistance or visit **www.tricare.mil/proofofpayment**.

Unlike other TRICARE beneficiaries, TFL beneficiaries should file claims in the overseas areas where they received care.

Claims for care you get outside the U.S. and U.S. territories must be filed within three years of either the date of service or the date of an inpatient discharge. Send claims to the appropriate TRICARE Overseas Program mailing address provided in the *Important Contact Information* section.

APPEALING A CLAIM OR PRE-AUTHORIZATION DENIAL

You can appeal decisions regarding claims payments or pre-authorization denials of requested services. Medicare and TFL have separate appeals processes. Medicare-related appeals should be submitted to Medicare. You should only submit appeals to WPS if TRICARE is the primary payer.

THIRD-PARTY LIABILITY

If TRICARE is the primary payer, the Federal Medical Care Recovery Act allows TRICARE to get money back for treatment costs if you're injured in an accident caused by someone else. If a claim appears to have third-party liability involvement, you'll receive the *Statement of Personal Injury—Possible Third Party Liability* form (DD

Form 2527). Within 35 calendar days, you must complete and sign this form and follow the directions for returning it to the appropriate claims processor. Visit **www.tricare.mil/claims** and click on "Third-Party Liability" to download *DD Form 2527*.

EXPLANATION OF BENEFITS

A TRICARE explanation of benefits isn't a bill. It's an itemized statement that shows the action TRICARE has taken on your claims. An EOB is for your information and files.

After reviewing the EOB, you have the right to appeal certain decisions regarding your claims and must do so in writing within 90 days of the date of the EOB notice. Be sure to keep EOB statements with your health insurance records for future reference.

For more information about appeals, visit **www.TRICARE4u.com** or see the *For Information and Assistance* section.

DEBT COLLECTION ASSISTANCE OFFICERS

TRICARE Debt Collection Assistance Officers are located at military hospitals and clinics and TRICARE Regional Offices to help resolve your TRICARE health care collection-related issues. Contact a DCAO if you received a negative credit rating or were contacted by a collection agency due to an issue related to your TFL claim.

When you visit a DCAO, you must bring or submit documentation associated with a collection action or adverse credit rating, including debt collection letters, EOB statements, and medical or dental bills from providers. The more information you provide, the faster the cause of the problem can be determined. The DCAO researches your claim, provides you with a written resolution of your collection problem, and informs the collection agency that action is being taken to resolve the issue.

DCAOs can't provide legal advice or repair your credit rating, but they can help by providing documentation for the collection or credit-reporting agency to explain the circumstances relating to the debt.

Visit the Customer Service Community Directory at **www.tricare.mil/bcacdcao** to find a DCAO near you.

TRICARE DCAOs can only assist you with TFL-related issues. Contact Medicare for assistance with Medicare-related issues.

Life Changes: Keep Your DEERS Information Up To Date

TRICARE For Life continues to provide health care coverage for you as your life changes. However, you need to take specific actions to make sure you remain TRICARE-eligible. It's essential that you keep information in the Defense Enrollment Eligibility Reporting System current for you and your family. DEERS is a database of uniformed service members (active duty and retired), their family members, and others who are eligible for military benefits, including TRICARE. Current DEERS registration is key to getting timely, effective TFL benefits.

Note: Your Social Security number and the SSNs of each of your covered family members should be included in DEERS for TRICARE coverage to be reflected accurately.

Maintaining your DEERS information is your responsibility. It's essential to verify your information in DEERS anytime you have a life-changing event. You have several options for updating and verifying DEERS information. See the *Important Contact Information* section.

Note: Only sponsors (or a sponsor-appointed individual with valid power of attorney) can add a family member in DEERS. Family members age 18 and older can update their own contact information.

USING MILCONNECT TO UPDATE INFORMATION IN DEERS

Active duty service members, retirees, and eligible family members can use the milConnect website to see health care eligibility and personnel information, Uniformed Services ID cards, and information on other benefits, including Servicemembers' Group Life Insurance.

You can also use milConnect to sign up for benefit notifications. When benefit changes occur, you'll get an email directing you to log on to milConnect at **https://milconnect.dmdc.osd.mil**.

You can log on to milConnect's secure site using a Common Access Card, Defense Finance and Accounting Service myPay PIN, or DS Logon. You can visit a Veterans Affairs Regional Office to complete an in-person proofing process to request a DS Logon, or you can go online for a remote-proofing process. Visit **https://myaccess.dmdc.osd.mil** for more information. If you need a new ID card, you can visit a Uniformed Services ID card office and request a DS Logon at the same time.

Find an ID card office near you at **https://idco.dmdc.osd.mil/idco**.

GETTING MARRIED OR DIVORCED

Marriage

It's extremely important for sponsors to register new spouses in DEERS to ensure their TRICARE eligibility and coverage are reflected accurately. To register a new spouse in DEERS, the sponsor needs to provide a copy of the marriage certificate to the nearest Uniformed Services ID card office. The new spouse is also required to show two forms of ID (for example, any combination of Social Security card, driver's license, birth certificate, current Uniformed Services ID card, or CAC). Once your spouse is registered in DEERS, they get a Uniformed Services ID card and may use TRICARE. Your spouse must show their ID card to get care.

Divorce

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

Former Spouse Coverage

Certain former spouses are eligible to continue TFL coverage as long as they:

- Don't remarry (If a former spouse remarries, the loss of benefits remains applicable even if the remarriage ends in death or divorce, unless the new spouse is a sponsor.)
- Aren't covered by employer-sponsored health plans

Figure 6.1 *Eligibility Situations for Former Spouses*

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

1. For divorce decrees, dissolutions, or annulments on or before Sept. 29, 1988, check DEERS for eligibility information.

- Aren't also former spouses of NATO or Partners for Peace nation members
- Meet the requirements of one of the two situations described in Figure 6.1 on the previous page

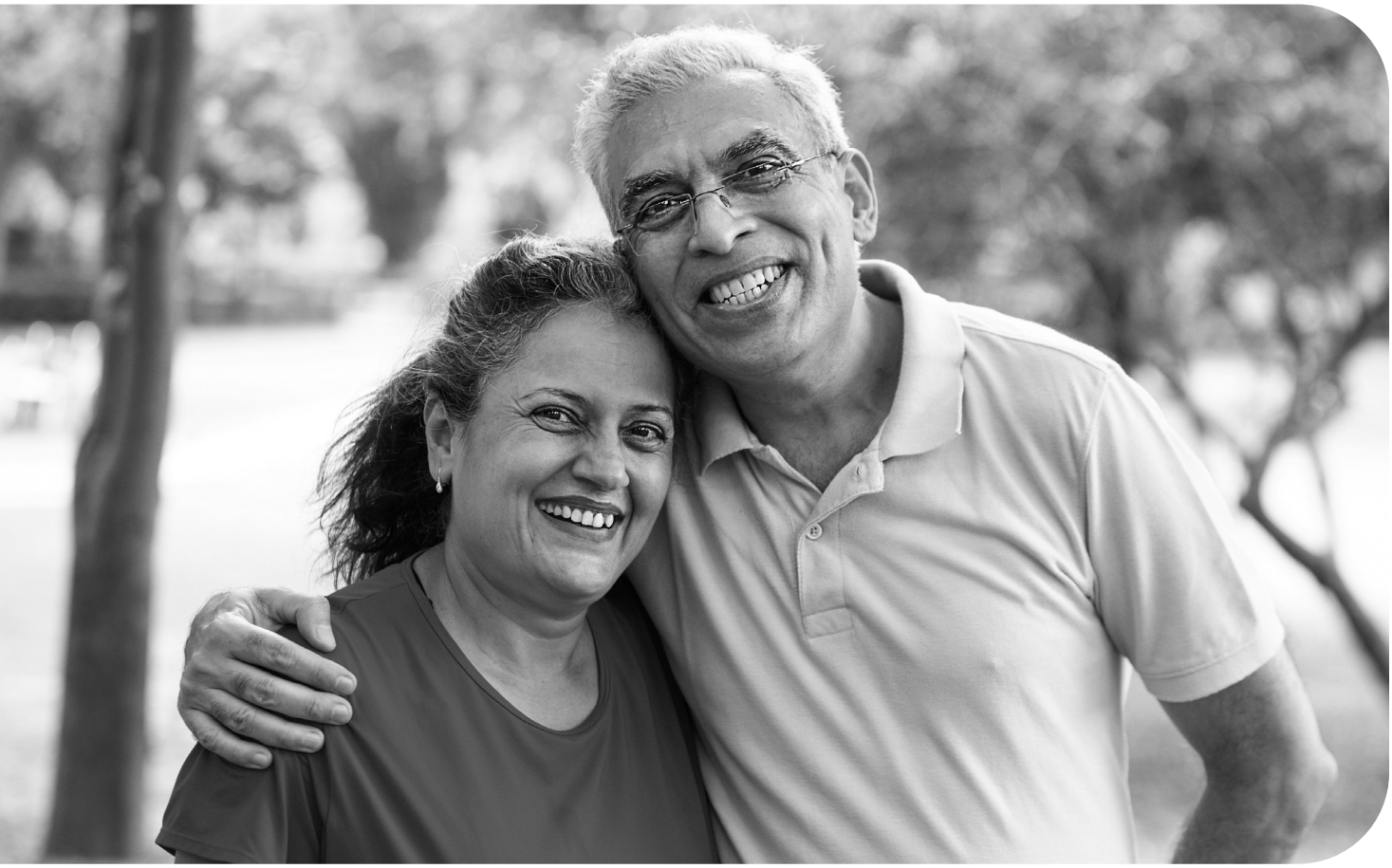
Former spouses who are TRICARE eligible must change their personal information in DEERS, so their name and SSN or DOD Benefits Number are listed for the primary contact information. The former spouse's TRICARE eligibility is shown in DEERS under his or her own SSN or DBN, not the sponsor's.

Former spouses who aren't eligible for TRICARE may not continue seeking health care services under the TRICARE benefit. If an ineligible former spouse continues to do so, the former spouse or the sponsor may have to pay TRICARE for those services.

MOVING

Whether you're moving across the street or overseas, TFL moves with you. Just update your personal information in DEERS, find a provider who is a Medicare participating or Medicare non-participating provider (in the U.S. and U.S. territories),* and continue to get care when you need it. See "Finding a Provider" in the *Getting Care* section.

* *The U.S. territories include American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.*



CHILDREN

Your children's coverage doesn't change because you're eligible for TFL. Any children who retain eligibility under the sponsor remain TRICARE-eligible until reaching age 21 (or age 23, if enrolled full-time at an approved college and if the sponsor provides over 50% of the financial support), as long as their DEERS information is current.

To extend coverage beyond your child's 21st birthday, contact your local Uniformed Services ID card office to verify what documentation you need to bring with you. To find an office near you, go to **https://idco.dmdc.osd.mil/idco**.

At age 21 (or 23, if enrolled full-time at an approved college and if the sponsor provided over 50% of the financial support), adult children may qualify to purchase TRICARE Young Adult coverage until reaching age 26, and later, Continued Health Care Benefit Program coverage. For more information on TYA, visit **www.tricare.mil/tya**. For more information on CHCBP, visit **www.tricare.mil/chcbp**.

Note: Children with disabilities may remain TRICARE-eligible beyond the normal age limits. Check with your sponsor's service for eligibility criteria.

SURVIVOR COVERAGE

If your TFL sponsor dies, you remain TRICARE-eligible and will continue to get TRICARE benefits as long as your DEERS information is up to date and you're either of the following:

- A surviving spouse who hasn't remarried (If you remarry, you can't regain TRICARE coverage later, even if you divorce or your new spouse dies.)
- A surviving unmarried child under age 21 (or age 23, if enrolled full-time at an approved college and if the sponsor provided over 50% of the financial support)

Note: Children with disabilities may remain TRICARE-eligible beyond normal age limits. Check with your sponsor's service for eligibility criteria.

SUSPENSION OF SOCIAL SECURITY DISABILITY INSURANCE

Medicare coverage may continue up to eight years and six months following suspension of Social Security Disability Insurance payments. When SSDI payments are suspended because you've returned to work, you'll get quarterly bills for the Medicare Part B premium. As long as you remain eligible for premium-free Medicare Part A, you must pay the Part B premium to maintain your TRICARE coverage.

For Information and Assistance

BENEFICIARY COUNSELING AND ASSISTANCE COORDINATORS

TRICARE Beneficiary Counseling and Assistance Coordinators can help you with TRICARE For Life questions and concerns, and they can advise you about getting health care. BCACs work at military hospitals and clinics and TRICARE Regional Offices. To locate a BCAC, visit the Customer Service Community Directory at **www.tricare.mil/bcacdcao**.

YOUR RIGHT TO APPEAL A DECISION

If you believe a service or claim was denied improperly, in whole or in part, you (or another appropriate party) may file an appeal. An appeal must involve an appealable issue. For example, you have the right to appeal Medicare or TFL decisions about claims payments.

Medicare and TFL have separate claims processes. For most services, Medicare is your primary payer. To appeal a Medicare decision, follow the instructions on your *Medicare Summary Notice*. Contact WPS Government Services to appeal TFL decisions.

Medicare Denials

Any services or supplies denied payment by Medicare and appealable under Medicare aren't considered for coverage by TFL. However, if a Medicare appeal results in some payment by Medicare, TRICARE considers coverage as the second payer.

For more information on Medicare appeals, read the back of your *Medicare Summary Notice* or contact Medicare.

TRICARE For Life Appeals Requirements

You may appeal a TFL denial of a requested pre-authorization of services even if no care was provided and no claim was submitted. There are some things you may not appeal. For example, when TRICARE is the primary payer, you may not appeal the denial of care from a provider who isn't TRICARE-authorized.

When services are denied based on medical necessity or a benefit decision, you're automatically notified in writing. The notification includes an explanation of what was denied or why a payment was reduced and the reasoning behind the decision.

Filing TRICARE For Life Appeals

TFL appeals must be filed with WPS within 90 days from the date that appears on the explanation of benefits or denial notification letter. If you aren't satisfied with a decision on an appeal, there may be further levels of appeal available to you. Your TFL appeal must meet the requirements listed in Figure 7.1 on the following page. For specific information about filing a TFL appeal, contact WPS.

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

Appeals should include the following:

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

Figure 7.1 *TRICARE For Life Appeals Requirements*

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

A description of the issue or concern must include:

- The specific issue in dispute
- A copy of the previous denial determination notice
- Any appropriate supporting documents

FILING A GRIEVANCE

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

The TFL grievance process provides the opportunity to report, in writing, any concern or complaint regarding health care quality or service. Any TFL civilian or military provider; TFL beneficiary; sponsor; or parent, guardian, or other representative of an eligible child may file a grievance. WPS is responsible for the investigation and resolution of all grievances.

Grievances are generally resolved within 60 days of receipt. Following resolution, the party that submitted the grievance is notified of the review completion.

Grievances may include such issues as:

- The quality of health care or services (for example, accessibility, appropriateness, level, continuity, or timeliness of care)
- The demeanor or behavior of providers and their staff members
- The performance of any part of the health care delivery system
- Practices related to patient safety

When filing a grievance, include the following information:

- Beneficiary's name, address, and phone number
- Sponsor's SSN or DBN
- Beneficiary's date of birth
- Beneficiary's signature

A description of the issue or concern must include the following:

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

See the *Important Contact Information* section for grievance contact information at WPS. Contact Medicare to file Medicare-related grievances.

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TRICARE For Life Handbooks are available in hard copy. To order, call WPS at 866-773-0404.

TRICARE For Life Contractor (U.S. and U.S. Territories)

WPS Government Services
866-773-0404
www.TRICARE4u.com

TRICARE Pharmacy Program Contractor

Express Scripts, Inc.
877-363-1303
https://militaryrx.express-scripts.com

TOP Regional Call Centers (Overseas)

TRICARE Eurasia-Africa

+44-20-8762-8384 (overseas)
877-678-1207 (stateside)
tricarelon@internationalsos.com

TRICARE Latin America and Canada

+1-215-942-8393 (overseas)
877-451-8659 (stateside)
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