TRICARE® For Life

FEBRUARY 2020

HANDBOOK

Learn how TRICARE and Medicare work together

Important Information

TRICARE Website:	www.tricare.mil
TRICARE For Life Contractor	
Wisconsin Physicians Service (WPS)—Military and Veterans Health:	1-866-773-0404
TRICARE For Life Website:	www.TRICARE4u.com
TRICARE East Region Contractor	
Humana Military:	1-800-444-5445
Humana Military Website:	HumanaMilitary.com
	www.tricare-east.com
TRICARE West Region Contractor	
Health Net Federal Services, LLC:	1-844-866-WEST (1-844-866-9378)
Health Net Federal Services, LLC Website:	www.tricare-west.com
Medicare:	1-800-MEDICARE (1-800-633-4227)
Social Security Administration:	1-800-772-1213

An Important Note About TRICARE Program Information

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

Keep Your DEERS Information Up To Date!

It is essential to keep information in the Defense Enrollment Eligibility Reporting System (DEERS) 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 dependent could be considered fraud and a basis for administrative, disciplinary and/or other appropriate action.

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

Most TRICARE plans meet the Affordable Care Act requirement for minimum essential coverage. You'll get an Internal Revenue Service Form 1095 from your pay center each January listing the coverage you had during the previous tax year. You can find other health care coverage options at **www.healthcare.gov**.

Important Contact Information

TRICARE FOR LIFE CONTRACTOR

Wisconsin Physicians Service (WPS)—Military and Veterans Health administers the TRICARE For Life (TFL) benefit and should be your primary contact for TRICARE-related customer service needs in the U.S. or U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands). International SOS Government Services, Inc. (International SOS) administers the TFL benefit overseas.

GENERAL CONTACT INFORMATION	GRIEVANCES
Phone: **1-866-773-0404** Online: **www.TRICARE4u.com** Written Correspondence: WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707	Email: **reportit@wpsic.com** 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)

You have several options for updating and verifying DEERS information:

In person (add a family member or update contact information)	Visit a local ID card office. Find an office near you at **www.dmdc.osd.mil/rsl**. Call to verify location and business hours.
Phone or fax (update contact information)	**1-800-538-9552** (phone) **1-866-363-2883** (TDD/TTY) **1-800-336-4416** (fax)
Online (update contact information)	milConnect: **https://milconnect.dmdc.osd.mil**
Mail (update contact information)	Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955

TRICARE REGIONAL CONTRACTORS

Regional contractors provide health care services and support in the TRICARE regions. They can help TFL beneficiaries with prior authorizations, but they do not provide referrals for TFL beneficiaries. You may go to **www.medicare.gov** for help in locating 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 are overseas, your TRICARE Overseas Program (TOP) 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 1-800-444-5445 HumanaMilitary.com www.tricare-east.com
TRICARE West Region
Health Net Federal Services, LLC 1-844-866-WEST (1-844-866-9378) www.tricare-west.com

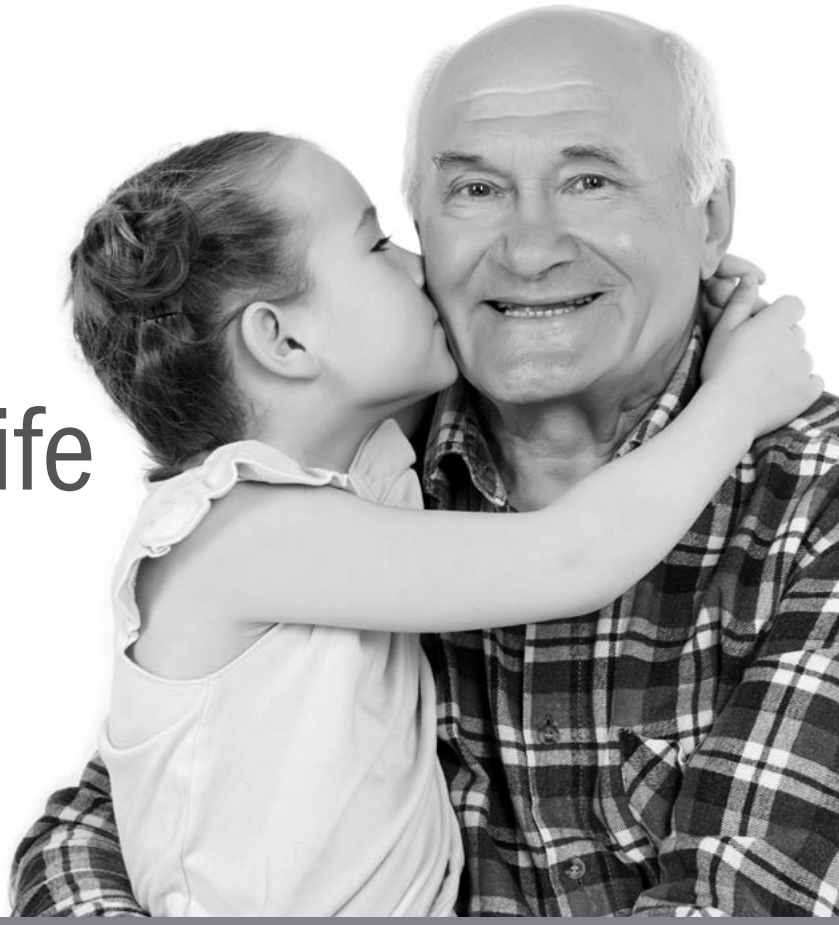
TOP Regional Call Centers (Overseas)

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

OTHER CONTACT INFORMATION

FOR MORE INFORMATION	RESOURCE NUMBERS	WEBSITES
Medicare	1-800-633-4227	www.medicare.gov
Social Security Administration	1-800-772-1213	www.ssa.gov
TRICARE Pharmacy Program	1-877-363-1303	www.tricare.mil/pharmacy www.express-scripts.com/TRICARE
TRICARE Dental Program	1-844-653-4061 (CONUS) 1-844-653-4060 (OCONUS) 711 (TDD/TTY)	www.uccitdp.com
Federal Employees Dental and Vision Insurance Program	See website	www.tricare.mil/fedvip www.benefeds.com
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
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 (TFL) provides comprehensive health care coverage. 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. Medicare-participating providers file your claims with Medicare. After paying its portion, Medicare automatically forwards the claim to TRICARE for processing (unless you have other health insurance [OHI]). TRICARE pays after Medicare and OHI for TRICARE-covered health care services. See “Finding a Provider” in the *Getting Care* section of this handbook for information about provider types.

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

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How TRICARE For Life Works

ELIGIBILITY

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

TRICARE Eligibility Requirements

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

- Medicare Part B coverage is required to remain TRICARE-eligible if you are a(n):
  - Retired service member (including retired National Guard and Reserve members drawing retirement pay)
  - Family member of a retired service member
  - Medal of Honor recipient or eligible family member
  - Survivor of a deceased sponsor
  - Eligible former spouse
- Medicare Part B coverage is **not** required to remain TRICARE-eligible if:
  - You are an active duty service member (ADSM) or active duty family member (ADFM) (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 are enrolled in TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA), or the US Family Health Plan (USFHP) (While you are not required to have Medicare Part B to remain eligible for TRS, TRR, TYA, or USFHP, you are strongly encouraged to sign up for Medicare Part B when first eligible to avoid paying a late-enrollment premium surcharge.)

Note: Regardless of age, ADFMs who have Medicare Part A may enroll in TRICARE Prime if they live in a Prime Service Area (PSA), 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 offered. It is typically an area near a military hospital or clinic. The TRICARE Prime enrollment fee is waived for any TRICARE Prime beneficiary who has Medicare Part B, regardless of age. For more information, visit **www.tricare.mil/prime**.

UNDERSTANDING MEDICARE

TFL is managed by the Department of Defense. Medicare is managed by the Centers for Medicare & Medicaid Services (CMS). The two agencies work together to coordinate benefits.

Medicare is a federal entitlement health insurance program for people:

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

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 (SSA) determines your entitlement to Medicare Part A based on your work history or your spouse's (this includes divorced or deceased spouses) work history. You are 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 are not entitled to premium-free Medicare Part A when you turn 65 under your own Social Security number (SSN), you must file for benefits under your spouse's (this includes divorced or deceased spouses) SSN if he or she is 62 or older. If your spouse is not yet 62, and you anticipate that he or she will 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 surcharge. You should then file for Part A benefits under your spouse's record two months before he or she turns 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 surcharge (10 percent for each 12-month period that you were eligible to enroll in Medicare Part B but did not) for as long as you have Medicare Part B. For specific information about your Part B premium and/or surcharge amount, call SSA at **1-800-772-1213**.

Medicare allows ADSMs and ADFMs who are entitled to Medicare based on age or disability (does not apply to those with ESRD) to delay Part B enrollment and sign up during a special enrollment period, which waives the late-enrollment premium surcharge. The special enrollment period for ADSMs and ADFMs is available anytime the sponsor is on active duty 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 do not have a special enrollment period and should enroll in Medicare Part A and Part B when first eligible.

USFHP and Medicare Entitlement

If you are a USFHP beneficiary under age 65 and entitled to premium-free Medicare Part A, you are strongly encouraged to have Medicare Part B (except for disabled ADFMs). If you are enrolled in USFHP and entitled to Medicare based on disability or age, you are not required to have Medicare Part B. As of Oct. 1, 2012, Medicare-eligible beneficiaries age 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 Entitlement Based on a Disability

If you receive Social Security disability benefits, you are entitled to Medicare in the 25th month of receiving disability payments. CMS will notify you of your Medicare entitlement date.

If you return to work and your Social Security disability payments are suspended, your Medicare entitlement continues for up to eight years and six months. When your disability payments are suspended, you will 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.

Medicare Entitlement Based on ESRD

If you are eligible for Medicare benefits based on ESRD, enroll in Medicare Part A and Part B when you are first eligible to remain TRICARE-eligible. ADSMs and ADFMs with ESRD do not have a special enrollment period and should enroll in Part B when first eligible to avoid the Part B late-enrollment premium surcharge.

Medicare Entitlement 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 Entitlement Based on Age

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

If you do not 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 65. Enroll no later than two months before the month you turn 65 to avoid a break in TRICARE coverage. You are eligible for Medicare coverage on the first day of the month before you turn 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 65. Enroll no later than one month before your birth month to avoid a break in TRICARE coverage. You are eligible for Medicare on the first day of the month you turn 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 surcharge for as long as you have Part B. The Medicare Part B surcharge is 10 percent for each 12-month period that you were eligible to enroll in Part B but did not.

Your Part B premiums are automatically taken out of your Social Security or U.S. Railroad Retirement Board monthly payments. If you do not 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.

FAQs

Frequently Asked Questions:

Medicare

I will be 65 soon and will become entitled to Medicare. I work full time and have employer-sponsored group health plan coverage, and 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 are entitled to 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 surcharge. 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 am not entitled to premium-free Medicare Part A when I turn 65, can I still use TFL?

Because you are not entitled to premium-free Medicare Part A, you do not need Medicare Part B to keep your TRICARE benefit. You do not 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 are not eligible for premium-free Medicare Part A under your own SSN when you turn 65, you must file for benefits under your spouse's (this includes divorced or deceased spouses) SSN if he or she is 62 or older. If your spouse is not yet 62, you must file for benefits under his or her SSN two months before he or she turns 62.

If you will 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 surcharge. Even if you are not eligible for premium-free Medicare Part A, you are eligible for Medicare Part B at age 65. See "Medicare Entitlement Based on Age" earlier in this section for more information.

If you sign up for Medicare and are not eligible for premium-free Part A under your or your spouse's (this includes divorced or deceased spouses) SSN, you will 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 (DEERS) record updated and get a new ID card. This allows you to keep your eligibility for TRICARE Prime or TRICARE Select after you turn 65.

Note: Uniformed services ID card offices will not 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.

Medicare Entitlement Based on an Asbestos-Related Disease

If you have 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 are 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 and/or TFL.

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, TFL pays the remaining amount and you pay nothing.

As the primary payer, Medicare approves health care services for payment. If Medicare does not pay because it determines that the care is not medically necessary, TFL also does not pay. You may appeal Medicare's decision and, if Medicare reconsiders and provides coverage, TFL also reconsiders coverage.

If a health care service is covered by both Medicare and TFL, but Medicare does not pay because you have used up your Medicare benefit, TFL becomes the primary payer. In this case, you are responsible for your TFL deductible and cost-shares.

Figure 1.1 ***TRICARE For Life Out-of-Pocket Costs***

TYPE OF SERVICE	MEDICARE PAYS	TRICARE PAYS	YOU PAY
Covered by TRICARE and Medicare	Medicare-authorized amount	Remaining amount	Nothing
Covered by Medicare only	Medicare-authorized 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)

If a health care service is normally covered by both Medicare and TFL, but you get the service from a provider who has opted out of Medicare, the provider cannot 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 (OHI). TFL pays the amount it would have paid if Medicare had processed the claim (normally TFL pays 20 percent of the TRICARE-allowable charge) and you are responsible for the remainder of the billed charges.

Similarly, U.S. Department of Veterans Affairs (VA) providers cannot 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. TFL pays up to 20 percent 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 is covered by Medicare only (for example, chiropractic care), Medicare processes the claim as the primary payer. TFL pays nothing, regardless of any action Medicare takes. You are responsible for the Medicare deductible and cost-shares.

Medical Services Covered by TRICARE but Not by Medicare

When you get care that is covered only by TFL (for example, TRICARE-covered services received overseas), TRICARE processes the claim as the primary payer. You are responsible for the applicable TFL 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 may bill. You are responsible for paying any amount that exceeds the TRICARE-allowable charge, in addition to your deductible and cost-shares. Visit **www.tricare.mil/overseas** for more information.

TFL claims are normally filed with Medicare first; however, when a health care service is not covered by Medicare, your provider may file the claim directly with Wisconsin Physicians Service (WPS)—Military and Veterans Health, unless you have OHI. See the *Claims* section of this handbook for more information.

Medical Services Not Covered by Medicare or TRICARE

When you get care that is not covered by Medicare or TFL (for example, most cosmetic surgery), neither makes a payment on the claim. You are responsible for the entire bill.

For more information on covered services, visit **www.medicare.gov** or **www.tricare.mil/coveredservices** or contact WPS.

See Figure 1.1 on the previous page for TFL out-of-pocket costs.

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, TFL pays last.

OHI Not Based on Current Employment

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

Other Health Insurance 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 TFL pays last. If there are fewer than 20 employees in the employer-sponsored plan, Medicare pays first, your OHI pays second and TFL 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 of this handbook 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, TFL 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 for processing.

Medicare does not provide coverage outside the U.S., U.S. territories or aboard ships outside U.S. territorial waters. Therefore, TFL 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 will be subject to the applicable catastrophic cap, deductibles and cost-shares. If a TFL beneficiary receives covered services from a network provider, the beneficiary's out-of-pocket costs will generally be lower. Prior authorization may be required (except for emergency care). When seeking care from a civilian provider, area- or country-specific requirements may also apply. For TFL deductibles and cost-shares, visit **www.tricare.mil/tflcosts**.

For requirements about getting care in the Philippines, see "Overseas Providers" in the *Getting Care* section of this handbook.

You should be prepared to pay upfront for services and submit a claim to the TRICARE Overseas Program (TOP) claims processor. Claims for care received overseas are submitted directly to the TOP claims-processing address for the area where you received care and must include proof of payment. See the *Claims* section of this handbook 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. For more information, visit **https://shipnpr.acl.gov**.

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

I am a TFL beneficiary and a retired federal employee. Can I suspend my Federal Employees Health Benefits (FEHB) 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). Eligible former spouses who have not remarried can get the form from the employing offices or retirement system maintaining their enrollments.

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

A referral or TRICARE prior authorization is not required under TFL when Medicare is the primary payer. However, when TFL becomes the primary payer, TRICARE prior authorization requirements apply.

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

Once you become entitled to premium-free Medicare Part A because you are age 65, you are eligible for TFL when you also have Medicare Part B. You are 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 will 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 hospitals or clinics to determine if TRICARE Plus is available and whether they may participate in it.

Enrollment in TRICARE Plus at one military hospital or clinic does not automatically extend TRICARE Plus enrollment to another military hospital or clinic. The military hospital or clinic is not 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 may 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 (TFL) is the primary payer, you must visit TRICARE-authorized providers and facilities. You will have significant out-of-pocket expenses when you get care from opt-out providers, or when seeing a U.S. Department of Veterans Affairs (VA) 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 do not accept the Medicare allowed amount as payment in full. They may charge up to 15 percent above the Medicare allowed amount, a cost that is covered by TFL.

Opt-Out Providers

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

Veterans Affairs Providers

VA providers cannot bill Medicare and Medicare cannot pay for services received from VA. If you are eligible for both TFL and VA benefits, you will 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 percent of the bill. By law, TRICARE can only pay up to 20 percent 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 Wisconsin Physicians Service (WPS)—Military and Veterans Health by calling **1-866-773-0404** to confirm coverage details and determine what is covered by TRICARE.

Military Hospitals and Clinics

A military hospital or clinic is usually located on or near a military base. You may 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 (ADFMs) enrolled in TRICARE Prime
3	Retired service members, their families and all others enrolled in TRICARE Prime or TRICARE Plus (primary care)
4	ADFMs not enrolled in TRICARE Prime TRICARE Reserve Select members and their families
5	Retired service members and their families, TRICARE Retired Reserve members and their families, beneficiaries enrolled in TRICARE Plus (specialty care) and all others not enrolled in TRICARE Prime

Overseas Providers

With TFL overseas, you may generally use any purchased care sector provider, also called a civilian provider, and get care at military hospitals and clinics if space is available, except in the Philippines, where you are required to see a certified provider for care. Additionally, TOP Select beneficiaries who reside in the Philippines and who seek care within designated Philippine locations are encouraged to see a TRICARE-preferred provider. Visit **www.tricare-overseas.com/philippines.htm** for more information.

When seeking care from a civilian provider, be prepared to pay upfront for services and submit a claim to the TRICARE Overseas Program (TOP) 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 are 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 of this handbook.

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 "prudent layperson" (someone with average knowledge of health and medicine) to 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 is medically necessary to

treat a covered medical—not a dental—condition). The TRICARE health care benefit does not cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontal, or emergency dental care that is not 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 is not 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 assistance in finding a civilian provider. Contact the TOP Regional Call Center within 24 hours if you are admitted to coordinate follow-on care.

URGENT CARE

Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but does require professional attention within 24 hours. You 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.

If it's after hours or you're not sure if you need to see a health care provider, contact the Military Health System (MHS) 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 **1-800-TRICARE (1-800-874-2273)**, option 1. You can talk to a registered nurse who can:

- Answer your urgent care questions
- Answer your pediatric care questions (pediatric nurses are available)
- 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

Note: *The MHS Nurse Advice Line is not intended for emergencies and is not a substitute for emergency treatment. If you think you may have a medical emergency, call 911 or go to the nearest emergency room.*

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 are 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.

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

PRIOR AUTHORIZATION FOR CARE

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

Prior authorization is a review of the requested health care service to determine if it is medically necessary at the requested level of care. If you have a prior authorization from a TRICARE regional contractor (Health Net Federal Services, LLC; Humana Military; or International SOS Government Services, Inc.) that covers the dates on your claim, WPS honors that prior authorization and no TFL prior authorization is required.

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

If you have questions about prior authorization requirements, contact WPS. See the *Important Contact Information* section at the beginning of this handbook for the WPS website and toll-free number.

The following services require prior authorization:

- Adjunctive dental services (dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition)*
- Extended Care Health Option 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 medications or those with quantity limitations)

Note: This list is **not** all-inclusive. For details about prior authorization requirements, contact WPS.

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

TRICARE For Life Coverage

MEDICAL COVERAGE

TRICARE For Life (TFL) and Medicare cover proven, medically necessary and appropriate care. TFL has special rules and limitations for certain types of care, and some types of care are not covered at all. TRICARE policies are very specific about which services are covered and which are not. It is in your best interest to take an active role in verifying coverage.

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

To determine if Medicare covers a specific service or benefit, visit **www.medicare.gov** or call **1-800-633-4227**. To determine if TFL covers the service or benefit, visit the TRICARE website at **www.tricare.mil** or call Wisconsin Physicians Service—Military and Veterans Health at **1-866-773-0404**. See Figure 1.1 in the *How TRICARE For Life Works* section of this handbook for more information on your out-of-pocket costs.

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

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

Note: This list is **not** all-inclusive.

* *If you are a retired sponsor, you may be eligible for the Retiree-At-Cost Hearing Aid Program and should call a participating military hospital or clinic. Visit **www.militaryaudiology.org** for more information.*

DENTAL COVERAGE

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

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 do not qualify to purchase coverage. For more information about the TDP, visit **www.uccitdp.com** or call United Concordia Companies, Inc. at **1-844-653-4061 (CONUS)** or **1-844-653-4060 (OCONUS)**.

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.com.**

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.com.**

FAQs

Frequently Asked Questions:
TRICARE For Life Coverage

Does TFL cover long-term care?

No. Long-term care (or custodial care) is not 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/insure/ltc** or call **1-800-582-3337**.

Does TRICARE cover skilled nursing care?

TFL 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 (SNF).

For TFL 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.

TFL 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 prior authorization on day 101, when TRICARE is the primary payer. TFL 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 **www.express-scripts.com/TRICARE** or call **1-877-363-1303**. The TRICARE pharmacy benefit is administered by Express Scripts, Inc. (Express Scripts).

When traveling overseas, be prepared to pay upfront for medications and file a claim to get money back for non-military hospital or clinic and non-network pharmacy services. TRICARE For Life recommends that you fill all of your prescriptions before traveling overseas.

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

Over-the-counter (OTC) drugs are not 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 do not 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 may 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 are enrolled at the military hospital or clinic.

Electronic prescribing (e-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 medications 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 is no cost for TRICARE Pharmacy Home Delivery for active duty service members. Copayments apply for all covered medications (up to a 90-day supply). Additionally, prescriptions are delivered to you with free standard shipping, and refills can be easily ordered 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 mail-order prescriptions, register before placing your first order. Once you are 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 on the next page.

Note: Overseas beneficiaries must have an APO/FPO 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 cannot be shipped to APO/FPO addresses. Beneficiaries living in Germany cannot use the home delivery option due to country-specific legal restrictions. If you live in

Germany, fill prescriptions at military or overseas pharmacies.

If you have prescription drug coverage through other health insurance (OHI), you can use TRICARE Pharmacy Home Delivery only if the medication is not covered under your OHI or if you exceed the OHI's coverage limit.

TRICARE Retail Network Pharmacies

Another option for filling your prescriptions is through TRICARE retail network pharmacies. To fill prescriptions (one copayment per 30-day supply), present your prescription and uniformed services ID card to the pharmacist.

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

Visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303** for customer service, including finding the nearest TRICARE retail network pharmacy.

Non-Network Pharmacies

When visiting non-network pharmacies, you pay the full price of your medication upfront and file a claim to get money back. Claims are subject to deductibles, out-of-network cost-shares and TRICARE-required copayments. All deductibles must be met before you can get money back. For details about filing a claim, see the *Claims* section of this handbook.

Figure 4.1 ***TRICARE Pharmacy Home Delivery Registration Methods***

ONLINE	Visit **www.express-scripts.com/TRICARE**.
PHONE	Call **1-877-363-1303** or **1-877-540-6261** (TDD/TTY).
MAIL	Download the registration form from **www.express-scripts.com/TRICARE**, and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072

PHARMACY POLICY

Quantity Limits

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

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 from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics (P&T) Committee, brand-name medications with generic equivalents, medications with age limitations and medications prescribed for quantities exceeding normal limits. Search for your drug at **www.express-scripts.com/tricareformulary** to see if it is covered under TRICARE, requires prior authorization or has quantity limits. You may also call **1-877-363-1303** for information about your drug.

Generic Formulary and Brand-Name Formulary Drugs

Generic drugs are medications approved by the U.S. Food and Drug Administration that are clinically equivalent to brand-name medications. Generic drugs provide the same safe, effective treatment as brand-name drugs. It is DoD policy to generally use generic formulary medications instead of brand-name medications whenever possible. A brand-name drug with a generic equivalent generally may be dispensed only after the prescribing provider completes a clinical assessment indicating the brand-name drug is medically necessary and after Express Scripts grants approval. Prescribers may call **1-866-684-4488** to submit a request for a brand-name drug to be dispensed instead of a generic, or a completed form may be faxed to **1-866-684-4477**. Find the *Brand over Generic Prior Authorization Request Form* by searching for the brand-name drug at **www.express-scripts.com/tricareformulary**. If a generic-equivalent drug does not exist or is not 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 is not considered medically necessary and when a generic equivalent is available, you are 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, call Express Scripts at **1-877-363-1303** or search for the non-formulary medication at **www.express-scripts.com/tricareformulary**.

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 **www.express-scripts.com/TRICARE**.

Non-Covered Drugs

Non-covered 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 drug.

Compound Drugs

Compound drugs are made by a pharmacist mixing multiple ingredients together to create a prescription drug that is 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 does not 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 Medication Care Management

Specialty medications are usually high-cost; self-administered; injectable, oral or infused drugs that treat serious chronic conditions (for example, multiple sclerosis, rheumatoid arthritis or hepatitis C). These drugs typically require special storage and handling and are not readily available at your local pharmacy. Specialty medications may also have side effects that require pharmacist and/or nurse monitoring.

The Specialty Medication Care Management program is in place to improve your health through continuous health evaluation, ongoing monitoring, assessment of

educational needs and medication-use management. This program provides:

- Access to proactive, clinically based services for specific diseases and is designed to help you get the most benefit from your medication
- Monthly refill reminder calls
- Scheduled deliveries to specified locations
- Specialty consultation with a nurse or pharmacist at any point during your therapy

These services are provided to you at no additional cost when you get your medications through TRICARE Pharmacy Home Delivery. Participation is voluntary.

If you or your provider orders a specialty medication from TRICARE Pharmacy Home Delivery, Express Scripts sends you additional information about the Specialty Medication Care Management program and how to get started.

With specific mailing instructions from you or your provider, TRICARE Pharmacy Home Delivery ships your specialty medication to your home. For your convenience and safety, TRICARE Pharmacy Home Delivery contacts you to arrange delivery before the medication is shipped.

Certain specialty medications may only be available through home delivery or retail pharmacies in the specialty network. The specialty network is a select network of retail specialty pharmacies in the TRICARE retail pharmacy network. These pharmacies have expertise in medication management for conditions that require specialty medications, and are able to provide these specialty medications to beneficiaries. Visit **www.express-scripts.com/TRICARE/pharmacy** to find a pharmacy in the specialty network.

PHARMACY CLAIMS

You do not need to file pharmacy claims for prescriptions filled at military pharmacies, through TRICARE Pharmacy Home Delivery or at TRICARE retail network pharmacies. 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 upfront and file a claim to get money back.

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

To file a 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 85072

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, see "Coordinating TRICARE For Life with Other Health Insurance" in the *How TRICARE For Life Works* section of this handbook. Call Express Scripts at **1-877-363-1303** with questions about filing pharmacy claims.

Pharmacy Claims Overseas

Overseas, you may fill prescriptions at military pharmacies or through home delivery, if available. Otherwise, you will need to fill prescriptions at overseas pharmacies by paying the full cost upfront 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 you disagree with the determination on your pharmacy claim (if your claim is denied), 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, and must include a copy of the claim decision.

Your signed, written request must state the specific matter you disagree with and must be sent to the following address:

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

Additional documentation in support of the appeal may be submitted; however, because the request for reconsideration must be postmarked or received within 90 calendar days of the date of the decision, do not delay the request for reconsideration for the sake of additional documentation. If additional documentation will be submitted at a later date, the letter requesting reconsideration must state that additional documentation will be submitted and specify the expected date of submission. Upon receiving your request, all TRICARE claims related to the entire course of treatment are reviewed.

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 (OHI), forwards the claim to TRICARE For Life (TFL) for processing.

However, when TFL is the primary payer (for example, if Medicare does not cover the health care service), your provider may be required to file your claim directly with Wisconsin Physicians Service (WPS)—Military and Veterans Health. If you have OHI, you must file the claim with your OHI before filing with TFL.

You are responsible for making sure your claims are filed within one year of either the date of service or the date of an inpatient discharge. To file a claim with 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 (EOB), if applicable.

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

- Patient's name
- Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN) (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 is not 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 one year of either the date of service or the date of an inpatient discharge. Send claims to the WPS/TRICARE For Life mailing address provided in the *Important Contact Information* section at the beginning of this handbook.

HEALTH CARE CLAIMS OVERSEAS

TFL is the primary payer for care overseas unless you have OHI and Medicare pays nothing. You are 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 at the beginning of this handbook.

APPEALING A CLAIM OR PRIOR AUTHORIZATION DENIAL

You may appeal decisions regarding claims payments or prior 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 TFL 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 are injured in an accident caused by someone else. The *Statement of Personal Injury—Possible Third Party Liability* form (DD Form 2527) is sent to you if a claim appears to have third-party liability involvement. 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 EOB is not a bill. It is 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. You should 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 of this handbook.

DEBT COLLECTION ASSISTANCE OFFICERS

TRICARE Debt Collection Assistance Officers (DCAOs) 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 and/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 cannot 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 (TFL) continues to provide health care coverage for you and your family as your life changes. However, you need to take specific actions to make sure you remain TRICARE-eligible. It is essential that you keep information in the Defense Enrollment Eligibility Reporting System (DEERS) current for you and your family. DEERS is a computerized database of uniformed service members (active duty and retired), their family members and others who are eligible for military benefits, including TRICARE. Proper and current DEERS registration is key to getting timely, effective TFL benefits.

Note: Your Social Security number (SSN) 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 is 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 at the beginning of this handbook.

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 may 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 will 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 (CAC), Defense Finance and Accounting Service myPay PIN or Department of Defense (DoD) Self-Service Logon (DS Logon). You may visit a Veterans Affairs Regional Office to complete an in-person proofing process to request a DS Logon, or you may 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.

GETTING MARRIED OR DIVORCED

Marriage

It is 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, he or she gets a uniformed services ID card and may use TRICARE. Your spouse must show his or her 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:

- Do not 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.)
- Are not 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 preceding requirements continue to be met and the former spouse does not 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 this requirement is met, the former spouse is eligible for TRICARE coverage for only one year from the date of the divorce, dissolution or annulment.[1]

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

- Are not also former spouses of North Atlantic Treaty Organization 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 TFL-eligible must change their personal information in DEERS, so their name and SSN or DoD Benefits Number (DBN), 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 are not 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 and/or the sponsor may have to pay TRICARE for those services.

CHILDREN

Your dependents' coverage does not change because you are entitled to 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 percent of the financial support), as long as his or her DEERS information is current.

To extend coverage beyond your child's 21st birthday, contact your local ID card office to verify what documentation is needed.

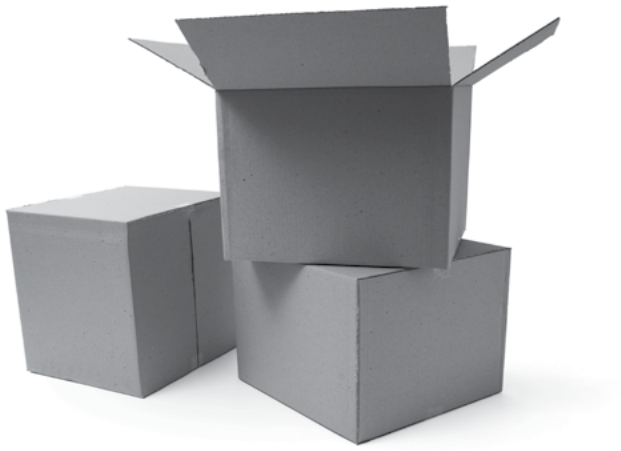
At age 21 (or 23), adult children may qualify to purchase TRICARE Young Adult (TYA) coverage until reaching age 26, and later, Continued Health Care Benefit Program (CHCBP) coverage. For more information on TYA, visit **www.tricare.mil/tya**. For more information on CHCBP, visit **www.tricare.mil/chcbp**.

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

MOVING

Whether you are 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 of this handbook.

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



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 are either of the following:

- A surviving spouse who has not remarried (If you remarry, TRICARE eligibility cannot be regained 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 percent 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 Social Security Disability Insurance payments are suspended because you have returned to work, you will get quarterly bills for the Medicare Part B premium. As long as you remain entitled to 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 (BCACs) can help you with TRICARE For Life (TFL) questions and concerns, and they can advise you about getting health care. BCACs are located 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 Wisconsin Physicians Service (WPS)—Military and Veterans Health to appeal TFL decisions.

Medicare Denials

Any services or supplies denied payment by Medicare and appealable under Medicare are not 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 prior 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 TFL is the primary payer, you may not appeal the denial of care from a provider who is not TRICARE-authorized.

When services are denied based on medical necessity or a benefit decision, you are 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 are not 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.

Prior 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 prior 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 contain the following:

- Beneficiary's name, address and phone number
- Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN)
- 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 will 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 will not 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 are not appropriate appealing parties, but may 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 are not 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 prior 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 dependent 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/or 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 at the beginning of this handbook for grievance contact information at WPS. Contact Medicare to file Medicare-related grievances.

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TRICARE Expectations for Beneficiaries

According to the Department of Defense (DoD), as a TRICARE beneficiary, you should expect to have the following abilities and support:

- **Get information:** You should expect to get accurate, easy-to-understand information from written materials, presentations and TRICARE representatives to help you make informed decisions about TRICARE programs, medical professionals and facilities.
- **Choose providers and plans:** You should expect a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.
- **Emergency care:** You should expect to access medically necessary and appropriate emergency health care services as is reasonably available when and where the need arises.
- **Participate in treatment:** You should expect to receive and review information about the diagnosis, treatment and progress of your conditions, and to fully participate in all decisions related to your health care, or to be represented by family members or other duly appointed representatives.
- **Respect and nondiscrimination:** You should expect to receive considerate, respectful care from all members of the health care system without discrimination based on race, color, national origin or any other basis recognized in applicable law or regulations.
- **Confidentiality of health information:** You should expect to communicate with health care providers in confidence and to have the confidentiality of your health care information protected to the extent permitted by law. You also should expect to have the ability to review, copy and request amendments to your medical records.
- **Complaints and appeals:** You should expect a fair and efficient process for resolving differences with health plans, health care providers and institutions that serve you.

Additionally, DoD has the following expectations of you as a TRICARE beneficiary:

- **Maximize your health:** You should maximize healthy habits such as exercising, not using tobacco and maintaining a healthy diet.
- **Make smart health care decisions:** You should be involved in health care decisions, which means working with providers to provide relevant information, clearly communicate wants and needs and develop and carry out agreed-upon treatment plans.
- **Be knowledgeable about TRICARE:** You should be knowledgeable about TRICARE coverage and program options.
- **You also should:**
  - Show respect for other patients and health care workers.
  - Make a good-faith effort to meet financial obligations.
  - Use the disputed claims process when there is a disagreement.

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Regional Contractors (Stateside)

TRICARE For Life
Wisconsin Physicians Service—
Military and Veterans Health
www.TRICARE4u.com
1-866-773-0404

TRICARE East Region
Humana Military
HumanaMilitary.com
www.tricare-east.com
1-800-444-5445

TRICARE West Region
Health Net Federal Services, LLC
www.tricare-west.com
1-844-866-WEST (1-844-866-9378)

TOP Regional Call Centers (Overseas)

TRICARE Eurasia-Africa
+44-20-8762-8384 (overseas)
1-877-678-1207 (stateside)
tricarelon@internationalsos.com

TRICARE Latin America and Canada
+1-215-942-8393 (overseas)
1-877-451-8659 (stateside)
tricarephl@internationalsos.com

TRICARE Pacific
Singapore: +65-6339-2676 (overseas)
1-877-678-1208 (stateside)
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