

TRICARE Fundamentals Course

TRICARE Options

4

Instructor Guide

References

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



Brain teasers

Each of the 8 items below is a separate puzzle.

How many can you figure out?

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

1. Go long

5. Split second timing

2. Sailing of the seven seas

6. Man overboard

3. Apartment

7. Tennessee

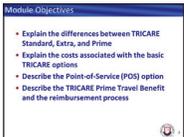
4. Neon light

8. Free for all

Module Objectives



Show slide #2



Stateside Objectives:

- Explain the differences between TRICARE Standard, Extra, and Prime
- Explain the costs associated with the basic TRICARE options
- Describe the Point-of-Service (POS) option
- Describe the TRICARE Prime Travel Benefit and the reimbursement process

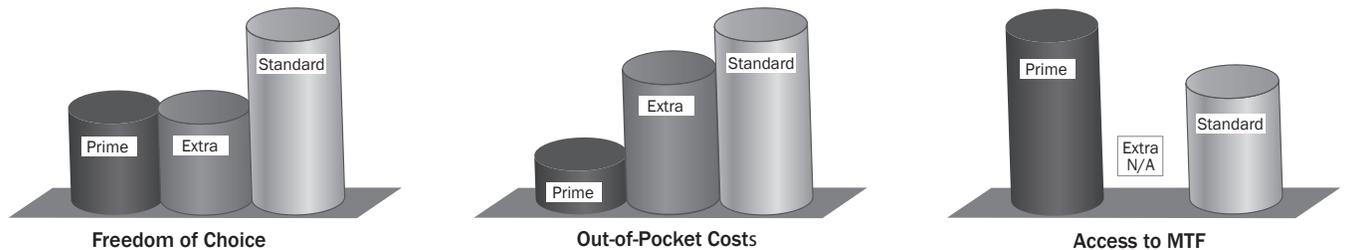
Overseas Objectives:

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

1.0 The Basic TRICARE Options

- **TRICARE Standard** is a fee-for-service option that offers the freedom to seek care from any TRICARE-authorized provider.
 - No enrollment forms or fees required
 - Available overseas (including U.S. territories) as TRICARE Overseas Program (TOP) Standard
- **TRICARE Extra** is a preferred-provider option where a Standard beneficiary receives a cost-share discount for using a TRICARE network provider.
 - No claims to file (network provider files for beneficiary)
 - No enrollment forms or fees required
 - Five percent cost-share discount
 - Not available overseas
- **TRICARE Prime** is a managed care option similar to a civilian health maintenance organization (HMO).
 - Enrollment is required
 - Offers lowest out-of-pocket cost
 - Care is coordinated through a primary care manager (PCM)
 - No claims to file (provider files for beneficiary)
 - Available overseas as TOP Prime

1.1 Comparing TRICARE Options



- If freedom of choice is the most important factor to a non-active duty beneficiary, TRICARE Standard is the preferred choice for health care.
- If cost savings is most important factor to the non-active duty beneficiary, TRICARE Prime (if available) is the best health care choice. TRICARE Extra is the next best choice due to the cost-share discount.
- If access to an MTF is the most important factor to the non-active duty beneficiary, TRICARE Prime is the best option, as it provides higher priority for accessing care within an MTF.

2.0 TRICARE Standard/TOP Standard and TRICARE Extra

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

- **TRICARE Standard is a fee-for-service option where non-active duty beneficiaries have the freedom to choose from a larger provider pool without having to get prior authorization for most TRICARE-covered medical services.** Standard is the basic entitlement under the law (for other than active duty members). Coverage is automatic as long as the beneficiary shows as eligible in the Defense Enrollment Eligibility Reporting System (DEERS). The Standard option is based on the beneficiary’s address in DEERS.
- TRICARE Standard is the stateside option, while TOP Standard is the overseas option.

2.0: Test question

2.1 Standard Eligibility

Standard is available for all TRICARE-eligible beneficiaries, except ADSMs. Beneficiaries must show a valid Uniformed Services ID card at the time of service for proof of eligibility.

2.2 Standard Enrollment

There are no fees or forms.

2.3 Military Treatment Facility (MTF) Access

Standard beneficiaries may receive health care from an MTF on a space-available basis.

2.4 Standard Benefit

- Standard covers most inpatient and outpatient care that is medically necessary and considered proven.
- Overseas providers may require TOP Standard beneficiaries to pay the full cost of care at the time of service; beneficiaries then file claims for reimbursement.
- Standard beneficiaries are responsible for making sure a claim is filed.
- Certain services are only available if a facility is Medicare-certified and/or TRICARE participating (e.g., skilled nursing care).

2.4.1 TRICARE Standard Prior Authorizations

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

2.4.2 Receiving Care Using Standard

- Emergency care never requires an authorization. In an emergency, Standard beneficiaries should call the local emergency number for the country where they're located or go to the nearest emergency room.
- Beneficiaries may seek routine and urgent care from any TRICARE-authorized or purchased care/host nation provider, or from an MTF if space is available.

2.5 TRICARE Extra

- **When a TRICARE Standard beneficiary receives care from a network provider, the beneficiary is using the TRICARE Extra option.** Beneficiaries get a 5% cost-share discount.
- TRICARE Extra is not available overseas, or in U.S. territories.
- All rules that apply to TRICARE Standard also apply to TRICARE Extra.

2.5: Test question

Show slide #3
 for Standard
 costs

Show slide #4
 for Extra costs

Note: Point out that cost-shares for Extra are based upon a negotiated rate, not the TRICARE maximum allowable charge that applies to TRICARE Standard. Emphasize to Students: “Per Diem” refers to the inpatient daily rate.

2.6 TRICARE Standard and TRICARE Extra Costs

	ADFM E-1–E-4	ADFM E-5 and Up	Retirees, Retiree Family Members, and Survivors
Enrollment Fee	N/A	N/A	N/A
Annual Deductibles	\$50 individual \$100 family	\$150 individual \$300 family	\$150 individual \$300 family
Cost-Shares	TRICARE Standard: 20% of TRICARE-allowable charge TRICARE Extra: 15% of rate negotiated with regional contractor		TRICARE Standard: 25% of TRICARE-allowable charge TRICARE Extra: 20% of rate negotiated with regional contractor
Catastrophic Cap	\$1,000 per family per fiscal year		\$3,000 per family per fiscal year
Civilian Inpatient Cost-Share	Per diem* or \$25 per admission, whichever is greater; no charge for separately billed professional charges		TRICARE Standard: Per diem* or 25% of the total charge, whichever is less, plus 25% of the TRICARE-allowable charge for separately billed professional services TRICARE Extra: \$250 per day or 25% of the total charge, whichever is less, plus 20% of the TRICARE-allowable charge for separately billed professional services
Civilian Inpatient Mental Health	Per diem* or \$25 per admission, whichever is greater		TRICARE Standard: <ul style="list-style-type: none"> High Volume Hospitals— 25% of hospital specific charges Low Volume Hospitals— Per diem* or 25% of the billed charges, whichever is less Partial Hospitalization— 25% of the TRICARE-allowable charge, plus 25% of the TRICARE-allowable charge for separately billed professional services TRICARE Extra: 20% of total charge, plus 20% of the TRICARE-allowable charge for separately billed professional services

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

Note: Costs are subject to change each fiscal year. Beneficiaries are responsible for paying the annual outpatient deductible and applicable cost-shares. The government shares the cost for TRICARE-covered services after the beneficiary pays the annual outpatient deductible. Deductibles and cost-shares count towards the catastrophic cap.

2.6.1 Balance Billing Limit (Stateside Only)

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

2.6.2 Standard Billing Example

A TRICARE Standard E-5 ADFM visits a non-network provider for an outpatient cardiology appointment. The cardiologist does “not participate” on the claim. The provider usually charges \$1,000 for this type of appointment. TRICARE’s allowable charge is \$850. Remember, the provider may balance bill the beneficiary for an additional 15% above the TRICARE-allowable charge.

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

Note: Although the total amount charged is \$1,000.00, the beneficiary is not responsible for paying more than 15% above the TRICARE-allowable charge. Under federal law, the provider can not legally hold the beneficiary responsible for the total amount of the visit.

Show slide #5



2.7 TRICARE Standard Exercise

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

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

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

	How much was charged per visit?	How much of each charge was applied to the annual outpatient deductible?	How much was Mrs. Teal's cost-share percentage and what was the dollar amount she paid per visit?
Mrs. Teal's First Visit	\$50	\$50	0% / \$50
Child #1's Visit	\$40	\$40	0% / \$40
Child #2's Visit	\$40	\$10	20% cost share—(\$30 x 20% = \$6.00 cost share) \$10 deductible + \$6 cost share = \$16 total
Child #3's Visit	\$40	\$0	20% cost share—(\$40 x 20%) \$8.00 out of pocket
Mrs. Teal's Follow-Up Visit	\$40	\$0	20% cost share—(\$40 x 20%) \$8.00 out of pocket

Show slide #6



2.8 TRICARE Extra Exercise

Mrs. Jade, an E-5 ADFM, and her three children are TRICARE Standard. They live with her mother within 10 miles of a military installation.

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

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

	How much was charged per visit?	How much of each charge was applied to the annual outpatient deductible?	How much was Mrs. Jade's cost-share percentage and what was the dollar amount she paid per visit?
Mrs. Jade's First Visit	\$100	\$100	0% cost share— \$100.00 out of pocket
Child #1's Visit	\$75	\$75	0% cost share— \$75.00 out of pocket
Child #2's Visit	\$75	\$75	0% cost share— \$75.00 out of pocket
Child #3's Visit	\$75	\$50	15% cost share— (\$25 x 15% = \$3.75) \$50 deductible + \$3.75 cost share = \$53.75 total
Mrs. Jade's Follow-Up Doctor's Visit	\$75	\$0	15% cost share— (\$75 x 15%) \$11.25 out of pocket

3.0 TRICARE Prime/TRICARE Overseas Program (TOP) Prime

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

- TRICARE Prime/TOP Prime is a managed care option similar to a civilian health maintenance organization (HMO).
- Prime is available in established geographic locations, referred to as Prime Service Areas (PSAs).
 - PSAs are typically within a 30-minute drive time of an MTF.
 - The contractor may propose additional PSAs; however, the government is ultimately responsible for identifying PSAs and approving the contractor’s proposed PSAs.

3.1 The Role of the Primary Care Manager (PCM)

- A PCM is assigned to each Prime enrollee and is responsible for:
 - Providing all routine, nonemergency health care, including urgent care
 - Submitting referrals for specialty care and establishing medical necessity when required
- PCMs are:
 - MTF providers (stateside and overseas)
 - Civilian network providers
 - Members of teams organized to support patient continuity and accountability if the individual’s assigned PCM is absent or unavailable
- PCMs may include:
 - Internists, family practitioners, pediatricians, general practitioners
 - Obstetricians/gynecologists, physician assistants, nurse practitioners
 - Certified nurse midwives when determined by the MTF commander or TAO Director or designee, to meet governing country rules and licensure
- PCM preference is noted on the Prime enrollment form and assignment is based on the sponsor’s status, beneficiary’s address, and PCM availability.
 - Within an MTF, PCMs are assigned according to MTF commander guidelines.

3.2 Prime Eligibility

Stateside	<ul style="list-style-type: none"> ● ADSMs ● ADFMs ● Transitional survivors and survivors ● Certain unremarried former spouses ● Retirees and retiree family members ● Certain National Guard/Reserve members and their eligible family members. Only when the sponsor is called or ordered to active duty on federal orders written for more than 30 consecutive days or when the sponsor is issued delayed-effective date active duty orders to serve for more than 30 consecutive days in support of a contingency operation (also known as “early eligibility”) ● Medal of Honor recipients and their eligible family members
Overseas	<ul style="list-style-type: none"> ● ADSMs permanently assigned and residing near an MTF location ● ADFMs on permanent change of station orders and command-sponsored to accompany the sponsor to the overseas location* ● ADFMs on service-funded orders to relocate to an overseas location without the sponsor ● National Guard or Reserve members called to active duty on written federal orders for more than 30 consecutive days with a final assignment to a TOP Prime location ● National Guard or Reserve members on federal orders written for more than 30 consecutive days and their command-sponsored family members if the sponsor was living in an TOP Prime location at the time of mobilization <ul style="list-style-type: none"> ○ Family members must have had the same overseas residential address as the National Guard or Reserve sponsor at the time of mobilization (as recorded in DEERS)

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

3.3 Prime Enrollment

Enrollment is required for Prime coverage.

- ADSMs must enroll based on their assignment status and service guidelines.
 - ADSMs who are permanently assigned to a PSA must enroll.
- Enrollment is voluntary for non-ADSMs, who may choose to enroll on an individual or family basis.
- Eligible beneficiaries (including ADSMs) must be registered in DEERS and submit a *TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form* (DD Form 2876).
 - Beneficiaries may get enrollment forms from the TRICARE Service Center (TSC), from the TRICARE website at www.tricare.mil/forms, or the regional contractor’s website.
 - Beneficiaries should submit enrollment forms, along with the initial enrollment fee (if applicable), to the closest TSC or mail it to their regional contractor.
- Stateside Prime-eligible beneficiaries (except ADSMs) may enroll online using the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe. To login to BWE, beneficiaries may use a Common Access Card (CAC), Defense Finance and Accounting Services (DFAS) myPay Account, or Department of Defense Self Service (DS) Logon.
- **Stateside**, the enrollment form and fee must be received (not postmarked) by the 20th of the month for coverage to begin on the first day of the following month. If received after the 20th of the month, Prime coverage begins on the first day of the second month.

3.3: Test question

- **Overseas**, TOP Prime coverage begins on the date listed on the enrollment form as long as the appropriate command sponsorship orders are received (when applicable) by the TOP contractor.
 - The 20th-of-the-month rule does not apply to ADSMs or to TOP Prime enrollees.
- Eligible beneficiaries, other than ADSMs, remain covered under Standard/Extra until TRICARE Prime coverage begins.
- The enrollment period is equal to one fiscal year and is automatically renewed each year, unless one of the following occur:
 - Enrollee transfers enrollment to another region
 - Enrollee voluntarily disenrolls
 - Enrollee becomes ineligible for Prime or TRICARE eligibility ends (i.e., member retires, the Guard or Reserve member is deactivated, ages out)

3.3.1 Prime Enrollment Fees

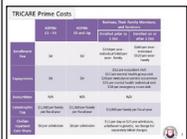
3.3.1: Test question

- **ADSMs and ADFMs do not pay enrollment fees.**
- All other Prime enrollees pay an annual enrollment fee per individual or family, per fiscal year (October 1–September 30). Enrollment fees may be adjusted each fiscal year.
 - Prime enrollment fees for survivors of active duty deceased sponsors and medically retired Uniformed Services members and their dependents are frozen at the rate in effect when classified and at the time of enrollment in Prime. (This does not include TRICARE Young Adult Prime.)
 - The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime.
 - For current Prime enrollment fees and exceptions visit www.tricare.mil/costs.
- An initial three-month payment by check must accompany the completed enrollment form (all payments that follow must be electronic with the exception of the West region, until April 1).
 - Acceptable forms of payment include credit card, electronic fund transfers (EFTs) through an enrollee's financial institution, or allotment from retirement pay established through the regional contractor or directly through uniformed service finance centers.
- Enrollment fees may be paid on an annual or quarterly basis or by monthly allotment.
- It's recommended that beneficiaries turning 65 make quarterly payments, monthly allotments, or EFT payments so that they can stop fee payments when they become Medicare entitled.

3.3.2 Prime Lockout and Disenrollment

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

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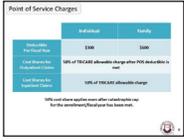


4.0 Prime Costs

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

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

Show slide #8



4.1: Test question

4.1 Point-of-Service Option

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

4.1.1 POS Costs

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

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

4.1.2 POS Does Not Apply in the Following Circumstances:

- Emergency department services
- Certain preventive care services from a network provider
- The initial eight behavioral health outpatient visits from a network provider
- TOP Prime-enrolled ADFMs who seek TRICARE-authorized care within 60 days of permanent transfer to the United States
- Prime newborn or adoptee care during the initial 60 days stateside/120 days overseas when they're deemed Prime (See Section 8.0 of this module for more information.)
- Other health insurance (OHI) is primary, including host nation insurance

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

4.1.3 POS Example

- A TRICARE-authorized provider treated a Prime-enrolled ADFM for medically necessary, TRICARE-covered specialty care.
- The family member sought care on his/her own without a referral from his/her PCM.
- TRICARE's allowable charge is \$850.00. Remember, under point of service, the enrollee must pay the POS deductible and a 50% cost-share.

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

Show slide #9

Thumbnail of slide #9 showing 'Access to Care Standards' table. The table lists standards for Urgent, Routine, Referred/Specialty, and Wellness/Preventive care across different TRICARE categories (e.g., TRICARE Prime, TRICARE Overseas, TRICARE Reserve Component, TRICARE Active Duty Family, TRICARE Retiree, TRICARE Retiree Spouse, TRICARE Retiree Child, TRICARE Retiree Spouse Child, TRICARE Retiree Spouse Child, TRICARE Retiree Spouse Child).

5.0 Prime Access Standards and Types of Care

- “Access to care” refers to established standards for accessing care in a timely manner and within a reasonable distance for TRICARE Prime enrollees.

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

- **Emergency care** refers to medical, maternity, or psychiatric emergencies that would lead a “prudent layperson” (someone with average knowledge of health and medicine) to believe that a serious medical condition exists, or the absence of medical attention would result in a threat to life, limb, or eyesight and requires immediate medical treatment. Or, the condition is so painful that sedative treatment is required to relieve suffering.
- **Urgent care** is generally defined as nonemergency acute illness or injury which requires medically necessary treatment, but would not result in disability or death if not treated immediately. This kind of illness or injury does require professional attention and should be treated within 24 hours to avoid further complications.
- **Routine care**, also known as primary care, includes general office visits for the treatment of symptoms, chronic or acute illnesses and diseases, and follow-up care for an ongoing medical condition. The PCM should be the primary source of all routine care.
- **Specialty care** is generally defined as care the PCM is not able to provide.
- **Wellness and preventive care** includes services, such as health screenings and examinations, often conducted at regular intervals, which are meant to keep beneficiaries healthy or detect health problems in a timely manner (e.g., mammograms, pap smears, cholesterol testing).

5.1 Getting Emergency Care

- Prime enrollees should go to the nearest source of emergency care.
- **Stateside**, Prime enrollees are required to notify their PCM or regional contractor within 24 hours of receiving emergency care and/or being admitted to an inpatient facility.
- **Overseas**, TOP Prime enrollees should contact the TOP Regional Call Center or country-specific Call Center after seeking emergency care stateside or overseas.
- Prime enrollees should get a copy of the emergency treatment records in case proof is needed of the reason for and results of emergency care. Please note that a claim may be denied if the diagnosis does not warrant emergency care.
- See Section 10.0 of this module for information on obtaining emergency care in Canada.

5.2 Referrals for Specialty Care

- When Prime enrollees need specialty care, their PCM writes a referral for specialty services from a specialty provider. The enrollee must make sure the regional or overseas contractor authorizes the service before scheduling the specialty appointment.
- MTF Prime enrollees may be referred to a different MTF, a civilian network, or purchased care/host nation provider.
 - MTFs have right of first refusal (ROFR), which provides them the opportunity to review each referral within their PSA to determine whether the MTF has the capability and capacity to provide the care.

- Getting the referral authorized is a multi-step process:

Stateside	<ul style="list-style-type: none"> ● The PCM submits the referral electronically, by fax, or via TSC to the contractor. <ul style="list-style-type: none"> ○ Regional contractor staff conduct a benefit review and issue the appropriate care determination (approval or denial). ○ It takes at least 48 hours for the referral to be entered into the regional contractor's system. ● The regional contractor sends a letter to the enrollee with the name(s) of a network specialty care provider and the referral authorization, including the number and types of visits authorized. <ul style="list-style-type: none"> ○ Before scheduling their appointment, beneficiaries may call the regional contractor's toll-free number three to five days after the referral is entered to confirm the authorization. <p>Note: A non-network provider may be authorized if there is no network specialist within access standards.</p> <ul style="list-style-type: none"> ● The Prime enrollee must contact the specialty provider(s) listed on the authorization letter to confirm appointment availability or call the regional contractor to request a change to the identified specialist. ● Before scheduling the appointment, the enrollee should try to get copies of information the specialty provider may need (e.g., x-rays, lab results). <ul style="list-style-type: none"> ○ MTF Prime enrollees must find out what the MTF's policy is for transferring medical records (e.g., x-rays) to the specialty care provider. ● Prime enrollees should take their PCM's or regional contractor's phone number (listed on their enrollment card) to their specialty appointment in case there are questions.
Overseas	<ul style="list-style-type: none"> ● TOP Prime enrollees who are referred to a purchased care/host nation network provider by the MTF can expect a "cashless, claimless" episode of care, as long as the care is properly coordinated and authorized by the TOP contractor. Before scheduling an appointment, the enrollee must confirm the authorization through their Regional or Country-specific Call Centers. ● All referrals, whether written by an MTF or host nation provider, must be authorized. <ul style="list-style-type: none"> ○ The TOP contractor conducts a benefit review and issues the appropriate care determination (i.e., approved or denied). ● If approved, the TOP contractor arranges for care to be provided by a certified host nation provider, gives the TOP Prime enrollee information on the specialty care provider, and may assist in coordinating the specialty appointment. ● See Section 10.0 of this module for information on obtaining specialty care in Canada.

5.2.1 TRICARE Prime Stateside Travel Benefits for Specialty Care

- When stateside-enrolled non-active duty TRICARE Prime enrollees are referred for and authorized medically necessary, nonemergency specialty care more than 100 miles from their assigned primary care manager's location, they may be eligible for the TRICARE Prime Travel Benefit, meaning they may be reimbursed for reasonable travel expenses. (This benefit is not available overseas.)
- The "greater than 100 mile rule" is statutory and is not negotiable when determining applicability of the Prime travel benefit. (An exception applies for Coast Guard ADSMs. See the 2002 or 2008 TRICARE Reimbursement Manual, Chapter 1, Section 30.)
- Active duty travel for medical care is handled through their service personnel and medical assets.

- MTF enrollees should contact the MTF point of contact for information on the reimbursement process before traveling.
- Civilian PCM-assigned Prime enrollee should contact a Prime travel benefit point of contact at the TRICARE Regional Office (TRO) before traveling.
- For more information on the Prime travel benefit, visit www.tricare.mil/travelreimbursement

6.0 TRICARE Prime Portability

TRICARE Prime coverage is portable. This means that when Prime enrollees move to a new Prime location, they may continue TRICARE Prime without a break in coverage.

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

6.1 Transferring Prime Within the Same Region

- Enrollees should update their address in DEERS and notify the regional contractor of their address change.
- Enrollees may request a PCM change for the new location by submitting a new *DD Form 2876*, contacting the regional contractor, using the BWE website, or completing the form and dropping it off at the TSC.

6.2 Transferring Prime to a Different Region

- When relocating from one region to another, Prime enrollees should not disenroll from their current region before leaving their location. Remaining enrolled to the current region ensures they avoid an interruption in TRICARE Prime coverage.
- While traveling to the new location, enrollees must get referrals from their PCM and authorization from their current regional contractor before getting nonemergency, specialty, or inpatient care to avoid POS charges. Enrollment transfers are effective on the date the gaining regional contractor processes a signed enrollment form or confirms transfer via phone call (if coordinated before leaving the old location). The gaining regional contractor assigns a new PCM to the enrollee, provides region- or site-specific TRICARE educational materials, and key telephone numbers.

6.3 Transfer Frequency and Enrollment Fees

- The number of moves within the same region per enrollment year is unlimited; enrollees must ensure address changes are updated in DEERS to reflect their new location.
- Prime-enrolled retirees and their eligible family members who move from one region to another and back to the original region are allowed two enrollment transfers per enrollment year.
- After transferring to a new region, enrollment fees are billed by and paid to the gaining regional contractor.
 - Since the unused portions of enrollment fees may not be refunded, when enrollees anticipate moving to an area where Prime is not available they should consider paying their enrollment fee on a quarterly or monthly allotment basis.

Show slide #10



6.4 Transferring to a Non-Prime Location

- Enrollees are covered by TRICARE Prime while en route to the non-Prime location.
- Upon arrival in a non-Prime Service Area (PSA), enrollees should update their address in DEERS and call the regional contractor or go to the BWE website to:
 - Transfer their enrollment to TRICARE Prime Remote/TRICARE Prime Remote for ADFMs, or TOP Prime Remote (ADSMs and ADFMs only)
 - Disenroll (other than ADSMs) and revert to Standard/Extra
- Beneficiaries may request a “drive time” waiver of TRICARE Prime access standards to remain enrolled in Prime if they move to a location outside of a PSA. The waiver determination is made by the contractor and must be approved by the MTF commander or regional director.
 - If approved, enrollees then travel a longer distance to see their assigned PCM and network specialty providers. Enrollees must still follow TRICARE Prime rules (e.g., using a PCM for routine care, obtaining referrals and authorizations).

6.5 Split Prime Enrollment Between Different TRICARE Regions

- TRICARE Prime split enrollment offers families the option to enroll one or some members in Prime in one region while the rest of the family is enrolled in Prime in another region. The sponsor or legal guardian must complete and sign an enrollment form for the affected family member(s) and submit it to the regional contractor where the other family member(s) lives.
- For those who pay enrollment fees:
 - The family may pay one enrollment fee to whichever regional contractor is chosen by the family to serve as the home regional contractor; or they may pay two individual enrollments to two different contractors as long as both enrollments are captured under the same sponsor. The regional contractor can provide assistance with this process.
 - Enrollment fees are applied to all family members and payment is recorded in DEERS, when applicable.

7.0 Traveling with Prime

7.1 Stateside Prime Enrollees Seeking Care When Traveling Overseas

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

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

7.2 TOP Prime Enrollees Seeking Care When Traveling Stateside

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

- TOP Prime enrollees are encouraged to schedule routine care appointments before traveling stateside to avoid POS charges.
- When stateside, TOP Prime enrollees must contact their Regional Call Center or the TOP contractor stateside call center for authorization before receiving services other than emergency care. Visit the TRICARE Overseas “Contact Us” website at www.tricare-overseas.com/contactus for regional call center contact information.
- Claims for care received by TOP Prime enrollees while traveling stateside should be submitted to the overseas claims processor. Enrollees should provide their overseas residential address and the TOP Prime claims address to stateside providers.

7.2.1 TOP Prime: Referrals and Authorizations When Traveling Stateside

- Routine care stateside is generally not authorized when traveling outside the enrollment region. Exceptions are made in unique circumstances on a case-by-case basis.
 - Routine care stateside requires a referral from the TOP Prime enrollee’s PCM, with appropriate justification of the unique circumstances, and an authorization from the TOP contractor.
- TOP Prime-enrollees traveling or between duty stations should try to seek all nonemergency care at MTFs whenever possible.
 - Nonemergency and urgent care outside of the MTF requires authorization from the TOP contractor.

Note: TOP Prime care authorizations are not portable to a stateside provider. Likewise, a stateside care authorization is not portable to an overseas provider. A new authorization is required when changing locations.

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

8.1 Newborn Coverage

- By policy, a newborn child is covered under TRICARE Prime for 60 days after birth, as long as another family member is already enrolled in a Prime option.
- After the initial 60 days, any claim submitted for the newborn processes as TRICARE Standard until the newborn is registered in DEERS and enrolled in TRICARE Prime.
 - The TRICARE Regional Director or TRICARE Area Office Director may extend the enrollment period up to 120 days on a case-by-case or regional basis.
 - Currently, a regional waiver for 120 days is in effect in all overseas locations.
- TRICARE eligibility ends on day 366 for any newborn who is not registered in DEERS.

8.2 Pre-Adoptive and Adopted Children Coverage

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

Show slide #11



Show slide #12



NOTE:
 Stateside
 instructors are
 not required to
 teach section
 10.0 since
 it overseas
 specific
 information.

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

Certain retirees who are not enrolled in TRICARE Prime or USFHP and were awarded Combat-Related Special Compensation (CRSC) may be entitled to the CRSC travel benefit. This provides these select retirees reimbursement for travel-related expenses when they must travel more than 100 miles from their referring provider’s location to obtain medically necessary, nonemergency specialty care for a documented combat-related condition. A written referral from their primary care provider is required. This travel benefit is not available overseas. The CRSC travel benefit is managed by the TROs. See the TRO websites for more information on this benefit.

10.0 Receiving Care in Canada

10.1 Routine Care in Canada

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

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

10.2 Emergency Care in Canada

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

10.3 Specialty Care in Canada

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

Note: “Cashless, claimless” care is coordinated by the TAO or Canadian Forces—not the TOP contractor in Canada.

Module Objectives



Show slide #14



Stateside Objectives:

- Explain the differences between TRICARE Standard, Extra, and Prime
- Explain the costs associated with the basic TRICARE options
- Describe the Point-of-Service (POS) option
- Describe the TRICARE Prime Travel Benefit and the reimbursement process

Overseas Objectives:

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

Test Questions

- 10) Which of the following TRICARE options requires enrollment?
- A. TRICARE Standard
 - B. TRICARE Prime
 - C. TRICARE Extra
 - D. None of the above
- 11) When getting care, beneficiaries using _____ have more freedom to choose any TRICARE-authorized provider but may pay higher out-of-pocket costs.
- A. TRICARE HMO
 - B. TRICARE Prime
 - C. TRICARE PPO
 - D. TRICARE Standard
- 12) TRICARE Standard beneficiaries receiving care from a network provider are using the _____ option for that episode of care.
- A. TRICARE HMO
 - B. TRICARE Prime
 - C. TRICARE Extra
 - D. TRICARE Standard
- 13) The _____ option allows non-active duty TRICARE Prime enrollees to receive nonemergency care from any TRICARE-authorized provider without requesting a referral from their primary care manager.
- A. Point of contact
 - B. Point of service
 - C. Port of call
 - D. Point of reference
- 14) Active duty service members and their family members pay _____ for TRICARE Prime enrollment.
- A. \$00.00 a year
 - B. \$260.00 a year
 - C. \$520.00 a year
 - D. \$12.00 per visit

