

# TRICARE Fundamentals Course

## Other Benefits

# 7

### Instructor Guide

#### References

10 USC § 1079 (d)–(f)

32 CFR §§ 199.5, 6, 8

2008 TRICARE Operations Manual, Chapter 6 and Chapter 18, Section 8

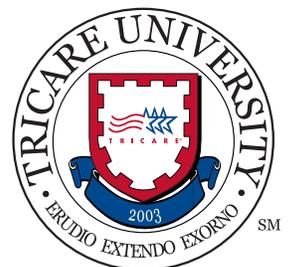
2008 TRICARE Policy Manual 2008, Chapter 9

[www.militaryhomefront.dod.mil](http://www.militaryhomefront.dod.mil)

[www.usfhp.com](http://www.usfhp.com)

[www.cap.mil/wsm](http://www.cap.mil/wsm)

[www.tricare.mil/tmaprivacy](http://www.tricare.mil/tmaprivacy)



## Brain teaser

What do you see in the picture below? **Answer: Man playing a saxophone or a woman's face**



# Module Objectives



- Identify who may be eligible for coverage under the TRICARE Young Adult program (TYA)
- State the purpose of TRICARE Plus
- Explain how the US Family Health Plan mirrors TRICARE Prime
- Describe the Extended Care Health Option (ECHO)

Show slide #2

#### Module Objectives

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Introduce Other TRICARE Programs.

Show slide #3 for 1.0

TRICARE Young Adult Program

- Premium-based program
- Extends TRICARE medical coverage to certain family members who have lost or will lose TRICARE eligibility due to age



Show slide #4 for 1.1

TYA Eligibility

- Eligibility is established by the uniformed service sponsor
- Eligible young adults must be:
  - A dependent of an eligible uniformed service sponsor
  - Unmarried
  - At least 21, but under age 26



## 1.0 TRICARE Young Adult Program (TYA)

The premium-based TYA program extends TRICARE medical coverage to qualified family members who lose TRICARE eligibility due to age.

### 1.1 TYA Eligibility

- Qualified young adults may purchase TYA coverage if they meet all of the following criteria:
  - Are a dependent of a TRICARE-eligible uniformed service sponsor
  - Aren't married
  - Are at least age 21 but under age 26
  - Aren't a member of the uniformed services
  - Aren't eligible to enroll in an employer-sponsored health plan based on the young adult's own employment
  - Aren't eligible for other TRICARE coverage
- TYA coverage depends on the sponsor's program eligibility status (e.g., active duty, retiree, Selected or Retired Reserve) and where the young adult dependent lives.
  - The young adult must meet all TRICARE Overseas and service approval requirements (i.e., command sponsorship) to purchase TRICARE Overseas Program (TOP) Prime/Remote coverage.
- Young adult dependents of TRICARE for Life sponsors are qualified to purchase a TYA Prime option (stateside, overseas, USFHP) the same as if they were eligible to enroll in TRICARE Prime before they aged out of TRICARE. They must meet all of the TYA and TRICARE Prime rules.
- TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) eligible sponsors must be enrolled in TRS or TRR for the young adult dependent to purchase coverage under TYA Standard/Extra (Prime options not available)
  - This also applies if the sponsor dies. The young adult dependent's sponsor must have been enrolled in either TRS or TRR before his/her death for the young adult to continue or purchase TYA coverage.
    - TYA coverage, under a TRS sponsor who dies, ends six months after the sponsor's death, or when the TYA-enrolled young adult turns 26, whichever comes first.
    - TYA coverage, under a TRR sponsor who dies, continues until the date the sponsor would have become a regular retiree or when the young adult reaches age 26, whichever comes first.
  - The young adult dependent can continue either TYA Standard or TYA Prime when his/her TRR sponsor becomes a regular retiree or until the young adult dependent reaches age 26, whichever comes first.
- TYA coverage ends when:
  - The young adult submits a *TRICARE Young Adult Application* (DD Form 2947) asking for coverage to end because he or she no longer qualifies for coverage (e.g., he or she gains health care under their employer)
  - The young adult's sponsor loses TRICARE eligibility
  - The young adult ages out at 26

### 1.2 TYA Enrollment

- Qualified young adult dependents may purchase TYA Standard/Extra or TRICARE Prime/TOP Prime or US Family Health Plan (USFHP) coverage on a month-to-month basis as long as they're listed in the Defense Enrollment Eligibility Reporting System (DEERS). (See the *Other Benefits* module for information on USFHP.)
  - TOP Prime and TOP Prime Remote program enrollment requirements still apply (i.e., the young adult must be command-sponsored at the time he/she loses TRICARE eligibility and show as TYA eligible in DEERS). See the *TRICARE Options* and *Prime Remote Options* modules for more information.

- To purchase coverage, qualified young adults must submit a *DD Form 2947* to their regional or overseas contractor, along with an initial three-month premium payment.
  - *DD Form 2947* is available online at [www.tricare.mil/forms](http://www.tricare.mil/forms) or [www.tricare.mil/tya](http://www.tricare.mil/tya).
- Coverage effective dates are as follows:
  - TRICARE Standard: the first day of the next month after the *DD Form 2947* is received or up to 90 days in the future
  - TRICARE Prime options: the “20th-of-the-month rule” applies for TYA
  - Young adult dependents losing previous TRICARE program coverage (e.g., aged out of TRICARE Prime at age 21) may purchase TYA coverage with an effective date of when they lost previous TRICARE program coverage as long as the *DD Form 2947* is postmarked within 30 days of the previous loss.
- Continuous enrollment requires an electronic debit from a checking or savings account or an automatic recurring credit card charge.
- Once the young adult dependent TYA coverage is in effect, he or she receives an enrollment card and welcome letter. The young adult and sponsor should then visit the nearest uniformed service ID card issuing facility for the young adult dependent to receive a new ID card to present when seeking health care services.
- A qualified young adult may purchase TYA coverage throughout the year unless locked out due to failure to pay TYA premiums or their sponsor’s failure to pay his or her own TRS or TRR premiums.
  - If locked out, the young adult dependent may submit a new *DD Form 2947* up to 45 days before the end of the 12-month lockout period for new coverage to begin after the lockout period ends.
  - Young adults may request reinstatement if there was an enrollment processing error or if there are extraordinary circumstances that justify continued TYA coverage.
    - Requests should be submitted to the regional, overseas, or USFHP contractor within 90 days of when the last full premium was paid.
    - Lockout waiver approval authority rests with the TRICARE Regional Office, TRICARE Area Office (TAO), or USFHP.

### 1.3 TYA Portability

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

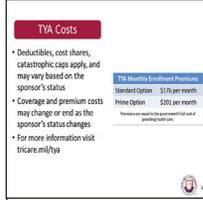
Show slide #5 for 1.2 coverage



### 1.4 TYA Coverage

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

Show slide #6 for 1.5



### 1.5 TYA Costs

#### 1.5.1 Monthly Premiums

- Premiums are based on what the government needs to cover the full cost of health care for qualified young adults.
- Premiums may change in January of each calendar year.
- Coverage and premium costs may change or end as the sponsor’s status changes (e.g., if a retiree moves overseas, TYA coverage shifts from TRICARE Prime to TOP Standard).

Show slide #7 for 2.0



2.0: Test Question Since TRICARE Plus is an MTF-based program, one MTF may allow Standard and TFL beneficiaries to enroll to the MTF and have an assigned PCM, while another MTF in the area may not offer this program.

MTF commanders may limit enrollment based on capability and capacity.

2.2: Enrollees are not guaranteed specialty care appointments within the TRICARE Prime access standards.

Enrollees must get referrals and authorizations for specialty care outside of the MTF.

## 1.5.2 Out-of-Pocket Expenses

- TRICARE Standard deductibles, and cost-shares apply, if enrolled in TYA Standard.
- TRICARE Prime copays and cost-shares apply if enrolled in TYA Prime.
- Deductibles, cost-shares, and copays for TRICARE-covered services apply to the individual/family's catastrophic cap.
- TYA premiums aren't credited to the catastrophic cap; they're used to offset health care costs.
- Pharmacy copays and cost-shares apply. (See the *Pharmacy* module for more information.)

## 2.0 TRICARE Plus

- TRICARE Plus is a primary care enrollment program offered at select military treatment facilities (MTFs) stateside and overseas.
  - Although TRICARE Plus isn't a health care plan, it offers primary care at the MTF with an assigned primary care manager (PCM) to Plus-enrolled beneficiaries.
  - MTF commanders may limit enrollment based on capability and capacity. Continued enrollment in TRICARE Plus is determined by the MTF commander on a case-by-case basis.

### 2.1 TRICARE Plus Eligibility

Eligible	Not Eligible
<ul style="list-style-type: none"> <li>• TRICARE Standard beneficiaries</li> <li>• TRICARE for Life beneficiaries</li> <li>• Dependent parents and parents-in-law</li> </ul>	<ul style="list-style-type: none"> <li>• Beneficiaries enrolled in a:               <ul style="list-style-type: none"> <li>○ Prime option (stateside or overseas)</li> <li>○ Civilian health maintenance organization (HMO)</li> <li>○ Medicare HMO</li> </ul> </li> </ul>

### 2.2 TRICARE Plus Enrollment

- There are no enrollment fees or cards associated with TRICARE Plus. Eligible beneficiaries must complete a *TRICARE Plus Enrollment Application* (DD Form 2853).
- The MTF validates eligibility in the Defense Enrollment Eligibility Reporting System (DEERS).
- Once approved, the *DD Form 2853* is forwarded to the regional contractor.
- The regional contractor enters the TRICARE Plus enrollment into the Defense Online Enrollment System (DOES). The TRICARE Plus enrollment is then reflected in DEERS.
- A TRICARE Plus enrollment indicator appears in the MTF's medical appointment system allowing MTF staff to schedule appointments for TRICARE Plus enrollees.

### 2.3 TRICARE Plus Disenrollment

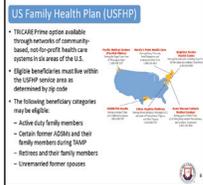
- TRICARE Plus enrollees may disenroll at any time by submitting a *TRICARE Plus Disenrollment Request* (DD Form 2854).
- The MTF sends the completed disenrollment request to the regional contractor for processing and recording in DEERS.

### 2.4 TRICARE Plus Portability

Unlike TRICARE Prime, TRICARE Plus isn't a portable health care plan. Beneficiaries who disenroll from TRICARE Plus at one MTF aren't guaranteed enrollment in TRICARE Plus at another MTF.

4.0: Test Question

Show slide #8 for 3.1



## 2.5 Specialty Care

- TRICARE Plus enrollees may be seen for specialty care at MTFs on a “space-available basis.” Otherwise, TRICARE Plus enrollees must seek specialty care from a civilian TRICARE-authorized provider, if TRICARE eligible (i.e., Standard, Extra, TRICARE for Life) or use Medicare or other health insurance, as applicable.
- The MTF isn’t responsible for any costs associated with care outside the MTF and the MTF cannot authorize care with civilian providers.
- TRICARE Standard/Extra, Medicare, or other health insurance (OHI) rules apply, as do applicable cost-shares and deductibles.

## 3.0 US Family Health Plan (USFHP)

USFHP is a TRICARE Prime health plan available at community-based, not-for-profit health care systems in six areas of the United States.

### 3.1 USFHP Designated Providers

There are six systems in different regions throughout the United States that sponsor the USFHP:

<p><b>Johns Hopkins Medicine</b></p> <p>Serving Maryland, Washington DC, and parts of Pennsylvania, Delaware, Virginia, and West Virginia</p> <p>1-800-808-7347 (toll free) 1-410-424-4528</p> <p><a href="http://www.hopkinsmedicine.org/usfhp">www.hopkinsmedicine.org/usfhp</a></p>	<p><b>Martin’s Point Health Care</b></p> <p>Serving Maine, New Hampshire, Vermont, upstate and western New York, and the northern tier of Pennsylvania</p> <p>1-888-241-4556 (USFHP line) <a href="http://www.usfhp.com/martinspoint">www.usfhp.com/martinspoint</a></p>	<p><b>Brighton Marine Health Center</b></p> <p>Serving Massachusetts (including Cape Cod), Rhode Island and northern Connecticut</p> <p>1-800-818-8589 1-888-815-5510</p> <p><a href="http://www.usfamilyhealth.org">www.usfamilyhealth.org</a></p>
<p><b>CHRISTUS Health</b></p> <p>Serving southeast Texas and southwest Louisiana</p> <p>1-800-67USFHP/1-800-678-7347</p> <p><a href="http://christus.usfhp.com/">http://christus.usfhp.com/</a></p>	<p><b>Pacific Medical Centers (PacMed Clinics)</b></p> <p>Serving the Puget Sound area of Washington State</p> <p>1-888-4-PACMED (1-888-958-2633)</p> <p><a href="http://www.pacificmedicalcenters.org">www.pacificmedicalcenters.org</a></p>	<p><b>Saint Vincent Catholic Medical Centers of New York</b></p> <p>Serving New York City, Long Island, Southern Connecticut, New Jersey, and Philadelphia and area suburbs</p> <p>1-800-241-4848</p> <p><a href="http://www.usfhp.net">www.usfhp.net</a></p>

### 3.2 USFHP Eligibility

To enroll, eligible beneficiaries must be registered in DEERS and live within one of the designated USFHP service areas, as determined by zip code.

Eligible	Not Eligible
<ul style="list-style-type: none"> <li>• ADFMs and unmarried dependent children until they lose eligibility (See the DEERS module for more information.)</li> <li>• Retired service members, their spouses, and unmarried dependent children (until they lose eligibility)</li> <li>• Medicare-eligible beneficiaries</li> <li>• Eligible unremarried former spouses of active duty or retired service members</li> <li>• Certain former active duty service members (ADSMs), including Guard/ Reserve members and their eligible family members during TAMP</li> </ul>	<p>Active duty service members</p>

Show slide 9 for 3.3

**USFHP Enrollment**

- Open enrollment year round
- Eligible beneficiaries must complete TRICARE Prime Enrollment Application (DD Form 2876)
- No enrollment fees for ADPMs or other beneficiaries who purchase Medicare Part B; all others pay an annual enrollment fee
  - Individual: \$200 annually
  - Family: \$400 annually

Show slide 10 for 3.6

**Exchange of Benefits**

- USFHP enrollment affects entitlement to use other government-sponsored health care programs
- Beneficiaries agree to not use:
  - TRICARE Standard/Extra, TRICARE for Life, or other TRICARE programs
  - TRICARE Pharmacy Home Delivery
  - MTF, except during emergencies or services not routinely covered under USFHP
  - Medicare Part A or Medicare Part B, except for services not routinely covered under USFHP

3.7: If a married couple has one person with Medicare Part B and one person without it, they may still join the USFHP Plan as a family. However the person without Medicare Part B pays an individual annual enrollment fee and is responsible for any necessary copayments.

**(3.8 note for next page)**

3.8: A TRICARE-eligible Prime enrollee who is not relocating may either transfer enrollment from a regional contractor to a USFHP-designated provider or from a USFHP-designated provider to a regional contractor only once during an enrollment period, but may not transfer back to the other plan during that enrollment period.

### 3.3 USFHP Enrollment

- Enrollment is open all year.
- There currently are no enrollment fees for ADFMs or Medicare-eligible beneficiaries who purchase Medicare Part B. All others pay an annual enrollment fee. For current USFHP fees visit [www.tricare.mil/costs](http://www.tricare.mil/costs).
- To enroll, eligible beneficiaries must complete a *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876). They must include an initial 3-month payment, payable by check or electronic funds transfer (ongoing payments may also be made via allotment).
- Re-enrollment is automatic at the beginning of each fiscal year.

### 3.4 USFHP Coverage

- USFHP is an organized system of health care delivery that relies on primary care managers (PCMs) to arrange for all of an enrollee's health care needs with specific specialty providers and hospitals. USFHP offers plan flexibility where enrollees choose their PCM. Family members may have different PCMs. PCMs may be changed upon request.
- Covered benefits are available only from USFHP-approved providers, except during a medical emergency.
- USFHP enrollees must get specialty referrals from their PCM and use USFHP network providers and facilities for specialty services.
- USFHP offers the point-of-service option where enrollees may self-refer for specialty care. (See the *TRICARE Options* module for more information.)

### 3.5 USFHP Costs

USFHP handles payment for covered services. There are no claim forms when USFHP-approved providers are used; enrollees are only responsible for the applicable copayment.

### 3.6 Exchange of Benefits

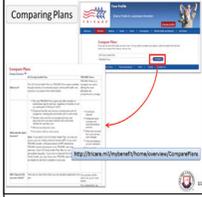
Enrollment in USFHP affects the beneficiary's entitlement to use other government-sponsored health care programs. By enrolling, the beneficiary agrees not to use the following health care benefits:

- TRICARE Standard/Extra, TRICARE for Life (TFL), and other TRICARE programs
- TRICARE Pharmacy Program (including TRICARE Pharmacy Home Delivery, TRICARE retail network pharmacies, and MTF pharmacies)
- MTF care, with the following exceptions:
  - When the beneficiary experiences an emergency and the nearest emergency room is an MTF
  - When the beneficiary receives a prescription from a dentist for dental care not covered by the USFHP, an MTF pharmacy may fill the dental prescription
  - Enrollees may seek services offered by an MTF that are not covered by the USFHP, such as routine hearing tests, on a space-available basis
- Medicare Part A or Part B (except for services not routinely covered under USFHP, such as chiropractic care)

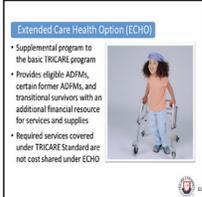
### 3.7 Medicare-Eligible Enrollees

- Purchase of Medicare Part B isn't currently required to become a USFHP enrollee. However, DoD highly encourages Medicare-eligible beneficiaries to purchase Part B when first available to avoid incurring higher Medicare Part B premiums due to delayed enrollment penalties.
- If a member disenrolls from USFHP, those with Medicare Part B still have an opportunity to access services under Medicare Part B and TFL.
- Members disenrolling from their USFHP without having Medicare Part B must apply for Medicare Part B before they can obtain TFL coverage. They're likely to have a break in Medicare and TRICARE coverage until Medicare Part B takes effect, and they will pay a higher Medicare Part B premium.

Show slide #11  
for 3.11



Show slide #12  
for 4.0



Show slide #13  
for 4.1



Point out the “financial assistance” provided via ECHO. Remind students that the basic TRICARE options are Prime, Standard & Extra. ECHO doesn’t replace those options.

**4.0: Test Question**

EFMP is a personnel program, it is not TRICARE. Through EFMP, family members with special medical and/or educational needs are identified. EFMP enrollment is especially important when ADSMs are being considered for accompanied overseas assignments.

### 3.8 USFHP Portability

- When enrollees move within their current USFHP’s zip code-defined service area, they should notify their USFHP-designated provider of their new address.
  - Enrollees wanting to change their PCM based on their new address should contact their USFHP-designated provider to receive a new membership card with the new PCM’s name and phone number.
- If enrollees move to another area in the country where the USFHP is available their enrollment may be transferred.
- If enrollees move to an area where USFHP is not available and they qualify for TRICARE Prime or Prime Remote enrollment, they can transfer their enrollment to the new location; otherwise, they revert to TRICARE Standard or TRICARE for Life, depending on their Medicare status.

### 3.9 Accessing Medical Care While on Vacation

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

### 3.10 USFHP Prescription Coverage

- USFHP also has a home delivery pharmacy option which allows enrollees to receive a 90-day supply for most prescription medications at the same cost as TRICARE Pharmacy Home Delivery. (See the *Pharmacy* module for costs.)
- Copayments for prescription medications through the USFHP are:
  - \$5 for generic formulary medications for a 30-day supply
  - \$12 for brand name formulary medications for a 30-day supply; \$9 for mail order up to a 90-day supply
  - \$25 for non-formulary medications for a 30-day supply; \$25 for mail order up to a 90-day supply

### 3.11 Comparing Plans

Beneficiaries may compare USFHP to other TRICARE plans online at: [www.tricare.mil/compareplans](http://www.tricare.mil/compareplans).

## 4.0 Extended Care Health Option Program (ECHO)

- ECHO is a supplemental program to the basic TRICARE program. It provides qualified active duty family members with an additional financial resource for services and supplies designed to assist in the reduction of the disabling effects of a family member’s qualifying condition.
- Potential ECHO beneficiaries must be ADFMs, have qualifying conditions, and be registered in the Exceptional Family Member Program (EFMP). (Under certain circumstances, this requirement may be waived.)
- Each service branch has its own EFMP and enrollment process.
- Members of the U.S. Public Health Service (USPHS) and National Oceanic and Atmospheric Administration (NOAA) are not eligible for the EFMP.

### 4.1 The Service’s Exceptional Family Member Program (EFMP)

- The EFMP identifies active duty family members (ADFMs) with special medical and/or educational needs. The EFMP involves the personnel community, medical commands and the DoD educational system to determine if required services are available to the family.
- Enrollment in EFMP helps ensure that services station families in geographical areas where the family members’ needs can be met. This is especially important when family members are being screened for approval to accompany the sponsor to an overseas location on permanent change of station order.

- An exceptional family member is defined as an authorized family member residing with the sponsor who may require special medical or educational services based on a diagnosed physical, intellectual, or emotional condition. An authorized family member may be a spouse, child, stepchild, adopted child, or foster child.
- Special medical or educational needs may include medical, mental health, developmental or educational requirements, wheelchair accessibility, adaptive equipment, assistive technology devices, and associated services.
- Enrollment in EFMP is mandated by the sponsor's branch of service when an ADFM with qualifying special needs is identified.
  - The sponsor, or an authorized person acting on the sponsor's behalf, must enroll the qualified family member in the service's EFMP by completing a *Family Member Medical Summary* (DD Form 2792) and a *Special Education/Early Intervention Summary* (DD Form 2792-1).
  - This may be waived for Guard/Reserve members.
- For more information on the EFMP, visit [www.militaryhomefront.dod.mil/tf/efmp](http://www.militaryhomefront.dod.mil/tf/efmp).

#### 4.2 ECHO and TRICARE Eligibility Status

- If a sponsor or provider believes a family member may qualify for ECHO services, the sponsor should speak with the family member's primary care manager or primary care provider, case manager, regional contractor, TAO, or USFHP provider to receive an eligibility determination.
- The following family members are eligible for ECHO benefits if they have a qualifying condition:
  - A spouse, dependent child, or an unmarried person whose sponsor is an active duty member of a uniformed service of the United States, including Guard/Reserve members on federal orders written for more than 30 consecutive days
  - A spouse, dependent child, or an unmarried person whose sponsor is a former member of a uniformed service of the United States and the spouse, child, or unmarried person is a victim of physical or emotional abuse (Benefits are limited to the period that the abused dependent is receiving transitional compensation.)
  - A transitional survivor (This is the surviving spouse, for up to three years from the sponsor's death, and surviving dependent children until they lose eligibility. See the *DEERS* module for more information on eligibility.)
  - A family member who is eligible for continued TRICARE medical benefits through the Transitional Assistance Management Program (TAMP).

#### 4.2: Test Question

The term "factual determination" will be mentioned again in the Claims and Appeals module.

- Each regional contractor, TAO, or USFHP system determines eligibility for ECHO. If they determine the beneficiary isn't eligible for ECHO, the decision is regarded as a factual determination and **isn't** appealable.

#### 4.3 ECHO Qualification Determination

- Qualification is based on the evidence of specific mental or physical disabilities and enrollment in EFMP, when applicable.
- The family member may need to see a TRICARE-authorized/USFHP provider to get the necessary testing, screening, and exams to determine and document the qualifying disability and the need for specialty services.
  - If enrolled in a Prime option (stateside or overseas) or the USFHP, the family member must first see their PCM for routine care and referrals for any necessary testing, screening, and exams.
  - If using TRICARE Standard, the family member doesn't need referrals unless required for certain services, as verified by the regional contractor or TAO.

Emphasize that beneficiaries are registered in ECHO, and enrolled in EFMP.

The ECHO Program is not available to retirees, retiree family members, or NATO family members.

FYI Note: Unless requirements listed in TPM, Chapter 9, Section 2.2 are met the spectrum of Attention-Deficit and Disruptive Disorders are not considered qualifying conditions for the ECHO.

#### 4.4 ECHO Qualifying Conditions

- ECHO qualifying conditions include: an extraordinary physical or psychological condition, defined as a complex physical or psychological clinical condition of such severity that it results in the beneficiary being home bound
- Multiple disabilities, where the cumulative effect of disabilities involves two or more separate body systems, none of which is individually an ECHO-qualifying condition
- Neuromuscular developmental conditions or other conditions that are expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability in infants or toddlers under age three

#### 4.5 ECHO Registration

- The sponsor or other authorized persons acting on behalf of the family member must submit the following documents to the regional contractor, TAO, or USFHP responsible for administering the ECHO program in their geographical area:
  - Proof the sponsor is an active duty service member in one of the uniformed services
  - Medical records of qualifying conditions (copies)
  - Proof from the sponsor's branch of service that the family member is enrolled in the EFMP
    - This requirement may be waived when either the sponsor's service doesn't provide the EFMP (i.e., Guard/Reserve, Coast Guard, USPHS, NOAA), the beneficiary is a transitional survivor, or the beneficiary resides with a custodial parent who is not the active duty sponsor.
- To avoid delay of ECHO services due to a delay in the EFMP enrollment process, the regional contractor, TAO, or USFHP may grant provisional ECHO status for a 90-day period.

#### 4.6 ECHO Benefits

##### 4.6.1 Services Covered Under ECHO

- Medical and rehabilitative services
- Durable equipment, including adaptation and maintenance
- Training to use assistive technology devices
- Assistive services, such as those from a qualified interpreter or translator
- Institutional care when a residential environment is required
- Transportation for institutionalized beneficiaries to receive authorized ECHO benefits
- In-home medical services
- ECHO respite care: ECHO family members are eligible for 16 hours of respite care per month in any month the family member receives other authorized ECHO benefits
- Applied behavior analysis (ABA) (which includes the DoD Enhanced Access to Autism Services Demonstration, discussed in Section 5.0 of this module) and other services that are not available through schools or other local community resources

##### 4.6.2 Services Not Available Under ECHO

- Inpatient care for medical or surgical treatment of an acute illness or an acute exacerbation of the qualifying condition
- Structural changes to living space and permanent fixtures, including changes necessary to accommodate installation of equipment or to facilitate entrance or exit
- Dental care and orthodontic treatment (covered under adjunctive dental care or purchase of a dental program option)
- Certain durable medical equipment and maintenance for beneficiary-owned equipment
- Homemaker services that provide assistance with household chores, except those provided by the ECHO Home Health Care benefit

### 4.6.3 ECHO Benefit Authorization

- ECHO benefits are authorized when:
  - The family member is registered in ECHO
  - The requested service/item is an allowable ECHO benefit
  - The requested service/item meets the public facility use requirement, when applicable
- The authorization specifies the requested services by type, scope, frequency, duration, dates, amounts, requirements, limitations, provider name and address, and all other information necessary to provide exact identification of approved benefits.
- Authorizations remain in effect until the regional contractor, TAO, or USFHP determines that:
  - The beneficiary is no longer eligible for ECHO
  - The authorized ECHO service or item is no longer appropriate or required by the family member
  - The authorized ECHO service or item becomes a basic TRICARE benefit as established by law | and/or policy
- All ECHO services, supplies, and equipment must be received from a TRICARE-authorized/USFHP provider.
- If the family member changes providers, they must obtain a new referral and authorization.
- Beneficiaries may appeal the denial of ECHO services and supplies.

Show slide #14 for 4.7

**ECHO Costs**

- No deductibles or enrollment fees
- Monthly cost shares are paid during months registered family members receive ECHO benefits
- Cost shares are based on the sponsor's pay grade
- ECHO cost shares do not accrue towards the beneficiary's TRICARE catastrophic cap
- Government's cost share limit is \$30,000 per fiscal year

### 4.7 ECHO Costs

- ECHO has no deductibles or enrollment fees.
- Beneficiaries may incur cost-shares for health services which:
  - Establish qualifying conditions
  - Confirm the severity of the disabling effects of a qualifying condition
  - Measure the extent of functional loss
- For example, the sponsor of a beneficiary who uses TRICARE Standard/Extra to receive diagnostic services that result in the diagnosis of an ECHO-qualifying condition is liable for cost-shares and deductibles associated with the diagnostic services. These cost-shares and deductibles are not reimbursable under the ECHO program.

Cost shares are only paid when ECHO services are used. If an ECHO beneficiary requires a TRICARE covered service that is already covered under Standard, it will not be cost shared under the ECHO Program.

#### 4.7.1 Cost-Shares

- Although ECHO allowable charges aren't subject to deductibles, a monthly cost-share must be paid during the months registered family members receive ECHO benefits. ECHO cost-shares don't count towards the family's catastrophic cap.
- Cost-shares are based on the sponsor's pay grade:

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

#### 4.7.2 Government's ECHO Cost-Share Limit

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

#### 4.8 Claims for Benefits with Prior Authorization

- All ECHO benefits must have prior authorization by the regional contractor, ECHO case manager, TAO, or USFHP before any services, supplies, or equipment are received.
- When family members file claims for ECHO-authorized care, they or their sponsor must submit:
  - A TRICARE DoD/CHAMPUS Medical Claim—Patient's Request For Medical Payment (DD Form 2642)
  - A copy of the authorization the beneficiary received from the regional contractor, ECHO case manager, or TAO
- Claims should be sent to the TRICARE claims processing contractor for the region where the family member lives.

#### 4.9 ECHO Resources

For more information about ECHO visit [www.tricare.mil/echo](http://www.tricare.mil/echo).

#### 5.0 DoD Enhanced Access to Autism Services Demonstration

- The DoD Enhanced Access to Autism Services Demonstration allows non-certified educational intervention service providers, or tutors, to provide services to ECHO enrollees in the U.S. diagnosed with an autism spectrum disorder.
- This demonstration was established to test the feasibility and advisability of permitting TRICARE reimbursement for Educational Interventions for Autism Spectrum Disorders delivered by paraprofessional providers who meet eligibility requirements.
- The demonstration provides information that will enable DoD to determine if the following applies:
  - There is increased access to these services
  - The services are reaching those most likely to benefit from them
  - The quality of ABA services is meeting an appropriate standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board
  - That state licensure and certification requirements, where applicable, are being met
- The demonstration is effective for services provided from March 15, 2008 through March 14, 2014.
- Non-certified tutors may provide ABA services under close supervision. Authorized supervisors are required to direct and oversee the tutors who provide the “hands-on” services and verify that tutors are trained and able to perform the services required to treat ECHO-enrollees with autism.
- For more information about the DoD Enhanced Access to Autism Services Demonstration, refer to the 2008 TRICARE Operations Manual, Chapter 18, Section 8 at <http://manuals.tricare.osd.mil>.

**Note:** The allowed cost of services provided by the DoD Enhanced Access to Autism Services Demonstration accrue to the ECHO FY government maximum limit. (See Section 4.7.2 of this module for more information.)

# Module Objectives



Show slide #15

Module Summary

- Identify who may be eligible for coverage under the TRICARE Young Adult Program (TYA)
- State the purpose of TRICARE Plus
- Explain how the US Family Health Plan mirrors TRICARE Prime
- Describe the Extended Care Health Option (ECHO)

## Summary:

- Identify who may be eligible for coverage under the TRICARE Young Adult program (TYA)
- State the purpose of TRICARE Plus
- Explain how the US Family Health Plan mirrors TRICARE Prime
- Describe the Extended Care Health Option (ECHO)

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Questions?

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## Appendix A: Computer/Electronic Accommodations Program

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

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

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

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

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

### CAP Eligibility

- Disabled employees who work for the DoD or one of the 66 federal agencies that have a partnership with CAP.
- ADSMs with limitations resulting from injury or illness sustained while on active duty.

### CAP Services

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

### CAP Websites

For more information on CAP, please visit:

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

## Module Review Sheet

### Question 1:

True/False. Beneficiaries may use any MTF as long as they are enrolled in TRICARE Plus?

### Answer 1:

True, if the MTF where they are seeking care has space available, however they may only have access to the TRICARE Plus Program at the MTF where they are enrolled.

### Question 2:

What is ECHO and who is eligible for it?

### Answer 2:

The Extended Care Health Option (ECHO) is a supplemental program to TRICARE and provides eligible active duty family members with an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition. Eligible beneficiaries include: spouses, dependent children, and unmarried persons whose sponsor is active duty; spouses, dependent children, unmarried persons who were victims of physical or emotional abuse; transitional Survivors; TAMP eligibles.

### Question 3:

How many USFHP Plan locations are there in the U.S. and what are these locations called?

### Answer 3:

Six. Designated Providers.

## Exam Questions and Answers: Other Benefits

29) The US Family Health Plan (USFHP) provides medical coverage using which TRICARE option copay structure?

- A. TRICARE Plus
- B. TRICARE Extra
- C. TRICARE Prime
- D. TRICARE Standard

**Answer: [C] Reference: Participant Guide, Other Benefits, Section 3.0**

30) TRICARE Plus is a(n) \_\_\_\_\_ enrollment program for TRICARE Standard/TRICARE For Life beneficiaries.

- A. Premium-based
- B. Web-based
- C. All of the above
- D. MTF-based

**Answer: [D] Reference: Participant Guide, Other Benefits, Section 2.0**

31) The Extended Health Care Option (ECHO) provides an additional \_\_\_\_\_ resource for active duty family members with qualifying conditions

- A. Financial
- B. Medical
- C. Educational
- D. None of the above

**Answer: [A] Reference: Participant Guide, Other Benefits, Section 4.0**

32) Which of the following statements concerning ECHO is TRUE? If a beneficiary is determined to be ineligible for ECHO \_\_\_\_\_.

- A. The beneficiary may contact the MTF commander for reconsideration
- B. The decision is not appealable
- C. The beneficiary may contact the PCM for reconsideration
- D. The beneficiary may contact the sponsor for reconsideration

**Answer: [B] Reference: Participant Guide, Other Benefits, Section 4.2**