

TRICARE Fundamentals Course

Glossary of Terms

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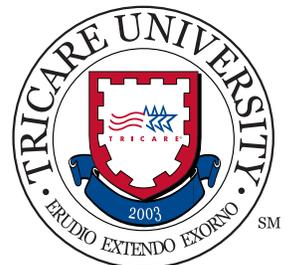
Instructor Guide

References

www.tricare.mil/mybenefit/Glossary

TRICARE Operations Manual 6010.56-M, February 1, 2008

TRICARE Operations Manual 6010.56-M, August 1, 2002



The following glossary lists and defines common terms seen when working with TRICARE beneficiaries. This list is not all inclusive. For additional terms, please go to www.tricare.mil/mybenefit/Glossary.do or consult the TRICARE manuals at www.manuals.tricare.osd.mil.

20th-of-the-Month Rule

The effective date of certain TRICARE programs is determined by the date the enrollment application is received by the appropriate contractor. If received by the 20th of the month, coverage begins on the first day of the next month. If the form is received after the 20th of the month, then coverage begins on the first day of the second month following receipt of the application. Please note that the application must be received and in processing by the 20th of the month, not merely postmarked by the 20th of the month.

Access Standards

Established standards for access to care in a timely manner and within a reasonable distance for TRICARE Prime enrollees beneficiaries. Drive times and distances may vary slightly depending on which option the beneficiary uses and where they're located. In general, Prime access standards for care include:

- The wait time for an urgent care appointment should not exceed 24 hours (one day).
- The wait time for a routine appointment should not exceed one week (seven days).
- The wait time for a specialty care appointment or wellness visit should not exceed four weeks (28 days).

Additionally, Prime enrollees should have access to a primary care manager whose office is within 30 minutes of their home under normal circumstances; specialty care should be available within one hour from their home.

Active Duty Service Member (ADSM)

An individual currently serving in one of the seven uniformed services of the United States under a call or order that does not specify a period of 30 days or less.

Adjunctive Dental Care

Dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition; or, is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

Appeal

A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative to resolve a disputed question.

Authorization for Care

The determination made by a licensed professional nurse or other health care professional that a beneficiary's requested treatment, service, procedure or admission is medically necessary, delivered in the appropriate setting, and is a TRICARE benefit.

Balance Billing

A term used to describe when a provider bills a beneficiary for the difference between billed charges and the TRICARE allowable charge after TRICARE (and any other health insurance) and the beneficiary have paid everything it's going to pay. Network and participating providers are prohibited from balance billing. By law, non-participating providers may charge up to 15 percent above the TRICARE allowable charge.

Benefit

The TRICARE benefit consists of those services, (payment amounts, cost-shares, and copayments) authorized by Title X and implemented via the TRICARE manuals.

Beneficiary

A person who, by law, is eligible for TRICARE benefits. Beneficiaries include: active duty service members (ADSMs) and their families, retired service members and their families, certain National Guard and Reserve members and their families, survivors and widows, certain unremarried former spouses, and Medal of Honor recipients and their families. Family members include spouses and children (biological, adopted, or step) up to age 21, 23, or 26 (depending on the child's eligibility). Eligibility for benefits is determined by the uniformed service.

Beneficiary Counseling and Assistance Coordinator (BCAC)

People located at military treatment facilities (MTFs) and TRICARE Regional and Area Offices, who serve as beneficiary advocates and are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE.

Billed Charge

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

Beneficiary Liability

The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of medical care or treatment received. Specifically, for the purposes of services and supplies covered by TRICARE, beneficiary liability includes any annual deductible amount, cost-sharing amounts, or, when a provider does not submit a claim on a participating basis on behalf of the beneficiary, amounts above the TRICARE-determined allowable cost or charge. Beneficiary liability also includes any expenses for medical or related services and supplies not covered by TRICARE.

Cashless-Claimless

When the TRICARE Overseas Program contractor authorizes a visit and payment to a certified host nation provider. The provider files the claim and doesn't require the enrollee to pay up front.

Catastrophic Cap

The maximum out-of-pocket expenses that a TRICARE beneficiary is responsible for in a given fiscal year (October 1–September 30). The following expenses are not creditable to the catastrophic cap:

- Point-of-service (POS) cost-shares and deductibles
- The additional 15 percent that nonparticipating providers may charge above the TRICARE-allowable charge
- TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and TRICARE Young Adult (TYA) premiums
- Services that are not covered by TRICARE

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

A program of medical care for spouses and dependent children of disabled or deceased disabled veterans who meet the eligibility requirements of the Department of Veterans Affairs.

Claim

Any request for payment for health care services rendered which is received from a beneficiary, a beneficiary's representative, or a network or non-network provider by a contractor on any TRICARE-approved claim form or other approved electronic medium. This includes requests for reimbursement of a dispensed pharmaceutical agents and diabetic supply items.

Clinical Preventive Services

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. They include such things as mammograms, cholesterol testing, colorectal cancer exams, prostate cancer exams, blood pressure readings and pap smears.

Confidentiality Requirements

The procedures and controls that assure the confidentiality of medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, and the Privacy Act.

Contingency Operation

A military operation that results in the call or order to, or retention of, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

Continued Health Care Benefit Program (CHCBP)

A premium-based health care program that offers temporary transitional health coverage for 18 to 36 months after TRICARE eligibility ends for certain former beneficiaries. Beneficiaries may purchase CHCBP within 60 days of loss of eligibility and are covered as if they had TRICARE Standard benefits.

Continuum of Care

All patient care services provided from “pre-conception to grave” across all types of settings. Requires integrating processes to maintain ongoing communication and documentation flow between the direct care system and network.

Contractor

An organization with which TMA enters into a contract for delivery of and/or processing of payment for health care services, performance of related support activities such as enrollment/application processing, quality monitoring or customer service.

Coordination of Benefits

A system to acquire collection of other health insurance (OHI) benefits before making any TRICARE benefit payment, except for Medicaid, the Indian Health Service and other programs identified by the Director, TMA (e.g., States Victim Assistance Programs).

Copayment

The fixed amount a TRICARE Prime enrollee pays for care in the civilian system.

Cost Share

The amount/percentage a beneficiary must pay for covered inpatient and outpatient services (other than the deductible, the annual TRICARE Prime enrollment fee, the balance billing amount, or disallowed amounts) as set forth in 32 CFR 199.4, 199.5, and 199.17.

Date of Determination

The date of completion appearing on the reconsideration determination, formal review determination, or hearing final decision.

Debt Collection Assistance Officer (DCAO)

Persons located at military treatment facilities (MTFs) and TRICARE Regional Offices (TROs/TAOs) who assist in resolving TRICARE-related collection actions. DCAOs work with beneficiaries that have a negative credit rating or were sent to a collection agency for a TRICARE-related debt.

Deductible

The amount beneficiaries have to pay in any one fiscal year before TRICARE begins cost-sharing.

Defense Enrollment Eligibility Reporting System (DEERS)

A system operated by the Department of Defense (DoD) used to reflect beneficiary eligibility. Beneficiaries are responsible for maintaining the accuracy of their DEERS records and updating information in the system, as necessary.

Defense Manpower Data Center (DMDC)

The office that manages the DEERS data repository and provides customer service for beneficiaries who are trying to establish, maintain, or determine their eligibility for TRICARE. The DMDC also distributes certificates of creditable coverage to beneficiaries upon loss of eligibility.

Demonstration

A study or test project with respect to alternative methods of payment for health and medical services, cost-sharing by eligible beneficiaries, methods of encouraging efficient and economical delivery of care, innovative approaches to delivery and financing services and prepayment for services provided to a defined population. Following completion and evaluation of the test project, it may or may not become part of the benefit.

Dental Treatment Facility (DTF)

Military facilities that provide dental care, primarily for active duty service members. DTFs may see other beneficiaries based on capacity and capability.

DoD Benefit Number

A unique 11-digit family member identifier that ties a family member to the sponsor and identifies the cardholder as one who has DoD benefits, such as health care and base exchanges services.

DoD Identification Number

A 10-digit electronic DoD identification number that replaces the sponsor's Social Security number on the uniformed services ID and the Common Access Card (CAC).

Double Coverage

Enrollment by a TRICARE beneficiary in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's TRICARE benefits.

Emergency Services

Medical services provided for a sudden or unexpected medical, dental, or psychiatric condition, or the sudden worsening of a chronic (ongoing) condition that is threatening to life, limb, or sight and needs immediate medical treatment, or which has painful symptoms that need immediate relief to stop a beneficiary's suffering.

Enrollee

A TRICARE beneficiary who elects coverage under TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Young Adult (TYA) Prime, TYA Standard, the US Family Health Plan (USFHP), TRICARE Overseas Program (TOP) Prime, or TRICARE Overseas Program (TOP) Prime Remote.

Enrollment Fees

The amount required to be paid by some categories of beneficiaries to enroll in and receive the benefits of TRICARE Prime.

Enrollment Transfer (Portability)

A transfer of TRICARE Prime enrollment from one location/region or contractor to another. There are two types of enrollment transfers:

- **Between Regions:** Enrollment transfer between regions/contractors. The term "contractors" also includes Designated Providers (DPs) under the US Family Health Plan. This typically involves a change of contractor and primary care manager.
- **Within a Region:** An enrollment transfer within a TRICARE region, which involves a change of address and possibly a change of primary care manager, but not a change of contractors.

Exceptional Family Member Program (EFMP)

The service identifies active duty family members with special medical and/or educational needs, documents required services, and involves the personnel community, medical commands, and the educational system in providing required services. Registration in EFMP is mandatory upon identification of an active duty family member with special needs. This helps to ensure that military families are stationed in geographical areas where the family member's needs can be met. EFMP registration is especially important when family members are being screened for approval to accompany their sponsor to an overseas location on permanent change of station orders.

Explanation of Benefits (EOB)

A statement, prepared by insurance carriers, health care organizations, and TRICARE, informing beneficiaries and providers of actions taken on a claim for health care coverage.

Exclusion

Exclusion means that items, services, and/or supplies furnished are not be reimbursed under TRICARE.

Extended Care Health Option (ECHO)

ECHO is a supplemental program to the TRICARE basic program that provides qualified active duty family members (ADFM) 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 family member's qualifying condition, such as moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is home bound.

Fee for Service (FFS)

A method of paying providers service-by-service. Beneficiaries generally pay a cost-share to a fee-for-service provider. TRICARE Standard is a fee-for-service option.

Fiscal Year (FY)

The federal government's 12-month accounting period which currently runs from October 1 through September 30 of the following year.

Fit for Duty

Medical and/or dental status of an active duty service member (ADSM), as determined by the ADSM's service.

Freedom of Information Act (FOIA)

A law enacted in 1967, as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing provisions making information available to the public. TMA and contractors are subject to these provisions.

Grievance

A written complaint on a non-appealable issue which deals primarily with a perceived failure of a network provider, contractor, or subcontractor to furnish the level or quality of care expected by a beneficiary.

Good Faith Payments

Payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for TRICARE benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary and have billed the beneficiary for services provided.

Health Benefits Advisors (HBAs)

Those individuals located at military treatment facilities (on occasion at other locations) and assigned the responsibility for providing general TRICARE information concerning availability of care from the uniformed services direct medical care system, and generally assisting beneficiaries (or sponsors)."

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

Health Maintenance Organization (HMO)

A health plan in which a fixed premium for an assortment of medical services, usually including primary and preventive care, is paid by the member. The primary purpose of an HMO is to coordinate care to eliminate unnecessary care and costs. HMOs typically have copayments rather than cost-shares. The TRICARE Prime options are similar to HMOs.

Host Nation Provider

A hospital, clinic, laboratory, individual doctor or provider licensed to practice or deliver health care in a foreign country.

Initial Determination

A formal written decision regarding a TRICARE claim, a request for benefit authorization, a request by a provider for approval as a TRICARE-authorized provider, or a decision sanctioning a TRICARE provider. Restrictions may apply. EOBs are considered initial determination documents.

Inpatient Care

Care provided to a patient admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation.

Inquiry

Requests for information or assistance made by or on behalf of a beneficiary, provider, the public or the government. Written inquiries may be made in any format (e.g., letter, memorandum, note attached to a claim). Allowable charge complaints, grievances, and appeals are not included in this definition.

Managed Care Support Contractor (MCSC)

Regional contractors providing managed care support to the Military Health System (MHS). The MCSCs are responsible for assisting the TMA Regional Directors, TROs, TAOs, and MTF Commanders in operating an integrated health care delivery system, combining resources of the military's direct medical care system and the contractor's managed care support to provide health, medical and administrative support services to eligible beneficiaries.

Medicaid

Medical benefits authorized under the Title XIX of the Social Security Act provided to welfare recipients and the medically indigent through programs administered by the various states.

Medically Necessary

By law, TRICARE may only pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury. TRICARE can only cost-share medically necessary supplies and services. Benefits are restricted to those drugs, devices, treatments, or procedures for which the safety and efficacy have been proven to be comparable or superior to conventional therapies.

TRICARE uses a hierarchy of reliable evidence to determine whether a drug, device, medical treatment or procedure moves from the status of unproven to the position of nationally accepted medical practice, as evidence includes:

- Well-controlled studies of clinically meaningful endpoints, published in refereed medical literature
- Published formal technology assessments
- Published reports of national professional medical associations

- Published national medical policy organization positions
- Published reports of national expert opinion organizations

Medical Necessity Determination—Pharmacy

A review by the contractor is applicable to non-formulary drugs and whether or not a beneficiary will pay the full \$25 non-formulary copayment for the drug. If medical necessity is justified, a beneficiary will pay the formulary copayment for all prescriptions for the drug after medical necessity is established. In general, in order for medical necessity to be established, one or more of the following criteria must be met for **all** of the available formulary alternatives:

- The use of the formulary alternative should not be administered
- The beneficiary experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the beneficiary is reasonably expected to tolerate the non-formulary medication
- The formulary alternative results in therapeutic failure, and the beneficiary is reasonably expected to respond to the non-formulary medication
- The beneficiary previously responded to a non-formulary medication and changing to a formulary alternative would incur unacceptable clinical risk
- There is no formulary alternative

Medicare

Medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons or persons with end stage renal disease or amyotrophic lateral sclerosis, through a national program administered by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Bureau. Medicare is divided into four parts:

- Medicare Part A: Covers inpatient stays, to include hospice and skilled nursing facility care.
- Medicare Part B: Covers outpatient services and products, such as doctor's services, outpatient hospital care and other medical services that Part A does not cover, such as physical and occupational therapy. (Other examples include x-rays, medical equipment or limited ambulance service.)
- Medicare Part C (Medicare Advantage Plan): Provides all of Medicare Part A and Part B coverage, and may offer vision, hearing, dental and/or health and wellness coverage.
- Medicare Part D: A prescription drug program available through Medicare-approved private insurance companies.

Medical Summary Notice (MSN)

After receiving a Medicare-covered service, Medicare sends Medicare eligible beneficiaries a Medicare Summary Notice (MSN) by mail every three months. The notice shows the beneficiary's services and/or supplies that providers and suppliers billed to Medicare during that three month period, what Medicare paid, and what the beneficiary may owe the provider. This notice is not a bill.

Military Medical Support Office (MMSO)

The joint services organization responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty for service members in remote locations. MMSO is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. Service Points of Contact (SPOCs) for Army, Marine Corps, Navy, and Air Force active duty service members are assigned to the MMSO.

Military Treatment Facility (MTF)

A military hospital or clinic usually located on a military installation.

Military Treatment Facility (MTF)-Referred Care

When MTF patients require medical care that is not available at the MTF, the MTF will refer the beneficiary to the civilian sector, and the contractor shall issue an authorization decision and process the claim ensuring that discounts, cost-shares, copayments, and/or deductibles are applied as appropriate.

National Defense Authorization Act (NDAA)

Established TRICARE in public law. The NDAA is under the jurisdiction of the Senate and House Armed Services Committees and provides statutory direction across all DoD programs by establishing, changing, or eliminating programs and activities, to include uniformed services health care services.

Negotiated Rate

The negotiated or discounted rate that network providers agree to accept/contract for covered services versus the usual TRICARE allowable charge.

Network Inadequacy

Any occurrence where a prime beneficiary is referred to a network provider outside of the time and/or distance standards (except when the beneficiary waives access standards) or is referred to a non-network provider.

Network Pharmacy

Retail pharmacies that serve TRICARE beneficiaries through a contractual agreement with the pharmacy contractor.

Network Provider

A professional or institutional provider who has a contractual relationship with a TRICARE MCSC to provide care services at a negotiated rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries and typically administers care to TRICARE Prime beneficiaries and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option). A network provider accepts the negotiated rate as payment in full for services rendered.

Non-Network Provider

Non-network providers do not have a signed agreement with regional contractors and still have to be TRICARE authorized for TRICARE to pay on the claim. May be a participating or non-participating provider.

Non-Participating Provider

A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnishes medical services or supplies to a TRICARE beneficiary, but does not agree on the TRICARE claim form to participate or to accept the TRICARE-determined allowable cost or charge as the total charge for the services. A non-participating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider. The beneficiary is responsible for paying the non-participating provider.

Other Health Insurance (OHI)

Primary coverage other than TRICARE. OHI is acquired through an employer, entitlement program, or other source.

Out-of-Pocket Costs

The amount of money a beneficiary must pay for services. This includes enrollment fees, cost-shares, deductibles, copayments, and all extra expenses incurred for non-covered services.

Participating Provider

An authorized provider or institutional provider who agrees to accept payment directly from TRICARE and to accept the TRICARE allowable charge plus applicable cost-shares paid by the beneficiary as payment in full for services. Providers may choose to participate on a claim-by-claim basis.

Pending Claim, Correspondence, or Appeal

The claim/correspondence/appeal case has been received but has not been processed to final disposition.

Point of Service (POS)

The POS option allows Prime option enrollees to self-refer for nonemergency care to any TRICARE-authorized provider. However, the enrollee pays higher out-of-pocket costs when using POS (50% cost-share).

Preferred Provider Organization (PPO)

An organization of providers who, through contractual agreements with a contractor, have agreed to provide services to beneficiaries at reduced rates and to file claims on behalf of the beneficiary (network providers). A membership allows a substantial discount below the regularly charged rates of the designated professionals partnered with the organization. TRICARE Extra is a PPO-like option for Standard beneficiaries.

Primary Care

The standard, usual, and customary services rendered in the course of providing routine care required for TRICARE beneficiaries. Services are typically, although not exclusively, provided by internists, family practitioners, pediatricians, general practitioners and obstetricians/gynecologists. It may also include services of non-physician providers (under supervision of a physician to the extent required by state law). These services include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services include care for routine illness and injury; periodic physical examinations of newborns, infants, children, and adults; immunizations, injections and allergy shots; and patient education and counseling (including family planning and contraceptive advice). Such services also include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services. Also known as routine care.

Primary Care Manager (PCM)

An MTF provider, team of providers or a civilian network provider to whom a beneficiary is assigned for primary care services (at the time of enrollment in TRICARE Prime). Enrolled beneficiaries agree to initially seek all nonemergency, non-mental health care services from their PCMs.

Prime Service Area (PSA)

A geographic area where TRICARE Prime benefits are offered. Regional contractors are required to establish a Prime service area at MTF and Base Realignment and Closure locations.

Prior Authorization

A process of reviewing certain medical, surgical and behavioral health services to ensure medical necessity, appropriateness of care, TRICARE coverage prior to services being rendered, or within 24 hours of an emergency admission. Services requiring prior authorization may vary from region to region.

Privacy Act, 5 USC 552a

A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. At the same time, it requires Government activities which collect, maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

Professional Fees

Charges for medical professional services that hospitals or third-party payers require to be separately identified on an inpatient billing form.

Provider

A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies in accordance with 32 CFR 199.

Provider Termination

When a provider's status as a TRICARE-authorized provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications to be a TRICARE-authorized provider.

Reconsideration

An appeal to a contractor of an initial determination issued by the contractor.

Referral

The process of sending a beneficiary to another professional provider for consultation or a health care service that the referring provider believes is necessary but is not prepared or qualified to provide.

Region

A geographic area determined by the Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Regional Contractor

A TRICARE civilian health care partner who provides health care services and support in each TRICARE region. The regional contractors help combine the services available at military treatment facilities (MTFs) and those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of beneficiaries within the region.

Regional Director

The individual responsible for supporting TRICARE contract administration in a specific region and directing the activities of the TRICARE Regional Office (TRO).

Residence

For TRICARE purposes, “residence” is a beneficiary’s dwelling place for day-to-day living. A temporary living place during periods of temporary duty or during a period of confinement, such as a residential treatment center, does not constitute a residence. Minor children’s residence is the same as the residence of the custodial parent(s) or the legal guardian. Incompetent adult beneficiaries’ residence is the same as the residence of the legal guardian. Under split enrollment, when an eligible family member resides away from home while attending school, their residence is where they currently live.

Respite Care

Short-term care for a patient in order to provide rest and change for primary caregivers who have been caring for the patient at home. Respite care consists of providing skilled and non-skilled services to a beneficiary such that in the absence of the primary caregiver, management of the beneficiary’s qualifying condition and safety are provided.

Retiree

A member or former member of a uniformed service who is entitled to retired, retainer, or equivalent pay based on duty in a uniformed service.

Routine Care

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

Secondary Payer

The plan or program whose medical benefits are payable in double coverage situations only after the primary payer adjudicates the claim.

Service Point of Contact (SPOC)

The uniformed services office or individual responsible for coordinating civilian health care for active duty service members (ADSMs) in stateside remote locations and the Virgin Islands and line-of-duty care for Guard/Reserve members. The service point of contact (SPOC) reviews requests for specialty and inpatient care to determine the impact on the ADSM’s fitness for duty; determines whether the ADSM receives care related to fitness for duty at a medical military treatment facility (MTF) or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for the remote ADSMs. The SPOC is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. SPOCs are assigned to the Military Medical Support Office (MMSO).

Specialty Care

Specialized medical diagnosis, treatment, or services that a primary care physician cannot provide.

Split Enrollment

Refers to multiple family members enrolled in a TRICARE Prime option under different regional contractors, including stateside and overseas and U.S. Family Health Plan (USFHP) designated providers.

Sponsor

The active duty service member, Guard/Reserve member, or retiree through whom family members are eligible for TRICARE.

Student Status

A dependent of a member or former member of a uniformed service who has not passed age 23, is enrolled as a full-time student in an accredited institution of higher learning, and is dependent on the sponsor for over 50 percent of his/her financial support.

Supplemental Health Care Program (SHCP)

The SHCP is a program for eligible uniformed service members and other designated patients who require medical care that is not available at a military treatment facility (MTF) and that upon the approval of the MTF Commander or the Director, TMA may be purchased from civilian providers under TRICARE payment rules.

Survivor

The status of a spouse three years after their active duty sponsor's death, as determined by the service. Survivors have the same enrollment fees, cost-shares, and copayments as a retiree family member.

Third Party Liability (TPL) Claims

TPL claims are claims in favor of the Government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The Government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (FMCRA).

Third Party Payer

An insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a worker's compensation program or plan, and any other plan or program (e.g., homeowners insurance) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

Timely Filing

The filing of TRICARE claims within prescribed time limits.

Transitional Assistance Management Program (TAMP)

Transitional health care for certain uniformed service members and their eligible family members who separate from active duty.

Transitional Care for Service Related Conditions (TCSRC)

The TCSRC benefit provides extended transitional health care coverage to former active duty service members with certain service-related conditions. The TCSRC coverage period is 180 days from the date the diagnosed condition is validated by a Department of Defense (DoD) physician. Family members are not eligible for this benefit.

Transitional Survivor

A TRICARE-eligible family member whose sponsor, at the time of death, was on active duty for 30 consecutive days or more. Transitional survivors are eligible to receive the same health care benefits as active duty family members to include coverage under Prime options, for as long as they maintain TRICARE eligibility. Spouses of the deceased sponsor are considered transitional survivors for three years from the date of the sponsor's death. Eligible dependent children (including qualifying students over 18) of the deceased sponsor remain transitional survivors as long as they remain eligible for TRICARE.

TRICARE

The DoD's managed health care program for active duty service members (ADSMs), service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard plan, TRICARE Extra plan, and TRICARE Prime plan.

TRICARE-Allowable Charge

The maximum amount TRICARE pays for a particular covered service. By law, the TRICARE allowable charge matches Medicare rates whenever practical.

TRICARE Area Office (TAO)

The office responsible for the development and execution of an integrated plan for the delivery of health care, within designated areas in the overseas region, including Eurasia-Africa, Latin America/Canada, and the Pacific.

TRICARE-Authorized Provider

A provider who meets TRICARE's licensing and certification requirements and is certified to provide care to TRICARE beneficiaries. There are two types of TRICARE-authorized providers: network and non-network.

TRICARE Dental Program (TDP)

A voluntary premium-based dental insurance program available to eligible active duty family members (ADFM), members of the National Guard and Reserve and their families, and other select members.

TRICARE Extra

A preferred provide organization (PPO)-like option where Standard beneficiaries choose to receive care in from civilian network providers (with reduced cost-sharing).

TRICARE for Life (TFL)

TRICARE for Life combines TRICARE Standard coverage with Medicare Part A and Medicare Part B to provide wrap-around medical coverage to beneficiaries worldwide who are eligible for Medicare and TRICARE. These are also known as dual-eligible beneficiaries. TRICARE beneficiaries entitled to premium-free Medicare Part A are required by federal law to have Medicare Part B to remain TRICARE eligible (with some exceptions).

TRICARE Management Activity (TMA)

The DoD organization responsible for managing the TRICARE contracts and day-to-day operations of the TRICARE benefit.

TRICARE Overseas Program (TOP)

The Department of Defense's (DoD's) health care program in all geographic areas and territorial waters outside of the 50 United States and the District of Columbia.

TRICARE Overseas Program-Prime (TOP Prime)

TOP Prime offers the benefits of TRICARE Prime in overseas military treatment facility (MTF) locations. TOP Prime enrollees are assigned a primary care manager (PCM) who delivers and/or manages routine and urgent medical care and coordinates care with the overseas contractor as needed. TOP Prime enrollees pay no copayments, cost-shares or deductibles for care rendered by the PCM or for authorized services rendered by a purchased care/host nation provider. TOP Prime is only available to active duty service members (ADSMs) and command-sponsored family members.

TRICARE Overseas Program Prime Remote (TOP Prime Remote)

Offers the benefits of TRICARE Prime to active duty service members (ADSMs) permanently assigned to designated remote overseas locations, and to their eligible family members. The TOP contractor has networks of licensed, purchased care/host nation providers in these remote overseas locations to deliver health care to TOP Prime Remote enrollees. The TOP contractor acts as enrollee's PCMs and authorizes all other care provided by host-nation providers.

TRICARE Plus

A primary care enrollment program offered at select military treatment facilities (MTFs). All beneficiaries eligible for care at MTFs (except those enrolled in TRICARE Prime or a health maintenance organization (HMO)) may seek enrollment for primary care at select MTFs where enrollment capacity exists.

TRICARE Prime

A health management organization (HMO)-like option where beneficiaries voluntarily enroll in a program which provides TRICARE Standard benefits and enhanced primary and preventive benefits with nominal beneficiary cost-sharing. TRICARE Prime requires beneficiaries to use a primary care manager (PCM) located at either the MTF or from the contractor's network and follow Prime rules for accessing specialty care services, except when beneficiaries are exercising their freedom of choice under the point-of-service (POS) option.

TRICARE Prime Remote (TPR)

A TRICARE Prime option that provides health care coverage through civilian network or TRICARE-authorized providers for uniformed service members who are assigned to duty stations and reside in remote areas, typically 50 or more miles from a military treatment facility (MTF). TPR requires enrollment.

TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

A TRICARE Prime option that provides health care coverage through civilian network or TRICARE-authorized providers for family members of uniformed service members who are assigned to duty stations and reside in certain designated remote areas, typically 50 or more miles from a military treatment facility. TPRADFM requires enrollment; family members must reside with the sponsor (with some exceptions).

TRICARE Prime Service Area (PSA)

A geographic area where TRICARE Prime benefits are offered. At a minimum, this includes areas around MTFs and Base Realignment and Closure (BRAC) sites.

TRICARE Regional Office (TRO)

A division of the TRICARE Management Activity (TMA) which oversees the integrated health care delivery system in the three United States-based TRICARE regions: North, South and West.

TRICARE Reserve Select (TRS)

A premium-based health care plan that qualified Selected Reserve members may purchase for themselves and eligible family members. Offers TRICARE Standard benefits.

TRICARE Retired Reserve (TRR)

A premium-based, worldwide health plan that qualified Retired Reserve members may purchase for themselves and eligible family members. Offers TRICARE Standard benefits.

TRICARE Retiree Dental Program (TRDP)

A voluntary dental insurance program available for purchase by retired service members and their eligible family members.

TRICARE Service Center (TSC)

A customer service center operated by the regional contractors and TRICARE Area Offices (TAOs) in each TRICARE region or overseas area. The TSC can help with enrollment, specialty care authorizations, and provides general TRICARE information and claim-processing assistance.

TRICARE Standard

A fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized provider. Beneficiaries are responsible for payment of an annual deductible and cost-shares, and may be responsible for other costs.

TRICARE Young Adult (TYA)

Voluntary premium-based program that extends TRICARE coverage to certain family members who have lost or will lose TRICARE eligibility due to age (typically 21 or 23).

Uniform Formulary

A list of TRICARE-covered prescription medications and supplies.

Uniformed Services

The seven uniformed services of the United States are: U.S. Army, U.S. Marine Corps, U.S. Navy, U.S. Air Force, U.S. Coast Guard, Commissioned Corps of the United States Public Health Service (USPHS) and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). The services determine TRICARE eligibility.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA provides employment/reemployment protection to uniformed service members who perform military service.

United States Public Health Service (USPHS)

An agency within the U.S. Department of Human Health Services (HHS) that has a Commissioned Corps that are classified as members of the “uniformed services.”

Unproven Drugs, Devices, and Medical Treatments or Procedures

Drugs, devices, medical treatments or procedures are considered unproven if:

- FDA approval is required and has not been given
- If the device is a FDA Category A Investigational Device Exemption (IDE)
- If there is no reliable evidence that documents that the treatment or procedure has been the subject of well-controlled studies of clinically meaningful endpoints that have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis
- If the reliable evidence shows that the consensus among experts regarding the treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis.

Urgent Care

Medically necessary services required for illnesses or injuries that will not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

US Family Health Plan (USFHP)

A TRICARE Prime-like option available in six geographic locations across the United States that offers benefits to active duty family members (ADFMs), retirees and their eligible family members, survivors, certain formers spouses and other eligible beneficiaries, including those 65 years of age and over, regardless of whether or not they participate in Medicare Part B (active duty service members cannot enroll in USFHP).

Veteran

A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable. Unless the veteran is eligible for “retired pay,” “retirement pay,” or “retainer pay,” (which refers to payments of a continuing nature and are payable at fixed intervals from the Government for military service) neither the veteran nor his or her family members are eligible for benefits under TRICARE.