TRICARE Overseas Program

TRICARE Overseas Program Handbook

Your guide to program benefits in the TRICARE Overseas Program

TRICARE

June 2010

Important Information

TRICARE Web site:	www.tricare.mil

TRICARE Overseas (TRICARE Eurasia-Africa, TRICARE Latin America and Canada, and TRICARE Pacific)

Overseas Toll-Free Number:	1-888-777-8343
Overseas Web site:	www.tricare.mil/overseas

TRICARE North Region Contractor

Health Net Federal Services, LLC:	1-877-TRICARE (1-877-874-2273)
Health Net Web site:	www.healthnetfederalservices.com

TRICARE South Region Contractor

Humana Military Healthcare Services, Inc.:	1-800-444-5445
Humana Military Web site:	www.humana-military.com

TRICARE West Region Contractor

TriWest Healthcare Alliance Corp.:	1-888-TRIWEST (1-888-874-9378)
TriWest Web site:	www.triwest.com

An Important Note About TRICARE Program Changes

At the time of printing, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact your regional contractor or local TRICARE Service Center. More information regarding TRICARE, including the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, can be found online at www.tricare.mil.

Welcome to the TRICARE Overseas Program

The TRICARE Overseas Program (TOP) is the Department of Defense health care program for geographical areas and territorial waters outside of the United States. While similar to the stateside program, TOP has some differences.

To ensure your access to the highest quality health care possible no matter where you are, TRICARE partners with the best available providers around the world and has established host nation provider networks around military treatment facilities (MTFs).

The TRICARE overseas region has three areas:

- **TRICARE Eurasia-Africa:** Africa, Europe, and the Middle East
- **TRICARE Latin America and Canada:** Canada, the Caribbean basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands
- **TRICARE Pacific:** Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries

This handbook provides information about program options, eligibility, enrollment, covered services, and accessing care when living or traveling overseas. There are many resources listed throughout this handbook to help you.

Visit **www.tricare.mil/tricaresubscriptions** to sign up for TRICARE news and updates via e-mail. Enter your e-mail address, select the topics that interest you, and click "Save" at the bottom of the page.

Your TRICARE Overseas Program Contractor

The TRICARE Management Activity selected International SOS Assistance, Inc. (International SOS), to administer the TRICARE program overseas. Visit the International SOS Web site at **www.tricare-overseas.com** for more information about overseas benefits. Call your TOP Regional Call Center for assistance with enrollment, authorizations, and referrals. Call your Medical Assistance number in an emergency. For contact information, see the "TRICARE Overseas Program Contact Information" figure.

TRICARE Overseas Program Regional Call Centers

TOP Regional Call Centers help coordinate care for TOP Prime beneficiaries. They also help coordinate emergency and urgent medical and dental care for active duty service members (ADSMs) on temporary duty (TDY) or authorized leave status overseas. An ADSM on TDY must provide a copy of his or her orders to the TOP Regional Call Center for the area where he or she is located to coordinate health care.

Medical Assistance

International SOS provides a Medical Assistance line for each overseas region. In an emergency, call the Medical Assistance line to locate the nearest medical facility or to coordinate overseas emergency care. The lines are available 24 hours a day, seven days a week, and you may call collect, if available.

Call your primary care manager (PCM), TOP Regional Call Center, or TRICARE Area Office (TAO) for urgent care assistance or for referrals and authorizations.

TRICARE Area Offices

A TAO is located in each overseas area to assist beneficiaries living or traveling overseas. TAOs provide information on prior authorization and referral requirements and help you locate the nearest TRICARE Service Center (TSC) or MTF. TAOs also provide authorizations for non-TOP Prime and non-TOP Prime Remote beneficiaries.

TRICARE Service Centers

TSCs are located throughout the overseas regions, typically at MTFs, where customer service representatives are available to assist you. TSCs are important resources when seeking care at MTFs or from host nation providers. Your local TSC can help you learn about TRICARE program options, transfer enrollment, provide claims assistance, resolve TRICARE problems, and file complaints. To locate a TSC near you, contact your TAO or visit **www.tricare.mil/contactus**.

Keep Your DEERS Information Current!

It is essential that you keep information in the Defense Enrollment Eligibility Reporting System (DEERS) current for you and your family. DEERS is a worldwide, computerized database of uniformed service members (*active duty and retired*), their family members, and others who are eligible for military benefits, including TRICARE. Proper and current DEERS registration is the key to receiving timely, effective TRICARE benefits, including

TRICARE Overseas Program Contact Information

TRICARE Eurasia-Africa	TRICARE Latin America and Canada	TRICARE Pacific
Africa, Europe, and the Middle East	Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands	Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries
TRICARE Overseas Program (TOP) Regional Call Center* +44-20-8762-8384 tricarelon@internationalsos.com **Medical Assistance*** +44-20-8762-8133	**TOP Regional Call Center*** +1-215-942-8393 tricarephl@internationalsos.com **Medical Assistance*** +1-215-942-8320	**TOP Regional Call Centers*** *Singapore:* +65-6339-2676 sin.tricare@internationalsos.com *Sydney:* +61-2-9273-2710 sydtricare@internationalsos.com **Medical Assistance*** *Singapore:* +65-6338-9277 *Sydney:* +61-2-9273-2760
TRICARE Area Office +49-6302-67-6314 314-496-6314 (*DSN*) +1-888-777-8343, option 1 (*stateside toll-free*) teoweb@europe.tricare.osd.mil www.tricare.mil/eurasiaafrica	**TRICARE Area Office** +1-706-787-2424 312-773-2424 (*DSN*) +1-888-777-8343, option 3 (*stateside toll-free*) taolac@tma.osd.mil www.tricare.mil/tlac	**TRICARE Area Office** +81-6117-43-2036 315-643-2036 (*DSN*) +1-888-777-8343, option 4 (*stateside toll-free*) tpao.csc@med.navy.mil www.tricare.mil/pacific

* *For toll-free contact numbers, visit* ***www.tricare-overseas.com****. Only call Medical Assistance numbers to coordinate overseas emergency care.*

doctors' appointments, prescriptions, and health care expense payments.

You have several options for updating and verifying DEERS information:

In Person[1] (*add or delete a family member or update contact information*)	• Visit a local identification card-issuing facility. • Find a facility near you at **www.dmdc.osd.mil/rsl**. • Call to verify location and business hours.
Phone[2]	• +1-800-538-9552 • +1-866-363-2883 (*TTY/TDD*)
Fax[2]	• +1-831-655-8317
Mail[2]	• Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771
Online[2]	• **DEERS Web site:** www.dmdc.osd.mil/appj/address/

1. *Only sponsors (*or sponsor-appointed individuals with valid powers of attorney*) can add or delete a family member. Family members age 18 and older may update their own contact information.*
2. *Use these methods to change contact information only.*

Important Note for National Guard and Reserve Members and Their Families

National Guard and Reserve members who are called or ordered to active duty for more than 30 consecutive days are eligible for TRICARE as ADSMs, and their family members are eligible for TRICARE as active duty family members (ADFMs). Active duty means full-time duty in the active military service of the United States.

Eligible ADFMs may enroll in TOP Prime (*depending on availability in your location*) or use TOP Standard. Your service personnel office determines eligibility for pre-activation benefits. Contact your unit personnel office regarding your eligibility. Your activation orders should contain your unit personnel office address and contact information.

Throughout this handbook, when we refer to ADSMs and ADFMs, we are also referring to activated National Guard and Reserve members and their families.

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For information about your patient rights and responsibilities, see the inside back cover of this handbook.

Getting Started

TRICARE is available to active duty service members (ADSMs), active duty family members (ADFMs), retired service members and their family members, survivors, and others who are registered in the Defense Enrollment Eligibility Reporting System (DEERS). The uniformed services include the:

- U.S. Army
- U.S. Air Force
- U.S. Navy
- U.S. Marine Corps
- U.S. Coast Guard
- Commissioned Corps of the Public Health Service
- Commissioned Corps of the National Oceanic and Atmospheric Association

Your beneficiary category and location determine which TRICARE Overseas Program (TOP) options are available to you. Figure 1.1 shows program options according to beneficiary type. Your options may change if your beneficiary status changes or after experiencing certain life events, such as moving, becoming entitled to Medicare, getting married, or having a child. For additional information, see the *Changes to Your TRICARE Coverage* section of this handbook.

Active Duty Service Members

ADSMs are **required** to enroll in TOP Prime. Depending on where you are stationed overseas, you must enroll in one of the two TOP Prime options:

- TOP Prime
- TOP Prime Remote

Active Duty Family Members

For the purpose of eligibility, the term "family members" includes the sponsor's TRICARE-eligible spouse and children. Unmarried children may remain TRICARE-eligible until age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides 50 percent of the financial support*). A disabled child may remain TRICARE-eligible beyond normal age limits. Contact DEERS for eligibility criteria.

ADFMs may enroll in TOP Prime if they are eligible in DEERS and one of the following:

- Command sponsored on the sponsor's permanent change of station orders

TRICARE Overseas Program Options by Beneficiary Type ***Figure 1.1***

Beneficiary Type	Program Options
Active duty service members	• TOP Prime • TOP Prime Remote • TRICARE Active Duty Dental Program*
Active duty family members and transitional survivors	• TOP Prime • TOP Prime Remote • TOP Standard • TRICARE For Life (TFL) (*if enrolled in Medicare Part A and Part B*) • TRICARE Dental Program
Retired service members and family members, survivors, Medal of Honor recipients, certain unremarried former spouses, and others	• TOP Standard • TFL (*if enrolled in Medicare Part A and Part B*) • Enhanced-Overseas TRICARE Retiree Dental Program

* *The TRICARE Active Duty Dental Program is only available in the United States and in U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).*

- Relocated on service-sponsored/funded orders
- National Guard and Reserve family members residing overseas with their sponsors who are activated for more than 30 days in support of a contingency operation
- Transitional survivors whose ADSM sponsors died while serving active duty orders for more than 30 consecutive days*

* *For more information about transitional survivors, see "Survivor Coverage" in the* Changes to Your TRICARE Coverage *section.*

Note: Command sponsorship is an authorization entitling family members to travel overseas at the government's expense. Command-sponsored family members are included on their sponsors' change of station orders.

ADFMs who are not eligible for, or choose not to enroll in, TOP Prime may use TOP Standard. See the *Overseas Program Options* section of this handbook for more information about TOP Standard.

Retired Service Members and Their Families

Retired service members and their family members are not eligible to enroll in TOP Prime. However, they may be eligible to use TOP Standard and receive military treatment facility (MTF) care on a space-available basis, or they may enroll in TRICARE Plus, pending individual MTF availability. Medicare-eligible retirees and family members who have both Medicare Part A and Part B receive benefits under TRICARE For Life (TFL). See "Other Overseas Programs" in the *Overseas Program Options* section of this handbook for more information about TFL.

National Guard and Reserve Members and Their Families

National Guard and Reserve members include members of the:

- Army National Guard
- Army Reserve
- Navy Reserve
- Marine Corps Reserve

- Air National Guard
- Air Force Reserve
- Coast Guard Reserve

When on Active Duty Orders for More than 30 Days

If you are activated for more than 30 consecutive days of federal service, you receive TRICARE benefits as an ADSM. Unless you are deployed or in transit to a theater of operations where operational medical assets are available, you must enroll in TOP Prime on the first day of the orders.

TRICARE-eligible family members who reside overseas with you receive coverage as ADFMs while you are activated. They may enroll in TOP Prime or TOP Prime Remote. They may also choose to use TOP Standard, which does not require enrollment.

If your family lives in the United States when you are activated, they are **not** eligible for TOP Prime. However, they may be eligible for the following U.S. program options:

- TRICARE Prime
- TRICARE Prime Remote for Active Duty Family Members

- TRICARE Standard and TRICARE Extra
- TFL (*if enrolled in Medicare Part A and Part B*)

Pre-Activation Benefit

National Guard and Reserve members who are issued delayed-effective-date active duty orders for more than 30 days in support of a contingency operation may be eligible for pre-activation TRICARE medical and dental benefits. The sponsor and his or her eligible family members may begin receiving benefits on the date orders were issued or 180 days before the sponsor reports to active duty, whichever is later.

Your service personnel office determines if you are eligible for pre-activation benefits when you receive your delayed-effective-date active duty orders. These benefits continue without a break in coverage when you begin serving active duty. If your orders are canceled, your pre-activation benefits end. If eligible, you may enroll or reenroll in TRICARE Reserve Select.

If you do not meet the pre-activation eligibility requirements, your and your family's coverage begins on the first day of your orders.

When on Active Duty Orders for 30 Days or Less

National Guard and Reserve members serving overseas on orders for 30 days or less are not eligible for TRICARE active duty benefits. However, if you are injured or become ill while on active duty, you are eligible for line-of-duty care through your uniformed service. Additionally, you may seek emergency and urgent care while serving on your orders. Visit **www.tricare.mil** for more information on line-of-duty care.

Overseas Program Options

The TRICARE Overseas Program (TOP) offers three program options to TRICARE beneficiaries living overseas: TOP Prime, TOP Prime Remote, and TOP Standard. Like their stateside counterparts, TOP Prime and TOP Prime Remote have lower out-of-pocket costs than TOP Standard, and TOP Standard allows beneficiaries to self-refer for most civilian care.

Additionally, certain programs—including TRICARE For Life (TFL) and TRICARE Reserve Select (TRS)—are available both in the United States and overseas.

TRICARE Overseas Program Prime

TOP Prime is a managed care option available to active duty service members (ADSMs) and their eligible family members who live with them near a military treatment facility (MTF). TOP Prime works like the U.S. TRICARE Prime program, with similar benefits, requirements, and costs. Enrollment is required, but there are no enrollment fees. With TOP Prime, you receive most of your care from an assigned primary care manager (PCM) at an MTF. Your PCM refers you for specialty care when necessary.

ADSMs stationed overseas must enroll in TOP Prime or TOP Prime Remote. Eligible active duty family members (ADFMs) may choose to enroll in TOP Prime; they may use TOP Standard; or they may enroll in TRICARE Plus, pending individual MTF availability.

TRICARE Overseas Program Prime Remote

TOP Prime Remote provides TRICARE Prime benefits to ADSMs and their eligible family members residing with them in remote overseas locations. Enrollment is required, but there are no enrollment fees. TOP Prime Remote enrollees are assigned host nation PCMs.

TRICARE Overseas Program Standard

TOP Standard is a fee-for-service option available to eligible, non-ADSMs living overseas. TOP Standard works like the U.S. TRICARE Standard program, with similar benefits, requirements, and costs. Enrollment is not required; coverage is automatic as long as you are shown as eligible in the Defense Enrollment Eligibility Reporting System and do not enroll in TOP Prime or TOP Prime Remote.

With TOP Standard, you manage your own health care and may generally seek care from any host nation provider without a referral. However, certain services, including inpatient nonemergency behavioral health care, require prior authorization from your TRICARE Area Office (TAO). Before seeking care, contact your TAO to determine if you are required to visit an authorized provider. Additionally, see the *Getting Care* section for details. You are responsible for paying an annual deductible and cost-shares, and you should expect to pay up front for care and submit a claim for reimbursement. Visit **www.tricare-overseas.com** for a list of host nation providers.

If an overseas ADFM does not enroll in TOP Prime or TOP Prime Remote, he or she is eligible for TOP Standard. For more information about TOP Standard, visit **www.tricare.mil** or contact the nearest TRICARE Service Center (TSC).

Note: TRICARE Extra is **not** available overseas.

Other Programs Overseas

TRICARE For Life

TFL is available both stateside and overseas to TRICARE beneficiaries who have both Medicare Part A and Part B. Although Medicare is not available outside of the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin*

Islands), **you must have Medicare Part B to remain TRICARE-eligible if you are entitled to premium-free Part A.**

Unless you have other health insurance, TRICARE is the primary payer for covered care you receive in areas where Medicare is not available. You are responsible for paying an annual deductible and cost-shares, which are the same as those under TRICARE Standard. When visiting host nation providers, expect to pay up front for care and file a claim with the TOP contractor for reimbursement. Medicare is the primary payer, and TRICARE pays last for Medicare- and TRICARE-covered services received in the United States or U.S. territories. Visit **www.tricare.mil/costs** for cost information.

Note: Medicare covers services provided onboard a ship in the territorial waters adjoining the land areas of the United States. In these locations, TFL works exactly as it does in the United States.

To learn more about TFL, visit **www.tricare.mil/tfl** or **www.TRICARE4u.com**. Contact the nearest TSC or TAO to request a copy of the *TRICARE For Life Handbook*.

TRICARE Reserve Select

TRS is a premium-based health plan that stateside and overseas National Guard and Reserve members may qualify to purchase. Qualifying members may purchase TRS member-only or member-and-family coverage and pay monthly premiums.

Overseas, TRS works like TOP Standard, with the same benefits, requirements, and costs. You may receive care from any host nation provider without a referral. However, certain services, including inpatient nonemergency behavioral health care, require prior authorization from your TAO. Before seeking care, contact your TAO to determine if you are required to visit an authorized provider.

You are responsible for paying an annual deductible and cost-shares, and you should expect to pay up front for care and submit a claim to the TOP contractor for reimbursement. For a list of providers, visit **www.tricare-overseas.com**.

Enrollment

Some TRICARE overseas options provide automatic coverage. However, others require you to take specific actions to enroll. It is important to understand which program options require enrollment and how to enroll. You must appear as eligible in the Defense Enrollment Eligibility Reporting System (DEERS) before you can access TRICARE benefits, regardless of whether or not your program option requires enrollment.

Automatic Coverage Programs

You are automatically covered by one of the following programs if you meet TRICARE's eligibility requirements and are shown as eligible in DEERS:

- TRICARE Overseas Program (TOP) Standard
- TRICARE For Life (*if enrolled in both Medicare Part A and Part B*)

Programs Requiring Enrollment

The following programs require enrollment:

- TOP Prime
- TOP Prime Remote
- TRICARE Reserve Select (TRS)

TRICARE Overseas Program Prime and TRICARE Overseas Program Prime Remote Enrollment

To enroll in either TOP Prime or TOP Prime Remote, submit a *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876) to your TOP Regional Call Center or TRICARE Service Center (TSC). Active duty service members (ADSMs), including National Guard and Reserve members activated for more than 30 consecutive days, are **required** to enroll in TOP Prime or TOP Prime Remote. Eligible active duty family members (ADFMs) may choose to enroll in TOP Prime or TOP Prime Remote, or they may use TOP Standard. TOP Prime coverage begins when your enrollment application is processed.

There are no enrollment fees for TOP Prime or TOP Prime Remote. Visit **www.tricare.mil/costs** for current cost information.

Split Enrollment

TOP Prime allows split enrollment when sponsors are stationed overseas but their family members live in the United States (*e.g., spouses who do not accompany sponsors on overseas tours of duty, children attending college in the United States*). Eligible ADFMs may enroll in stateside TRICARE Prime in the regions where they live. If they are currently enrolled in TPRADFM and the sponsor receives unaccompanied orders, they can remain in TPRADFM in their current location. If they choose not to enroll in TRICARE Prime or TPRADFM, if currently eligible, they are automatically covered under TRICARE Standard and TRICARE Extra.

Key points to remember about split enrollment:

- Families with college students, children living with former spouses, or families otherwise separated can enroll together in different stateside regions, but cannot enroll together in different overseas areas.
- There is no limit on the number of family members who can enroll.

- In most cases, only command-sponsored family members who accompany their sponsors on overseas orders may enroll in TOP Prime or TOP Prime Remote.

To enroll in TRICARE Prime, ADFMs must contact the appropriate stateside TRICARE regional contractor. See Figure 7.2 in the *Changes to Your TRICARE Coverage* section of this handbook for contact information.

Disenrollment

TOP Prime and TOP Prime Remote enrollment is continuous, and you do not have to reenroll every year to maintain coverage. However, certain events cause you to be disenrolled:

- **Sponsor status change:** Any change in sponsor status (*e.g., retirement or National Guard and Reserve member deactivation*) causes automatic disenrollment from your TOP Prime program. If you remain eligible for TOP Prime or TOP Prime Remote, submit a new enrollment application to your TOP Regional Call Center or TSC before the status change occurs to avoid a break in coverage.
- **Sixty days following overseas departure:** When you change stations back to the United States, you remain enrolled in TOP Prime until you reach your new location. At that time, enroll in your new stateside region. If you do not, you are involuntarily disenrolled from TOP Prime or TOP Prime Remote 60 days after leaving your overseas area.
- **Voluntary disenrollment:** If you choose to disenroll from TOP Prime or TOP Prime Remote before the annual enrollment renewal date, you are subject to a 12-month lockout,* which means you will not be permitted to reenroll in any stateside or overseas TRICARE Prime program for 12 months. You must contact your TOP Regional Call Center or local TSC to initiate a voluntary disenrollment. Overseas ADSMs must remain enrolled in either TOP Prime or TOP Prime Remote and may not voluntarily disenroll.

  Note: ADFMs may voluntarily disenroll without penalty at their annual renewal dates. The 12-month lockout provision does not apply if you disenroll at the end of a one-year enrollment period.
- **Loss of eligibility:** Your TOP Prime or TOP Prime Remote coverage automatically ends if your DEERS record indicates loss of TRICARE eligibility. If you believe you are still TRICARE-eligible, update DEERS to reestablish eligibility. Once DEERS is updated, you must reenroll in TOP Prime or TOP Prime Remote, or you will be covered under TOP Standard.

  If you lose eligibility, you may qualify for transitional health care. TRICARE sends you a certificate of creditable coverage when TRICARE eligibility ends. See "Loss of Eligibility" in the *Changes to Your TRICARE Coverage* section for more information about transitional health care options and certificates of creditable coverage.

* *The 12-month lockout provision does not apply to ADFMs of sponsors grades E-1 through E-4.*

TRICARE Reserve Select Enrollment

TRS requires enrollment. TRS is a premium-based health care plan that qualifying National Guard and Reserve members may purchase. TRS offers coverage similar to TRICARE Standard, but a monthly premium is charged. You will receive comprehensive coverage and can obtain care from any TRICARE-authorized provider. Before seeking care, contact your TAO to determine if you are required to visit an authorized provider. Annual deductibles and cost-shares apply. Visit **www.tricare.mil/reserve/reserveselect** for information about TRS coverage.

Note: TRICARE Extra is not available overseas.

Getting Care

This section helps explain how to access health care overseas. Each program option has specific guidelines about how to access care. These guidelines will help you get the most from your benefits and avoid paying unnecessary out-of-pocket costs.

Providers

Military Treatment Facilities

A military treatment facility (MTF) is a military hospital or clinic usually located on or near a military base. MTF appointments are limited, and active duty service members (ADSMs) and active duty family members (ADFMs) have priority. Certain beneficiaries, including those who use TRICARE Overseas Program (TOP) Standard and TRICARE For Life (TFL), may receive care at MTFs on a space-available basis only. Figure 4.1 shows overseas MTF appointment priorities.

Overseas MTF Appointment Priorities *Figure 4.1*

1	Active duty service members (ADSMs)
2	TRICARE Overseas Program (TOP) Prime and TOP Prime Remote active duty family members (ADFMs) and survivors whose ADSM sponsors died during active duty
3	Non-TOP Prime and non-TOP Prime Remote ADFMs TRICARE Reserve Select for Selected Reserve members and their families
4	Retired service members, their families, and all others not enrolled in TOP Prime or TOP Prime Remote

If you wish to receive care at an MTF, call the MTF to see if they can provide the care you need. Visit **www.tricare.mil/mtf** to locate an MTF.

Host Nation Providers

TRICARE certifies network and non-network host nation providers to provide care to overseas beneficiaries. Network host nation providers have established agreements with the TOP contractor, International SOS Assistance, Inc.

Non-network host nation providers may not provide cashless/claimless services. When you visit a non-network host nation provider, you may be required to pay up front and file a claim for reimbursement. Before seeking care, contact your TOP Regional Call Center or TRICARE Area Office (TAO) to determine if you are required to visit authorized providers. Visit **www.tricare-overseas.com** for more information.

Types of Care

Emergency Care

TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a "prudent layperson" (*someone with average knowledge of health and medicine*) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb, or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others.

In an emergency, go immediately to the nearest emergency care facility or call the Medical Assistance number for your region. Prior authorization is not required. However, if you are admitted, you must call your primary care manager (PCM), TOP Regional Call Center, or TAO **before you leave the facility**, preferably within 24 hours or on the next business day to coordinate authorization, continued care, and payment.

TRICARE Overseas Program Prime Enrollees in Canada

TOP Prime enrollees in Canada should call the U.S. Embassy or the nearest Canadian Forces Health Facility (CFHF) for local ambulance service contact information. Have your local phone number and address available. Do not hang up the phone until directed to do so by the operator. Call the Canadian Forces Member Health Information Line at **+1-877-MEDDENT (+1-877-633-3368)** or visit **www.tricare.mil/tlac/canada_cfhf.cfm** to locate the nearest CFHF.

Beneficiaries age 17 or younger who live in Ottawa should seek emergency care at the Children's Hospital of Eastern Ontario if it is the nearest available emergency facility.

Urgent Care

Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but do require professional attention within 24 hours. You could require urgent care for a condition such as a sprain, sore throat, or rising temperature, as each of these has the potential to develop into an emergency if treatment is delayed longer than 24 hours.

Routine Care

Routine (*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. Routine care also includes preventive care measures to help keep you healthy.

Specialty Care

Specialty care is nonemergency care that your PCM or primary care provider cannot provide.

Note: If you are a TOP Prime Remote ADSM, see "Specialty Care for TOP Prime Remote Active Duty Service Members" later in this section.

TRICARE Overseas Program Prime and TRICARE Overseas Prime Remote Care

Access Standards

TRICARE Prime programs, including TOP Prime and TOP Prime Remote, provide for the following standards for access to care:

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

Point-of-Service Option

The TRICARE Prime point-of-service (POS) option allows TOP Prime and TOP Prime Remote ADFMs to pay additional out-of-pocket fees to receive nonemergency health care services from any host nation provider without referrals. Before seeking care, contact your TOP Regional Call Center to determine if you are required to visit an authorized provider. For cost details, visit **www.tricare.mil/costs**.

POS cost-shares apply to the following:

- Receiving care from any host nation provider without a PCM referral
- Self-referring to a host nation provider for nonemergency care

The POS option does **not** apply to the following:

- ADSMs
- Newborns and adopted children during the first 120 days after birth or adoption
- Emergency care
- Clinical preventive care received from a network host nation provider
- The first eight outpatient behavioral health care visits to a network host nation provider per fiscal year (FY) (*October 1–September 30*)
- Beneficiaries with other health insurance

The POS option results in significantly higher out-of-pocket costs. TRICARE only reimburses 50 percent of the negotiated or allowable charge after you meet the POS deductible. POS costs do not apply to your annual catastrophic cap.

Note: Prior authorization requirements still apply when using the POS option. Contact your TOP Regional Call Center for information about services that require prior authorization before seeking care.

Services that Do Not Require Referrals

TOP Prime and TOP Prime Remote ADFMs do not need referrals for certain services, including clinical preventive services and the first eight outpatient behavioral health care visits to a

network provider per FY. You must see a network host nation provider for clinical preventive services and behavioral health care. If you seek care from a non-network provider without a PCM referral, you are using the POS option, resulting in higher out-of-pocket costs. Visit **www.tricare.mil/costs** for cost details.

For more information about these services, see the *Covered Services, Limitations, and Exclusions* section of this handbook. Remember, you never need a referral for emergency care.

Note: ADSMs always require referrals for nonemergency civilian care, including clinical preventive services, behavioral health care, and specialty care.

Urgent Care

In most cases, you can receive urgent care from your PCM by making a same-day appointment. If you do not coordinate in advance with your PCM, you may still use the POS option, resulting in higher out-of-pocket costs. For cost details, visit **www.tricare.mil/costs**.

If you are away from home and urgent treatment cannot wait until you return home to see your PCM, you must contact your PCM for a referral or call the TOP Regional Call Center for assistance before receiving care.

Routine Care

You receive most of your routine care from your PCM. You do not need a referral to visit your PCM. If your PCM is unable to provide the care needed, he or she can refer you to another provider. If you receive routine care from another provider without a PCM referral, you are using the POS option, resulting in higher out-of-pocket costs. For cost details, visit **www.tricare.mil/costs**.

Routine Care in Canada

The reciprocal health care agreement between the United States and Canada allows ADSMs and command-sponsored ADFMs stationed in Canada to receive inpatient and outpatient medical services at CFHFs at no cost. ADSMs can also receive cost-free dental care at CFHFs.

The service area includes the following Canadian provinces:

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

Specialty Care

There may be times when you need to see a specialist for a diagnosis or treatment that your PCM cannot provide. Your PCM can provide a referral to access services from specialty providers and coordinate a referral request with your TOP Regional Call Center, if necessary. If you receive specialty care without a PCM referral, you are using the POS option, resulting in higher out-of-pocket costs. For cost details, visit **www.tricare.mil/costs**.

Referrals for Specialty Care

Contact your TOP Regional Call Center for details about obtaining referrals. If you live near an MTF and are referred for specialty care, inpatient admissions, or procedures requiring prior authorization, your call center first attempts to coordinate care at your MTF. If services are not available at the MTF, the TOP Regional Call Center coordinates care with a network host nation provider.

If your PCM refers you to a specialist who would like to refer you to another specialist, the specialist must contact your PCM. Your PCM or the specialist must contact your TOP Regional Call Center to obtain authorization for additional specialty care, if necessary.

TRICARE Overseas Program Prime Remote Active Duty Service Members: If Local Specialty Care Is Not Available

If specialty or diagnostic services are not available locally, you may need to travel outside your area to receive care, which may not be cashless/claimless. If care is not available, the TOP Regional Call Center contacts the TAO to coordinate medical temporary duty (TDY) to an MTF or the nearest TOP Prime Remote network facility. You must complete a medical TDY form and fax all medical information related to the appointment to receive funds for travel orders and per diem.

The TAO schedules the appointment on your behalf, notifies you of the appointment time, and provides information about obtaining required travel funding from your service organization.

Note: In addition to ADSMs enrolled in TOP Prime Remote, any ADSM on leave or TDY in any remote location worldwide may contact the TOP Regional Call Center to seek assistance for emergency and urgent health care and dental care.

For TOP Regional Call Center contact information, see "Your TRICARE Overseas Program Contractor" in the *Welcome to the TRICARE Overseas Program* section or visit **www.tricare-overseas.com**.

Fitness-for-Duty Appointments

The local TRICARE POC coordinates fitness-for-duty appointments, flight physicals, and medical care for ADSMs on leave or TDY in the United States. Contact your TRICARE POC for assistance. The TRICARE POC will gather the required information from you and coordinate the request with the TOP Regional Call Center.

TRICARE Overseas Program Standard Care

TOP Standard beneficiaries manage their own health care and can make appointments with host nation providers. Before seeking care, contact your TAO to determine if you are required to visit an authorized provider. If you are not located near an MTF, TRICARE Service Center (TSC), or U.S. Embassy Health Unit, visit **www.tricare-overseas.com** for a list of providers or contact your TAO or TOP Regional Call Center for assistance.

You do not need a referral for care. Prior authorization from your TAO is required for certain services, including nonemergency inpatient behavioral health care admissions. Contact your TAO to learn about prior authorization requirements in your region before seeking care.

Be prepared to pay up front for care and file claims with the TOP contractor for reimbursement. See the *Claims* section for more information.

Prior Authorization for Care

A prior authorization is a review of the requested health care service to determine if it is medically necessary at the requested level of care. Prior authorizations must be obtained **before** services are rendered or within 24 hours or on the business day following emergency admissions.

TOP Prime and TOP Prime Remote beneficiaries must obtain prior authorization from their TOP Regional Call Centers, if necessary. If the service is authorized, your TOP Regional Call Center gives your PCM or specialty care provider an authorization number and specific instructions. For example, prior authorizations for medical or surgical services specify begin and end dates. Prior authorizations for behavioral health care services specify begin and end dates as well as the number of authorized visits. You must receive authorized care before the authorization expires. If not, you must get another referral and authorization from your PCM, primary care provider, or specialty care provider.

TOP Standard, TRS, and TFL beneficiaries must obtain prior authorization from their TAOs.

Services Requiring Prior Authorization

ADSMs require prior authorization for all inpatient and outpatient specialty services. An additional fitness-for-duty review is required for maternity care, physical therapy, behavioral health care services, family counseling, and smoking cessation programs.

TOP Prime and TOP Prime Remote ADFMs require prior authorization for the following services:

- Adjunctive dental services
- Extended Care Health Option services
- Home health care services (*only available in the United States and U.S. territories [*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*]*)
- Hospice care (*only available in the United States and U.S. territories*)
- Nonemergency inpatient admissions for substance use disorders and behavioral health care
- Outpatient behavioral health care beyond the eighth visit to a network host nation provider per FY
- Transplants—all solid organ and stem cell*

This list is **not** all-inclusive, and **each overseas area has additional prior authorization requirements**. Contact your TOP Regional Call Center to learn about requirements in your region, as they may change periodically. See the *Welcome to the TRICARE Overseas Program* section of this handbook for contact information.

* *Medicare certification for organ transplant centers is only required for transplants performed in the United States and U.S. territories where Medicare is available. TRICARE may cover organ transplants in overseas locations when medically necessary, reasonable, and commonly accepted in the country where the transplant is performed.*

Getting a Second Opinion

You have the right to request a consultation with another provider for a second medical opinion when you or the initial provider is uncertain about a contemplated course of action. Your PCM, primary care provider, or TOP Regional Call Center may also request a second medical opinion on your behalf. If you wish to seek a second opinion, contact your PCM, primary care provider, TSC, TAO, or TOP Regional Call Center to explain your situation and ask questions you have about the first specialist's suggested care. Then you, your PCM, or your primary care provider can request a referral to another specialist from your TSC, TAO, or TOP Regional Call Center. Be sure to indicate the request is for a second opinion.

Covered Services, Limitations, and Exclusions

TRICARE covers most medically necessary inpatient and outpatient care that is considered proven. There are special rules and limitations for certain types of care, and some types of care are not covered at all. **This section is not all-inclusive.** TRICARE policies are very specific about which services are covered and which are not. One of your duties under *TRICARE's Patient Bill of Rights and Responsibilities* is to be knowledgeable about your TRICARE coverage and program options. It is in your best interest to take an active role in verifying coverage. Visit **www.tricare.mil** for additional information about covered services and benefits.

Note: All host nation care must meet TRICARE's rules for coverage. You are financially responsible for 100 percent of the cost for care that TRICARE does not cover.

Outpatient Services

Figure 5.1 provides coverage details for outpatient services. **Note:** This chart is **not** all-inclusive.

Outpatient Services: Coverage Details ***Figure 5.1***

Service	Description
Ambulance Services	The following ambulance services are covered: • Transfers from a beneficiary's home, accident scene, or other location to a military treatment facility (MTF) or hospital • Transfers between MTFs or hospitals • Ambulance transfers from a hospital-based emergency facility to a hospital more capable of providing the required care • Transfers between an MTF, hospital, or skilled nursing facility and another hospital-based or freestanding outpatient therapeutic or diagnostic department/facility The following are excluded: • Use of an ambulance service instead of taxi service when the patient's condition would have permitted use of regular private transportation • Transport or transfer of a patient primarily for the purpose of having the patient nearer to home, family, friends, or personal physician • Medicabs or ambicabs that function primarily as public passenger services transporting patients to and from their medical appointments **Note:** TRICARE only pays for special transportation for beneficiaries who are registered and being transported for Extended Care Health Option services when special transport is required to ensure the beneficiary's safety. See "TRICARE Extended Care Health Option" later in this section for more information. **Note:** Air or boat ambulance is only covered when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the beneficiary to the nearest hospital with appropriate facilities, and the patient's medical condition warrants speedy admission or is such that transfer by other means is not advisable.
Ancillary Services	Covers certain diagnostic radiology and ultrasounds, diagnostic nuclear medicine, pathology and laboratory services, and cardiovascular studies

Outpatient Services: Coverage Details (continued)

Service	Description
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Generally covered if prescribed by a physician and if directly related to a medical condition. Covered DMEPOS generally include: • DMEPOS that are medically necessary and appropriate and prescribed by a physician for a beneficiary's specific use • Duplicate DMEPOS that are necessary to provide a fail-safe, in-home life-support system (*In this case, "duplicate" means an item that meets the definition of DMEPOS and serves the same purpose, but may not be an exact duplicate of the original DMEPOS. For example, a portable oxygen concentrator may be covered as a backup for a stationary oxygen generator.*) **Note:** Prosthetic devices must be approved by the U.S. Food and Drug Administration.
Emergency Services	TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a "prudent layperson" (*someone with average knowledge of health and medicine*) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb, or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others.
Home Health Care	Covers part-time or intermittent skilled nursing services and home health care services (*All care must be provided by a participating home health care agency and be authorized in advance by the TRICARE Area Office.*) **Note:** Home health care is **not** available overseas except in U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).
Individual Host Nation Provider Services	Covers office visits; outpatient, office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services (*e.g., physical and occupational therapy and speech pathology services*); and medical supplies used within the office
Laboratory and X-ray Services	Generally covered if prescribed by a physician (*Some exceptions apply, e.g., chemo-sensitivity assays and bone density X-ray studies for routine osteoporosis screening.*)
Active Duty Service Member (ADSM) Respite Care	Covers respite care for ADSMs who are homebound as a result of serious injuries or illnesses incurred while serving on active duty; available if the ADSM's plan of care includes frequent[1] interventions by the primary caregiver The following respite care limits apply: • 40 hours per calendar week • Five days per calendar week • Eight hours per calendar day **Note:** Respite care must be provided by a TRICARE-authorized Home Health Agency (HHA) and requires prior authorization from the TRICARE Overseas Program Regional Call Center and the ADSM's approving authority (*i.e., Military Medical Support Office or referring MTF*).

1. More than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.

Inpatient Services

Figure 5.2 provides coverage details for inpatient services. **Note:** This chart is **not** all-inclusive.

Inpatient Services: Coverage Details *Figure 5.2*

Service	Description
Hospitalization (*semi-private room/ special care units when medically necessary*)	Covers general nursing; hospital, physician, and surgical services; meals (*including special diets*); drugs and medications; operating and recovery room care; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products **Note:** Surgical procedures designated "inpatient only" may only be covered when performed in an inpatient setting.
Skilled Nursing Facility Care (SNF) (*semi-private room*)	Covers regular nursing services; meals (*including special diets*); physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances (*TRICARE covers an unlimited number of days as medically necessary.*) **Note:** SNF care is **not** available overseas except in U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

Clinical Preventive Services

Figure 5.3 provides coverage details for covered clinical preventive services. **Note:** This chart is **not** all-inclusive.

Clinical Preventive Services: Coverage Details *Figure 5.3*

Service	Description
Comprehensive Health Promotion and Disease Prevention Examinations	A comprehensive clinical preventive exam is covered if it includes an immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening. School enrollment physicals for children ages 5–11 are also covered. **TRICARE Prime programs only:** Beneficiaries in each of the following age groups may receive one comprehensive clinical preventive exam without receiving an immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening (*one exam per age group*): 2–4, 5–11, 12–17, 18–39, and 40–64.
Targeted Health Promotion and Disease Prevention Services	The screening examinations listed below may be covered if provided in conjunction with a comprehensive clinical preventive exam. The intent is to maximize preventive care.

Cancer Screenings	• **Colonoscopy:** Perform a colonoscopy once every 10 years starting at age 50, or as listed below for individuals at increased risk for:
	  • Hereditary non-polyposis colorectal cancer syndrome: Perform a colonoscopy once every two years beginning at age 25, or five years younger than earliest age of diagnosis in affected relative(s), whichever is earlier, and then annually after age 40.
	  • Familial risk of sporadic colorectal cancer: For first-degree relatives with sporadic colorectal cancer or adenoma before age 60, or with multiple first-degree relatives with colorectal cancer or adenomas, perform a colonoscopy every three to five years, beginning 10 years earlier than the youngest affected relative.
	• **Fecal occult blood testing:** Conduct testing annually starting at age 50.

Clinical Preventive Services: Coverage Details (continued)

Service	Description

Cancer Screenings (*continued*)	• **Mammograms:** Perform a mammography annually beginning at age 40. For high-risk patients, a baseline mammogram is appropriate at age 35 and annually thereafter.
	  • Magnetic resonance imaging (MRI): Perform an MRI annually for asymptomatic beneficiaries age 30 or older considered to be at high risk for developing breast cancer by American Cancer Society® guidelines. The guidelines include women with a:
	  • BRCA1 or BRCA2 gene mutation
	  • First-degree relative (*parent, child, or sibling*) with a BRCA1 or BRCA2 gene mutation
	  • Lifetime risk of approximately 20–25 percent or greater as defined by BRCAPRO or other models that are largely dependent on family history
	  • History of chest radiation between ages 10–30
	  • History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with one of these syndromes
	• **Physical exam for colorectal cancer:** A digital rectal exam should be included in periodic health exams of individuals age 40 and older.
	• **Proctosigmoidoscopy or sigmoidoscopy:** Conduct the procedure once every three to five years beginning at age 50.
	• **Prostate cancer:** Perform a digital rectal exam and prostate-specific antigen screening annually for certain high-risk men ages 40–49 and all men over age 50.
	• **Routine Pap smears:** Perform a Pap smear annually for women starting at age 18 (*younger, if sexually active*) or less often at patient and provider discretion (*though not less than every three years*). Routine human papillomavirus (HPV) screenings are not covered.
	• **Skin cancer:** Exams are covered at any age for a beneficiary who is at high risk due to family history or increased sun exposure.

Cardiovascular Diseases	• **Cholesterol test:** Testing is covered for a lipid panel at least once every five years beginning at age 18. • **Blood pressure screening:** Screening is covered annually for children (*ages 3–6*) and a minimum of every two years after age 6 (*children and adults*).

Eye Examinations	• **Well-child care coverage (*infants and children up to age 6*):**
	  • **Infants:** One eye and vision screening is covered at birth and at 6 months.
	  • **Children (*ages 3–6*):** One routine eye exam is covered every two years.
	• **Adults and children (*over age 6*):** TRICARE Prime program active duty service members (ADSMs) and active duty family members (ADFMs) are covered for one eye exam per year.
	• **Diabetic patients (*any age*):** Eye exams are not limited. One eye exam per year is recommended.
	• **Retired service members, their families, and others:** Not covered after age 6.
	Note: ADSMs enrolled in a TRICARE Prime program must receive all vision care at military treatment facilities unless specifically referred by their primary care managers to civilian network providers, or to non-network providers if network providers are not available.

Hearing	Preventive hearing examinations are only allowed under the well-child care benefit. A newborn audiology screening should be performed on high-risk newborns before hospital discharge or within the first three months after birth. Evaluative hearing tests may be performed at other ages during routine exams.

Clinical Preventive Services: Coverage Details (continued)

Service	Description
Immunizations	Age-appropriate doses of vaccines, including annual influenza vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). The following rules apply: • The HPV vaccine is covered for all females ages 11–26 who have not completed the vaccine series, regardless of sexual activity or clinical evidence of previous HPV infection. The HPV vaccine is not covered after age 26. • The TRICARE medical (*not pharmacy*) benefit covers a single dose of the shingles vaccine Zostavax,® administered in a provider's office, for beneficiaries age 60 and older. • Cost-sharing for the tick-borne encephalitis vaccine may be authorized in certain areas for at-risk ADFMs, retirees, and retiree family members. A TRICARE-authorized provider must administer the vaccine. Coverage is effective the date the recommendations are published in the CDC's *Morbidity and Mortality Weekly Report*. Refer to the CDC's Web site at **www.cdc.gov** for a current schedule of recommended vaccines. **Note:** Immunizations for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered.
Infectious Disease Screening	TRICARE covers screening for infectious diseases, including rubella antibodies and HIV, and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, hepatitis A and B, meningococcal meningitis, and tuberculosis. Routine HPV screening is not covered.
Patient and Parent Education Counseling	Counseling services expected of good clinical practice that are included with the appropriate office visit are covered at no additional charge for dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; dental health promotion; accident and injury prevention; stress; bereavement; and suicide risk assessment.
School Physicals	Covered for children ages 5–11 if required in connection with school enrollment. **Note:** Annual sports physicals are not covered.
Well-Child Care (*birth to age 6*)	Covers routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference measurement; routine immunizations; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with American Academy of Pediatrics (AAP) and CDC guidelines. Your child can receive preventive care well-child visits as frequently as the AAP recommends, but no more than nine visits in two years. Visits for diagnosis or treatment of an illness or injury are covered separately under outpatient care.

Behavioral Health Care Services

TRICARE Overseas Program Prime Behavioral Health Care

Active Duty Service Members

Active duty service members (ADSMs) must have referrals and prior authorizations before seeking behavioral health care services. We do not want to discourage you from getting care, but we want to make sure your condition does not adversely affect your health and your ability to perform worldwide duty. Your primary care manager (PCM) and/or TRICARE Overseas Program (TOP) Regional Call Center coordinate your behavioral health care referrals and authorizations.

Note: In the event of a behavioral health emergency, go immediately to the nearest emergency room or call the Medical Assistance number for your region.

Active Duty Family Members

TOP Prime and TOP Prime Remote active duty family members (ADFMs) do not need referrals or prior authorizations for the first eight outpatient behavioral health care visits to network host nation providers per fiscal year (FY) (*October 1–September 30*). After the eighth visit, your behavioral health care provider must obtain prior authorization from your military treatment facility (MTF) or TOP Regional Call Center. Point-of-

service (POS) fees apply to care received from a non-network host nation provider without a referral and prior authorization from your MTF or TOP Regional Call Center. Before seeking care, contact your TOP Regional Call Center to determine if you are required to visit an authorized provider.

TRICARE Overseas Program Standard

TOP Standard beneficiaries do not need prior authorization for the first eight outpatient behavioral health care visits to host nation providers per FY. However, prior authorization is required for additional visits. Before seeking care, contact your TRICARE Area Office (TAO) to determine if you are required to visit an authorized provider.

Note for ALL TRICARE beneficiaries: A physician referral **is required for all visits** to counselors who require physician supervision (*e.g., behavioral health care counselors, licensed or certified mental health counselors, pastoral counselors*).

Authorized Behavioral Health Care Providers

The following types of behavioral health care providers may be authorized by TRICARE:

- **Certified psychiatric nurse specialists** are licensed, master's-level psychiatric nurses with an additional American Nurses Association certification in behavioral health care. They perform psychotherapy and manage medications.
- **Mental health, licensed professional, and pastoral counselors** have master's degrees in counseling. They perform counseling and psychotherapy services but cannot prescribe medication. In order to provide services to TRICARE beneficiaries, these providers require written physician referrals and ongoing clinical supervision from a doctor of medicine (MD) or doctor of osteopathic medicine (DO).
- **Certified marriage and family therapists** have master's degrees in counseling, with an emphasis on family and marriage therapy. They perform individual counseling and family and marriage therapy but cannot prescribe medication.

- **Licensed clinical social workers** have master's-level degrees in social work, with additional training in psychotherapy and counseling. They perform psychotherapy and counseling services but cannot prescribe medication.
- **Clinical psychologists** have doctoral-level degrees (*doctorates in philosophy or doctorates in psychology*) in psychology. They perform psychotherapy, psychological testing, and counseling services but usually cannot prescribe medication.
- **Psychiatrists** are physicians who have general medical degrees (*MDs or DOs*) and have completed advanced residency training in psychiatry. Most psychiatrists treat persons with more serious disturbances for which medication is helpful (*e.g., major depression, bipolar disorder, attention deficit/hyperactivity disorder*). Psychiatrists perform psychotherapy, manage medication, and work in collaboration with the provider types listed above.

If you are unsure about the type of provider that would best meet your needs, visit the *Mental Health and Behavior* Web page at **www.tricare.mil** for more information.

Figure 5.4 provides coverage details for outpatient behavioral health care. **Note:** This chart is **not** all-inclusive.

Behavioral Health Care Services: Outpatient Coverage Details ***Figure 5.4***

Service	Description

Outpatient Psychotherapy (*physician referral and supervision required when seeing licensed or certified mental health counselors and pastoral counselors*)	The following outpatient psychotherapy limits apply:
	• **Psychotherapy:** Two sessions per week, in any combination of the following types:
	  • **Individual (*adult or child*):** 60 minutes per session; may extend to 120 minutes for crisis intervention
	  • **Family or conjoint:** 90 minutes per session; may extend to 180 minutes for crisis intervention
	  • **Group:** 90 minutes per session
	• **Collateral visits**
	• **Psychoanalysis** (*requires prior authorization*)

Psychological Testing and Assessment	Testing and assessment is covered when medically or psychologically necessary and provided in conjunction with otherwise-covered psychotherapy. Psychological tests are considered to be diagnostic services and are not counted toward the limit of two psychotherapy visits per week. **Limitations:** • Testing and assessment is generally limited to six hours per fiscal year (*October 1–September 30*) (*Testing requires a review for medical necessity.*) **Exclusions:** Psychological testing is not covered for the following circumstances: • Academic placement • Job placement • Child-custody disputes • General screening in the absence of specific symptoms • Teacher or parental referrals • Diagnosed specific learning disorders or learning disabilities
Medication Management	If you are taking prescription medications for a behavioral health condition, you must be under the care of a provider who is authorized to prescribe those medications. Your provider will manage the dosage and duration of your prescription to ensure you are receiving the best care possible.

Figure 5.5 provides coverage details for inpatient behavioral health care. **Note:** This chart is **not** all-inclusive.

Behavioral Health Care Services: Inpatient Coverage Details ***Figure 5.5***

Service	Description
Acute Inpatient Psychiatric Care	Acute inpatient psychiatric care may be covered on an emergency or nonemergency basis. Prior authorization from your primary care manager (PCM), TRICARE Area Office (TAO), or TRICARE Overseas Program (TOP) Regional Call Center, is required for all nonemergency inpatient admissions. In emergency situations, authorization is required for continued stay. **Limitations:** • **Patients age 19 and older:** 30 days per fiscal year (FY)[1] or in any single admission • **Patients age 18 and under:** 45 days per FY[1] or in any single admission • Inpatient admissions for substance use disorder detoxification and rehabilitation count toward the 30- or 45-day limit **Note:** Stay limits may be waived if determined to be medically or psychologically necessary.
Partial Hospitalization Program (PHP) (*where available*)	Psychiatric PHPs provide interdisciplinary therapeutic services at least three hours per day, five days a week, in any combination of day, evening, night, and weekend treatment programs. The following rules apply: • Prior authorization is required. PHP admissions are not considered emergencies. • Facilities must be TRICARE-authorized. • PHPs must agree to participate in TRICARE. **Limitations:** • PHP care is limited to 60 treatment days (*whether full- or partial-day treatment*) per FY[1] or for a single admission. These 60 days are not offset by or counted toward the 30- or 45-day acute inpatient psychiatric care limit. • Treatment for a diagnosis of a substance use disorder is limited to the rehabilitation treatment maximum outlined in Figure 5.6 on the following page.
Residential Treatment Center (RTC) Care (*where available*)	RTC care provides extended care for children and adolescents with psychological disorders who require continued treatment in a therapeutic environment. The following rules apply: • Facilities must be TRICARE-authorized. • Unless therapeutically contraindicated, the family and/or guardian should actively participate in the continuing care of the patient through either direct involvement at the facility or geographically distant family therapy. • Prior authorization from your PCM, TAO, or TOP Regional Call Center is required. • RTC care is considered elective and will not be covered for emergencies. • Admission primarily for substance use rehabilitation is not authorized. • Care must be recommended and directed by a psychiatrist or clinical psychologist. **Limitations:** • Care is limited to 150 days per FY[1] or for a single admission. (*Limitations may be waived if determined to be medically or psychologically necessary.*) • RTC care is only covered for patients age 21 or younger.

1. October 1–September 30

Figure 5.6 provides coverage details for substance use disorder services. **Note:** This chart is **not** all-inclusive.

Behavioral Health Care Services: Substance Use Disorder Services ***Figure 5.6***

Service	Description
Inpatient Detoxification	TRICARE covers emergency and inpatient hospital services for the treatment of the acute phases of substance use withdrawal (*detoxification*) when the patient's condition requires the personnel and facilities of a hospital. The following limits apply: • In a diagnosis-related group-exempt facility, services are limited to seven days per episode. • Services count toward the 30- or 45-day inpatient behavioral health care limit. • Services do not count toward the 21-day rehabilitation limit.
Inpatient Rehabilitation	Rehabilitation (*residential or partial*) is limited to 21 days per year, per benefit period.[1] All inpatient stays count toward the 30- or 45-day inpatient limit.
Outpatient Care	Outpatient care must be provided by an approved, substance use disorder facility. The following limits apply: • **Individual or group therapy:** 60 visits per benefit period[1] • **Family therapy:** 15 visits per benefit period[1] • **Partial hospitalization program care:** 21 treatment days per fiscal year (*October 1–September 30*)

1. A benefit period begins with the first day of covered treatment and ends 365 days later. Stay limits for inpatient services may be waived if determined to be medically necessary.

Emergency and inpatient hospital services are only considered medically necessary when the patient's condition requires hospital personnel and facilities. All treatment for substance use disorders requires prior authorization from your PCM, TAO, or TOP Regional Call Center.

Visit **www.tricare.mil** for additional information about behavioral health care coverage.

Pharmacy Benefits

TRICARE offers comprehensive prescription drug coverage and several options for filling prescriptions. International SOS Assistance, Inc. (International SOS), provides host nation pharmacy benefits overseas. TRICARE Pharmacy Program benefits are limited in overseas areas.

You need a prescription and a valid uniformed services identification (ID) card or Common Access Card to fill prescriptions in overseas locations, including U.S. territories (*American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

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

Visit **www.express-scripts.com/TRICARE** for more information about the TRICARE Pharmacy Program, administered by Express Scripts, Inc. (Express Scripts). Visit **www.tricare.mil/pharmacy** for pharmacy cost information.

Military Treatment Facility Pharmacy

MTF pharmacies are the least expensive options for filling prescriptions. At MTF pharmacies, you may receive up to a 90-day supply of most medications at no cost. Non-formulary medications are generally not available at MTF pharmacies. Call or visit the nearest MTF pharmacy to check the availability of a particular drug.

Visit **www.tricare.mil/militarypharmacy** for more information about MTF pharmacies. Local herbal or unique host nation medications may not be filled at MTF pharmacies.

Mail Order Pharmacy Registration Methods *Figure 5.7*

Online	Visit **www.express-scripts.com/TRICARE**
Phone	Dial your toll-free in-country access code: • **Germany:** 00+800-3631-3030 • **Italy:** 00+800-3631-3030 • **Japan–IDC:** 0061+800-3631-3030 • **Japan–Japan Telecom:** 0041+800-3631-3030 • **Japan–KDD:** 010+800-3631-3030 • **Japan–Other:** 0033+800-3631-3030 • **South Korea:** 002+800-3631-3030 • **Turkey:** 0811-288-0001 (*Once prompted, input 1-877-363-1303.*) • **United Kingdom:** 00+800-3631-3030 **Note:** If you do not live in one of these areas, call **+1-866-ASK-4PEC (+1-866-275-4732)**.
Mail	Download the registration form from **www.express-scripts.com/TRICARE**, and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954

Mail Order Pharmacy

Outside of the United States and U.S. territories, you can only use the Mail Order Pharmacy if you have an APO/FPO address or are assigned to a U.S. Embassy or State Department. You must have a prescription written by a U.S.-licensed provider. The Mail Order Pharmacy is your least expensive option when not using an MTF. You can get up to a 90-day supply of medication for one copayment. Prescriptions are delivered with free standard shipping, and you can easily order refills online, by phone, or by mail.

The Mail Order Pharmacy also provides you with refill reminders, convenient notifications about your order status, and assistance with renewing expired prescriptions. If you have questions about your prescriptions, pharmacists are available to talk confidentially with you 24 hours a day, seven days a week.

Register for the Mail Order Pharmacy by using any of the options in Figure 5.7.

For faster processing of your mail-order prescription, register for the Mail Order Pharmacy before placing your first order. Your provider can fax or call in your prescriptions after you register.

If you live in a U.S. territory, you can expect your medication to arrive at your U.S. Postal Service home address within about 14 days after Express Scripts receives your prescription. If you live in another overseas location, allow extra time for delivery to your APO/FPO address. Mailing conditions can affect the effectiveness of the medication and may limit mail-order services. Refrigerated medications cannot be delivered to APO/FPO addresses.

If you have prescription drug coverage through other health insurance (OHI), you can only use the Mail Order Pharmacy if your OHI does not cover the medication you need or if you exceed the OHI's coverage dollar limit.

TRICARE Retail Network Pharmacy

TRICARE retail network pharmacies are only available in the United States and U.S. territories (*American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). You must present your prescription and your uniformed services ID card to the pharmacist.

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

When you fill a prescription (*one copayment for each 30-day supply*) at a network pharmacy, you do not need to submit a claim for reimbursement. Visit **www.express-scripts.com/TRICARE** or call **+1-877-ASK-4PEC (+1-877-275-4732)** to find a TRICARE retail network pharmacy.

Host Nation Pharmacy

Filling prescriptions at a host nation pharmacy may be the most expensive pharmacy option. Be prepared to pay up front and file a claim for reimbursement.

TRICARE reimburses TOP Prime and TOP Prime Remote beneficiaries for 100 percent of their out-of-pocket costs when they have referrals and use host nation pharmacies. TOP Standard deductibles and cost-shares apply when non-TOP Prime and non-TOP Prime Remote beneficiaries visit host nation pharmacies. Visit **www.tricare.mil/costs** for more information on pharmacy costs.

Note: Prescription drugs that are not approved by the U.S. Food and Drug Administration (FDA) may be cost-shared if International SOS substantiates that the drug is commonly used for the intended purpose in the host nation. Medications that are considered over-the-counter drugs in the United States are not reimbursable.

Quantity Limits

TRICARE has established quantity limits on certain medications, which means the Department of Defense (DoD) only pays up to a specified, limited amount of medication each time you fill a prescription. Quantity limits are often applied to ensure safe and appropriate use of medications. Exceptions to established quantity limits may be made if the prescribing provider justifies medical necessity. Visit **www.tricareformularysearch.org** for a general list of TRICARE-covered prescription drugs that have quantity limits.

Prior Authorization

Some drugs require prior authorization from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics Committee, brand-name medications with generic equivalents, medications with age limitations, and medications prescribed for quantities exceeding normal limits. Visit **www.tricareformularysearch.org** for a general list of TRICARE-covered prescription drugs that require prior authorization. Call **+1-877-ASK-4PEC (+1-877-275-4732)** to inquire about a specific drug if you do not have Internet access.

Generic Drug Use Policy

Generic drugs are FDA-approved and clinically equivalent to brand-name medications. Generic drugs provide the same safe, effective treatment as brand-name medications. It is DoD policy to use generic medications instead of brand-name medications whenever possible. A brand-name drug with a generic equivalent may be dispensed only after the prescribing provider completes a clinical assessment that indicates the brand-name drug is medically necessary and after Express Scripts grants approval. If a generic-equivalent drug does not exist, the brand-name drug is dispensed at the brand-name copayment. You are responsible for paying the entire cost of a prescription that is filled with a brand-name drug that is not considered medically necessary and when a generic equivalent is available.

Non-Formulary Drugs

The DoD Pharmacy and Therapeutics Committee may recommend to the Director of the TRICARE Management Activity that certain drugs be placed in the third (*non-formulary*) tier. These medications include any drug in a therapeutic class determined not as relatively clinically effective or as cost-effective as other drugs in the same class. Third-tier drugs may be available through the Mail Order Pharmacy or retail network pharmacies for additional costs. You may be able to fill non-formulary prescriptions at formulary costs if your provider establishes medical necessity by completing and submitting the appropriate TRICARE pharmacy medical necessity form. For forms and medical necessity criteria, visit **www.pec.ha.osd.mil/forms_criteria.php** or call **+1-877-ASK-4PEC (+1-877-275-4732)**.

Note: ADSMs may not fill prescriptions for non-formulary medications unless medical necessity is established. If medical necessity is established, ADSMs may receive non-formulary medications through the Mail Order Pharmacy or at retail network pharmacies at no cost. Overseas ADSMs must have APO/FPO addresses to use the Mail Order Pharmacy, unless they live in U.S. territories. Retail network pharmacies are only located in the United States and certain U.S. territories (*American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

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

Visit the online TRICARE Formulary Search Tool at **www.tricareformularysearch.org** to learn more about medications and common drug interactions, check for generic equivalents, or determine if a drug is classified as a non-formulary medication.

Specialty Medication Care Management

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

The Specialty Medication Care Management program is only available to beneficiaries who use the Mail Order Pharmacy. The program is structured to improve your health through continuous health evaluation, ongoing monitoring, assessment of educational needs, and management of medication use. This program provides:

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

These services are provided to you at no additional cost when you receive your medications through the Mail Order Pharmacy, and participation is voluntary. If you or your provider orders a specialty medication from the Mail Order Pharmacy, Express Scripts sends you additional information about the Specialty Medication Care Management program and how to get started.

You may submit a specialty medication prescription by mail, or your provider may submit it by fax. With specific mailing instructions from you or your provider, the Mail Order Pharmacy ships your specialty medication to your U.S. Postal Service or APO/FPO address. For your convenience and safety, the Mail Order Pharmacy contacts you to arrange delivery before the medication is shipped. **Note:** Some specialty medications may not be available through the Mail Order Pharmacy because the medication's manufacturer limits the drug's distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, the Mail Order Pharmacy either forwards your prescription to a pharmacy of your choice that can fill it or provides you with instructions about where to send the prescription to have it filled. Visit **www.tricareformularysearch.org** to determine if your specialty medication is available through the Mail Order Pharmacy.

Dental Options

Overseas ADSMs receive dental care at military overseas dental treatment facilities (ODTFs). If necessary, ADSMs enrolled in TOP Prime or TOP Prime Remote may receive care from overseas civilian providers through the TRICARE Active Duty Dental Program (ADDP) in the United States and U.S. territories. For all other beneficiaries, TRICARE offers two dental programs—the TRICARE Dental Program (TDP) and the Enhanced-Overseas TRICARE Retiree Dental Program (TRDP). Each program is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

TRICARE Active Duty Dental Program

The ADDP, administered by United Concordia Companies, Inc. (United Concordia), is available

in the United States and U.S. territories. The ADDP provides civilian dental care to ADSMs through ODTFs located on bases or sometimes co-located at MTFs. ADDP benefits are available to ADSMs who are either referred by ODTFs to the civilian dental community or who live and work more than 50 miles from an ODTF.

For more information about the ADDP, visit **www.addp-ucci.com** or **www.tricare.mil/dental**.

If you do not live near an ODTF, contact your TOP Regional Call Center for information about dental care, and see "In Remote Overseas Locations" later in this section.

Non-Remote Overseas Locations

Non-remote locations* have fixed uniformed services ODTFs. ADSMs in non-remote countries receive all dental care at ODTFs when available. The ODTF may authorize host nation dental care if the ODTF is unable to provide the required services.

* *Non-remote countries include Azores, Bahrain, Belgium, Diego Garcia, Germany, Iceland, Italy/Sardinia, Japan, Portugal, South Korea, Spain, Turkey, and the United Kingdom.*

Remote Overseas Locations

Remote overseas locations do not have fixed ODTFs; however, they may have part-time fixed ODTFs. International SOS provides dental care services for ADSMs in remote overseas locations, except U.S. territories. Only credentialed, qualified providers in the TOP Prime Remote referral network can provide cashless, claimless dental services to ADSMs.

Note: Treatment plans that exceed $500 per episode or $1,500 per calendar year require prior authorization and approval from the TAO Dental Director (*or designee*), even for routine care. Contact your TOP Regional Call Center for dental care approval and prior authorization assistance.

TRICARE Dental Program

The TDP, administered by United Concordia, is a voluntary dental insurance program available in the United States and certain overseas areas to eligible ADFMs, National Guard and Reserve members and their family members, and Individual Ready Reserve members and their family members. ADFMs are encouraged to enroll or remain enrolled in the TDP when moving overseas with their sponsors.

TDP-enrolled ADFMs do not have to be command sponsored or listed on the sponsor's change of assignment orders to use TDP in the overseas service area. Premium costs are the same for all enrollees, but non-command sponsored ADFMs pay cost-shares.

Visit **www.TRICAREdentalprogram.com** or call United Concordia at **+1-888-418-0466** for more information or to locate a host nation provider.

Enhanced-Overseas TRICARE Retiree Dental Program

The Enhanced-Overseas TRDP is a voluntary dental insurance program administered by Delta Dental® of California. The Enhanced-Overseas TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, retired National Guard and Reserve members (*including those who are entitled to retired pay but will not begin receiving it until age 60*) and their eligible family members, certain survivors, and Medal of Honor recipients and their immediate family members and survivors.

Maternity Care

Prenatal care is important, and we strongly encourage you to seek appropriate medical care if you are pregnant or anticipate becoming pregnant. TRICARE covers all necessary maternity care, from your first obstetric visit through six weeks after your child is born, including:

- Obstetric visits throughout your pregnancy
- Medically necessary fetal ultrasounds
- Hospitalization for labor, delivery, and postpartum care
- Anesthesia for pain management during labor and delivery

- Medically necessary caesarean section
- Management of high-risk or complicated pregnancies

Newborns are covered separately. See "Having a Baby or Adopting a Child" in the *Changes to Your TRICARE Coverage* section for information about TRICARE coverage for your newborn.

TRICARE does not cover the following services:

- Fetal ultrasounds that are not medically necessary (*e.g., to determine your baby's sex*), including three- and four-dimensional ultrasounds
- Services and supplies related to noncoital reproductive procedures (*e.g., artificial insemination*)
- Management of uterine contractions with drugs that are not FDA-approved for that use (*i.e., off-label use*)
- Home uterine activity monitoring and related services
- Unproven procedures (*e.g., lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent miscarriages, salivary estriol test for preterm labor*)
- Umbilical cord blood collection and storage, except when stem cells are collected for subsequent use in the treatment of tumor, blood, or lymphoid disease
- Private hospital rooms (*TRICARE generally does not cover private rooms; however, some MTFs may have private postpartum rooms.*)

Maternity Ultrasounds

TRICARE may cover maternity ultrasounds needed to:

- Estimate gestational age due to unknown date of last menstrual period, irregular periods, size/date difference of greater than two weeks, or pregnancy while on oral contraceptive pills (*Confirmation of estimated gestational age is not a medically necessary indication.*)
- Evaluate fetal growth when the fundal height growth is significantly greater than expected (*more than 1 cm per week*) or less than expected (*less than 1 cm per week*)
- Conduct a biophysical evaluation for fetal well-being when the mother has certain conditions (*e.g., insulin-dependent diabetes mellitus, hypertension, systemic lupus, congenital heart disease, renal disease, hyperthyroidism, prior pregnancy with unexplained fetal demise, multiple gestations, post-term pregnancy after 41 weeks, intrauterine growth retardation, preeclampsia, decreased fetal movement, isoimmunization*)
- Evaluate a suspected ectopic pregnancy
- Determine the cause of vaginal bleeding
- Diagnose or evaluate multiple births
- Confirm cardiac activity (*e.g., when fetal heart rate is not detectable by Doppler, suspected fetal demise*)
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
- Evaluate fetus condition in late registrants for prenatal care

A physician is not obligated to perform an ultrasonography on a patient who is low risk and has no medical indications.

Some providers offer patients routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation. **TRICARE does not cover routine ultrasound screening.** Only maternity ultrasounds with valid medical indications that constitute medical necessity are covered by TRICARE. For additional details on maternity ultrasound coverage, visit **www.tricare.mil**.

Getting Maternity Care

Visit your PCM or primary care provider or contact your TOP Regional Call Center or TAO as soon as you think you may be pregnant. Your PCM, primary care provider, TOP Regional Call Center, or TAO can refer you to an obstetrician if necessary. You may see the same provider throughout your pregnancy or request a change at any time.

Maternity care services require prior authorizations and referrals. For more information, contact your PCM, MTF, TOP Regional Call Center, TRICARE Service Center (TSC), or TAO.

TRICARE Overseas Program Prime and TRICARE Overseas Program Prime Remote

Non-Active Duty Service Members

If you are enrolled in TOP Prime or TOP Prime Remote and you relocate to a new region during your pregnancy, you may transfer your enrollment to your new region and select a new PCM. When you arrive at your new location, submit a *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876) to the TOP Regional Call Center or a TSC in your new region. Your PCM and TOP Regional Call Center will coordinate with your new provider to ensure continuity of care. You are encouraged to obtain copies of your health care records from your PCM before relocating.

If your PCM is at an MTF, you should receive maternity care from the MTF. If you are not located near an MTF or MTF care is unavailable, your PCM will refer you to a civilian network provider. TOP Prime and TOP Prime Remote ADFMs may use the POS option to self-refer to obstetricians; however, higher out-of-pocket costs apply.

Active Duty Service Members

ADSMs who are pregnant at the time of release from active duty should contact their local Beneficiary Counseling and Assistance Coordinators to determine if maternity care is available through MTFs.

For continued maternity care, ADSMs who are pregnant at the time of release from active duty may choose to:

- Work through their services (*unit personnel and MTF administrative channels*) to establish ongoing eligibility for care within MTFs
- Receive transitional TRICARE coverage for health care services through the Transitional Assistance Management Program (TAMP), if they are eligible
- Enroll in the Continued Health Care Benefit Program (CHCBP), if they qualify

CHCBP is administered by Humana Military Healthcare Services, Inc. For CHCBP details, visit **www.humana-military.com**. To learn more about TAMP, visit **www.tricare.mil**.

Women, Infants, and Children Overseas Program

DoD offers the Women, Infants, and Children (WIC) Overseas Program to eligible beneficiaries. The WIC Overseas Program supplements the food participants usually buy with additional nutritious foods. Program staff provide ideas for meal planning and food preparation. Your WIC counselor gives you an approved food list and redeemable food checks called "drafts," which you redeem for specific foods and quantities in overseas commissaries and NEXMARTs.* The WIC Overseas Program also offers nutrition and health screenings for you and your children. Screenings may help identify health conditions early so that you can seek proper medical attention.

* *Drafts are only accepted at these overseas stores.*

Eligibility

Members of the uniformed services, DoD civilian employees, DoD contractors, and family members may be eligible to participate in the WIC Overseas Program. Those who may be eligible include:

- Expectant mothers—during pregnancy and throughout the first six weeks after giving birth
- Mothers—until the infant is 6 months old if bottle-feeding or 1 year old if breast-feeding

- Infants and children—until the end of the month in which they turn 5

Contact your local WIC Overseas Program office to find out if you are eligible. Program counselors evaluate income, family size, and other criteria to determine eligibility. There are no enrollment fees or costs.

Visit **www.tricare.mil/wic** or contact your base or installation information operator, TOP Regional Call Center, or TAO to learn more or to locate the nearest WIC Overseas Program office. You can also call the WIC Overseas Program Manager at **+1-877-267-3728** or e-mail the WIC Overseas Program at **wicoverseas@choctawarchiving.com**.

Hospice Care

TRICARE offers hospice care if you or a TRICARE-eligible family member has a terminal illness. Hospice care emphasizes supportive services, rather than cure-oriented treatment, for patients with life expectancies of six months or less. This benefit allows for personal care and home health aid services, which are otherwise limited under TRICARE's basic program options.

Note: Hospice care is **not** available overseas except in U.S. territories.

Hospice Benefit Coverage

The hospice benefit covers four levels of care:

- Routine home care
- Continuous home care
- Inpatient respite care
- General hospice inpatient care

Note: Respite care is covered when medically necessary and is limited to no more than five days at a time. General inpatient care is limited to varying short-term stays.

Hospice patients may shift among the levels of care, depending on their needs, the needs of family members caring for them, and the determination of the medical team managing their care.

Care is managed by the hospice care team, in consultation with the patient and his or her family. The hospice care team evaluates and approves changes in the level of care. Care may include:

- Counseling
- Medical equipment, supplies, and medications
- Medical social services
- Medically necessary short-term inpatient care
- Nursing care
- Other covered services related to the terminal illness
- Physical and occupational services
- Physician services
- Speech and language pathology

For more information on TRICARE's hospice coverage, visit **www.tricare.mil/mybenefit**.

TRICARE Extended Care Health Option

TRICARE Extended Care Health Option (ECHO) provides financial assistance to qualifying ADFMs based on specific mental or physical disabilities, and it offers beneficiaries an integrated set of services and supplies beyond those offered by the basic TRICARE programs. Potential ECHO beneficiaries must be ADFMs, have qualifying conditions, and be registered to receive ECHO benefits. A record of ECHO registration is stored with the beneficiary's Defense Enrollment Eligibility Reporting System (DEERS) information.

Conditions qualifying an ADFM for ECHO coverage include:

- Moderate or severe mental retardation
- A serious physical disability
- An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
- A diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (*under age 3*) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability

- Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems

Note: Active duty sponsors with family members seeking ECHO benefits **must enroll** in their services' Exceptional Family Member Programs (*unless waived in specific situations*) and register for ECHO in order to be eligible. There is no retroactive registration for the ECHO program. All ECHO services require prior authorization from the TAO or TOP Regional Call Center.

Extended Care Health Option Benefits

ECHO provides coverage for the following products and services:

- Applied Behavioral Analysis Therapy and other types of special education (*which can include applied behavioral analysis but excludes education for which the school system is responsible*) that are not available through local community resources
- Assistive services (*e.g., those from a qualified interpreter or translator*)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)*
- Rehabilitative services
- Respite care (*during any month when at least one other ECHO benefit is received*)*
  - ECHO respite care: Up to 16 hours of care*
  - EHHC respite care: Up to eight hours per day, five days per week (*for those who qualify*)*
- Training for special education and use of assistive technology devices
- Institutional care when a residential environment is required
- Transportation under certain limited circumstances

For information on the ECHO program, including costs and maximum cost-shares (*i.e., ECHO cap*), visit the ECHO Web site at **www.tricare.mil/echo**.

* *These services are only available in the United States, Guam, Puerto Rico, and the U.S. Virgin Islands.*

TRICARE Overseas Program Prime and TRICARE Overseas Prime Remote Aeromedical Evacuation

When medical care is not available at your location, you may be eligible for aeromedical evacuation to a facility that can provide the care you need.

Note: Aeromedical evacuations will only be approved for medically necessary urgent and emergency care.

Note for non-TOP Prime and non-TOP Prime Remote enrollees: TOP Standard, TRICARE For Life (TFL) and TRICARE Reserve Select beneficiaries may access aeromedical evacuation services when medically necessary and on a space-available basis only. TOP Regional Call Centers identify local aeromedical evacuation resources but are not required to schedule evacuations, coordinate with receiving providers, obtain medical records, or provide guarantees of payment for non-enrolled beneficiaries.

Each overseas area has its own guidelines and procedures for aeromedical evacuation.

Eurasia-Africa Evacuation

Medical personnel at your location or at the nearest TOP Regional Call Center determine if acceptable local medical care is available. If you require aeromedical evacuation, the attending physician **must** work with the Eurasia-Africa TOP Regional Call Center. The call center coordinates with the TAO and the Theater Patient Movement Requirements Center (TPMRC) Eurasia-Africa and arranges for an accepting physician to meet you at your destination. Your unit's medical liaison,

TRICARE point of contact (POC), or the TAO can assist with aeromedical evacuation or relocation to an MTF. Considering the time-critical nature of many requests, the attending physician should contact the TPMRC Eurasia-Africa via telephone (*see Figure 5.8*).

Once the TPMRC receives a request, an on-call flight surgeon assesses your evacuation request and assigns one of the following categories of patient movement:

- **Urgent (*to save life, limb, or eyesight*):** Evacuate as soon as possible.
- **Priority:** Evacuate within 24 hours.
- **Routine:** Evacuate within 72 hours or an acceptable period agreed to by attending physician and flight surgeon; individual may be moved by commercial means.

Submit requests for routine medical or dental appointments to the TPMRC at least 30 days prior to a requested appointment. The TPMRC will inform you of the appointment details within five working days after receiving your request.

Figure 5.8 lists aeromedical contact information for Eurasia-Africa.

Eurasia-Africa Evacuation Contacts ***Figure 5.8***

Theater Patient Movement Requirements Center	+49-6371-47-8040 +49-6371-47-2235 +49-6371-47-2264 312-480-8040 (*DSN*) 312-480-2235 (*DSN*) 312-480-2264 (*DSN*) tpmrc.europe@ramstein.af.mil
TRICARE Overseas Program Regional Call Center	+44-20-8762-8133

If you are sent to Germany, see Figure 5.9 for emergency contact details.

Germany Evacuation Contacts ***Figure 5.9***

Landstuhl Regional Medical Center	+49-6371-86-8160 +49-6371-86-8414 314-486-8160 (*DSN*) 314-486-8414 (*DSN*)

Latin America and Canada Evacuation

Figure 5.10 lists aeromedical evacuation contact information for Latin America and Canada.

Latin America and Canada Evacuation Contacts ***Figure 5.10***

Canada (*for beneficiaries enrolled in Canada*)	Contact your Canadian Forces Health Facility (CFHF). • **Locate a CFHF:** +1-613-945-6653
Other areas and for TRICARE Prime and TRICARE Prime Remote active duty service members and family members visiting Canada[1]	• **TRICARE Overseas Program (TOP) Regional Call Center:** +1-215-942-8393 • **Medical Assistance:** +1-215-942-8320 The TOP Regional Call Center may not be able to facilitate cashless, claimless service, but can assist in coordinating emergency transport.

1. Based on medical necessity, the Latin America and Canada TOP Regional Call Center may be able to assist with aeromedical evacuations in TOP Prime Remote areas.

Pacific Evacuation

If you are a TOP Prime beneficiary in the Pacific area, contact the aeromedical evacuation office at your local MTF to learn about aeromedical evacuation procedures. Staff can help you schedule an appointment for medical care that is not available at your local MTF and assist with travel arrangements.

If you are a TOP Prime Remote beneficiary, medical personnel at the TOP Regional Call Center determine if acceptable local medical care is available and, if so, coordinate travel arrangements with your local TRICARE POC and TAO.

The TOP Regional Call Center or the TRICARE POC requests appointment coordination from the TAO for care at an MTF or from a TRICARE network provider in the United States.

Appointment locations are based on care availability and cost-effectiveness. Aeromedical evacuation funding is service-specific and must be requested through your local TRICARE POC. The TOP Regional Call Center coordinates with the TAO to arrange emergency and urgent medical evacuation

and care. See Figure 5.11 for medical evacuation contact details for the Pacific area.

Pacific Evacuation Contacts *Figure 5.11*

Singapore	• **TRICARE Overseas Program (TOP) Regional Call Center:** +65-6339-2676 • **Medical Assistance:** +65-6338-9277
Sydney	• **TOP Regional Call Center:** +61-2-9273-2710 • **Medical Assistance:** +61-2-9273-2760

Care Aboard Commercial Seagoing Vessels

If you receive medical care aboard a commercial cruise ship, you must pay out of pocket and file a claim with the TOP contractor for reimbursement when you return home. TRICARE only reimburses covered, medically necessary services. You are responsible for paying the entire cost of care that TRICARE does not cover.

If you do not coordinate urgent or routine care in advance with your PCM, you may use the POS option, resulting in significantly higher out-of-pocket costs. TRICARE only reimburses 50 percent of the negotiated or allowable charge after you meet the POS deductible.

If you have OHI, including traveler's and host nation insurance programs, your OHI must pay first. Medicare pays before TRICARE when TFL beneficiaries receive care on ships in territorial waters adjoining the land areas of the United States.

Services or Procedures with Significant Limitations

Figure 5.12 shows a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist. **Note:** This list is **not** all-inclusive.

Visit **www.tricare.mil** for additional information.

Services or Procedures with Significant Limitations *Figure 5.12*

Service	Description
Abortions	Abortions are only covered when the life of the mother would be endangered if the pregnancy were carried to term. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.
Breast Pumps	Heavy-duty, hospital-grade electric breast pumps (*including services and supplies related to the use of the pump*) for mothers of premature infants are covered. An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period. Hospital-grade electric breast pumps may also be covered after the premature infant is discharged from the hospital with a physician-documented medical reason. This documentation is also required for premature infants delivered in non-hospital settings. Breast pumps of any type, when used for reasons of personal convenience, are excluded even if prescribed by a physician.
Cardiac and Pulmonary Rehabilitation	Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.
Cosmetic, Plastic, or Reconstructive Surgery	Surgery is only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after cancer surgery, or reconstruct the breast after cancer surgery.
Cranial Orthotic Device or Molding Helmet	Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly.
Dental Care and Dental X-rays	Both are covered only for adjunctive dental care (*i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition*).

Services or Procedures with Significant Limitations (continued)

Service	Description
Education and Training	Education and training are only covered under the TRICARE Extended Care Health Option and diabetic outpatient self-management training services. Diabetic outpatient self-management training services must be performed by programs approved by the American Diabetes Association.® The provider's "Certificate of Recognition" from the American Diabetes Association must accompany the claim for reimbursement.
Eyeglasses or Contact Lenses	Active duty service members (ADSMs) may receive eyeglasses at MTFs at no cost. For all other beneficiaries, the following are covered: • Contact lenses and/or eyeglasses for treatment of infantile glaucoma • Corneal or scleral lenses for treatment of keratoconus • Scleral lenses to retain moisture when normal tearing is not present or is inadequate • Corneal or scleral lenses to reduce corneal irregularities other than astigmatism • Intraocular lenses, contact lenses, or eyeglasses for loss of human lens function resulting from intraocular surgery, ocular injury, or congenital absence **Note:** Adjustments, cleanings, and repairs for eyeglasses are not covered.
Facility Charges for Non-Adjunctive Dental Services	Hospital and anesthesia charges related to routine dental care for children under age 5, or those with disabilities, may be covered in addition to dental care related to some medical conditions.
Food, Food Substitutes and Supplements, or Vitamins	Food, food substitutes and supplements, or vitamins are covered when used as the primary source of nutrition for enteral, parenteral, or oral nutritional therapy. Intraperitoneal nutrition therapy is covered for malnutrition as a result of end-stage renal disease.
Gastric Bypass	Gastric bypass, gastric stapling, gastroplasty, or laparoscopic adjustable gastric banding (*Lap-Band® surgery*)—to include vertical banded gastroplasty—is covered when one of the following conditions is met: • The patient is 100 pounds over the ideal weight for height and bone structure and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (*and other severe respiratory diseases*), hypothalamic disorders, and severe arthritis of the weight-bearing joints. • The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category. • The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (*a takedown*).
Genetic Testing	Testing is covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient. Routine genetic testing is not covered.
Hearing Aids	Hearing aids are covered only for active duty family members who meet specific hearing loss requirements.
Laser/LASIK/Refractive Corneal Surgery	Surgery is covered only to relieve astigmatism following a corneal transplant.
Private Hospital Rooms	Private rooms are not covered unless ordered for medical reasons or because a semi-private room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room, but will receive only the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.
Shoes, Shoe Inserts, Shoe Modifications, and Arch Supports	Shoe and shoe inserts are covered only in very limited circumstances. Orthopedic shoes may be covered if they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered.

Exclusions

In general, TRICARE excludes services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (*including behavioral health disorders*), injury, or for the diagnosis and treatment of pregnancy or well-child care. All services and supplies (*including inpatient institutional costs*) related to non-covered conditions or treatments, or provided by unauthorized providers, are excluded.

The following specific services **are excluded under all circumstances. This list is not all-inclusive.** Visit **www.tricare.mil** for additional information.

- Acupuncture
- Alterations to living spaces
- Artificial insemination, including in vitro fertilization, gamete intrafallopian transfer, and all other such reproductive technologies
- Autopsy services or post-mortem examinations
- Birth control/contraceptives (*non-prescription*)
- Bone marrow transplants for treatment of ovarian cancer
- Camps (*e.g., for weight loss*)
- Care or supplies furnished or prescribed by an immediate family member
- Charges that providers may apply to missed or rescheduled appointments
- Costs associated with late payment fees, collection interest, or other legal fees when claims have not been properly processed, regardless of the cause
- Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (*e.g., educational, vocational, and socioeconomic counseling; stress management; or lifestyle modification*)
- Custodial care
- Diagnostic admissions
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chair lifts
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships, or other such charges or items
- Experimental or unproven procedures
- Fees paid for copies of host nation civilian medical records
- Foot care (*routine*), except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes
- General exercise programs, even if recommended by a physician and regardless of whether rendered by an authorized provider
- Inpatient stays:
  - For rest or rest cures
  - To control or detain a runaway child, whether or not admission is to an authorized institution
  - To perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis
  - In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- Learning disability services
- Medical exams required for immigration, passport, or other legal documentation support requirements
- Medications:
  - Drugs prescribed for cosmetic purposes
  - Fluoride preparations
  - Food supplements
  - Homeopathic and herbal preparations
  - Multivitamins
  - Over-the-counter products (*except insulin and diabetic supplies*)
  - Weight-reduction products
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopaths
- Non-surgical treatment of obesity or morbid obesity
- Personal comfort or convenience items, such as beauty and barber services, radio, television, and telephone

- Postpartum inpatient stay for a mother to stay with a newborn infant (*usually primarily for the purpose of breast-feeding the infant*) when the infant (*but not the mother*) requires the extended stay, or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (*but not the newborn infant*) requires extended postpartum inpatient stay
- Preventive care, such as routine, annual, or employment-requested physical examinations; routine screening procedures; and immunizations, except as provided under the clinical preventive services benefit (*See "Clinical Preventive Services" earlier in this section.*)
- Psychiatric treatment for sexual dysfunction
- Services and supplies:
  - Provided under a scientific or medical study, grant, or research program
  - Furnished or prescribed by an immediate family member
  - For which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE-eligible
  - Furnished without charge (*i.e., cannot file claims for services provided free-of-charge*)
  - For the treatment of obesity, such as diets, weight-loss counseling, weight-loss medications, wiring of the jaw, or similar procedures (*For gastric bypass, see "Services or Procedures with Significant Limitations" earlier in this section.*)
  - Inpatient stays directed or agreed to by a court or other governmental agency (*unless medically necessary*)
  - Required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted
  - That are (*or are eligible to be*) fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (*In such instances, TRICARE is the secondary payer for any remaining charges.*)
- Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth
- Smoking cessation supplies
- Sterilization reversal surgery
- Surgery performed primarily for psychological reasons (*such as psychogenic surgery*)
- Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE
- Transportation, except by ambulance
- X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer-screening mammography, cancer screening, Pap tests, and other tests allowed under the clinical preventive services benefit

Claims

Health Care Claims

Network host nation providers file claims for TRICARE Overseas Program (TOP) Prime beneficiaries. However, expect to pay up front and file claims for reimbursement when you visit non-network host nation providers. You do not have to file claims for military treatment facility (MTF) care.

Note: Claims for services provided in Puerto Rico are reimbursed according to stateside guidelines and TRICARE-allowable charges. Claims for services provided in the Philippines and Panama are reimbursed based on government-provided foreign fee schedules.

Claims must be filed within one year of the date of service or within one year of the date of an inpatient discharge.

Note: Claims for separately billed professional charges incurred during an inpatient admission must be submitted within one year of the **date the service was received**, even if that date is before the date you were discharged.

Beneficiaries may download *TRICARE DoD/ CHAMPUS Medical Claim—Patient's Request for Medical Payment* (DD Form 2642) and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from the International SOS Assistance, Inc., Web site at **www.tricare-overseas.com**. You can also obtain forms and instructions at TRICARE Service Centers (TSCs) and MTFs. To locate a TSC or MTF, visit **www.tricare.mil/contactus**.

Complete *DD Form 2642*, and attach a readable copy of the provider's bill, which must include the following:

- Patient's name
- **Sponsor's** Social Security number (SSN) (*Eligible former spouses should use their SSNs, not the sponsors'.*)
- Provider's name and address (*If more than one provider's name is on the bill, clearly circle the name of the person who provided the service the claim is filed for. Failing to clearly identify the appropriate provider may delay or prevent claims processing.*)
- Date and place of each service
- Description of each service or supply provided
- Charge for each service
- Diagnosis (*If the diagnosis is not on the bill, be sure to complete block 8a on the form.*)

If you already paid the bill, note that clearly on both the claim form and the bill. **You must submit proof of payment with your claim form.** Proof of payment may include a receipt, canceled check, credit card statement, or invoice from the provider that clearly states payment was received. Always keep a copy of the paperwork for your records. Be sure to use your **overseas residential mailing address** on the claim form. Using a U.S. address may result in payment problems.

Send your claims to the TOP contractor for the overseas region where you live. If you receive care while traveling, file your TRICARE claims in the region where you live, not the region where you received care.

Note: Different rules apply for TRICARE For Life (TFL) claims. TFL beneficiaries should visit the TFL contractor's Web site at **www.TRICARE4u.com** for more information.

Figure 6.1 and 6.2 show claims processing addresses for overseas.

For general claims information, write to:

TRICARE Overseas Program
General Claims Information
P.O. Box 7992
Madison, WI 53707-7992

Active Duty Service Members Health Care Claims *Figure 6.1*

TRICARE Eurasia-Africa	TRICARE Latin America and Canada	TRICARE Pacific
Send claims to: TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968	**Send claims to:** TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968	**Send claims to:** TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968

Non-Active Duty Service Members Health Care Claims *Figure 6.2*

TRICARE Eurasia-Africa	TRICARE Latin America and Canada	TRICARE Pacific
Send claims to: TRICARE Overseas Region 13 P.O. Box 8976 Madison, WI 53707-8976	**Send claims to:** TRICARE Overseas Region 15 P.O. Box 7985 Madison, WI 53707-7985	**Send claims to:** TRICARE Overseas Region 14 P.O. Box 7985 Madison, WI 53707-7985

Foreign Currency or U.S. Dollar Reimbursement

The TOP contractor issues reimbursements to beneficiaries in U.S. dollars unless the beneficiary specifically request reimbursement in foreign currencies.

Due to U.S. embargoes and international banking regulations, only certain host nation currencies are available for reimbursement. Regardless of the currency used for reimbursement, TRICARE does not reimburse differences due to changes in currency value (*e.g., U.S. dollar, host nation currency*). Mark Box 13 on *DD Form 2642* to receive payment in the local host nation currency.

Pharmacy Claims

The type of pharmacy you use determines the pharmacy claims processor. You do not need to file claims to fill prescriptions for covered medications at MTFs, TRICARE retail network pharmacies, or through the Mail Order Pharmacy. Expect to pay the full cost up front and file claims for reimbursement when visiting non-network pharmacies or host nation pharmacies. File non-network pharmacy claims with the TRICARE Pharmacy Program contractor, Express Scripts, Inc. (Express Scripts). File host nation pharmacy claims with the TOP contractor.

TRICARE Pharmacy Program Claims

When visiting non-network pharmacies in the United States and U.S. territories (*American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), beneficiaries should expect to pay up front and file claims with Express Scripts for reimbursement.

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

Note: Point-of-service deductibles and cost-shares apply for active duty family members (ADFMs).

To file a claim, download *DD Form 2642* at **www.tricare.mil/claims**. Complete the form and attach the required paperwork, as described on the form. Prescription claims require the following information for each drug:

- Patient's name
- Prescription name, strength, date filled, days' supply, quantity dispensed, and price
- National Drug Code, if available
- Prescription number
- Name and address of the pharmacy
- Name and address of the prescribing physician

Mail your claim forms and paperwork to:

Express Scripts, Inc.
TRICARE Claims
P.O. Box 66518
St. Louis, MO 63166-6518

Call Express Scripts at **+1-866-ASK-4PEC (+1-866-275-4732)** for more information about filing non-network retail pharmacy claims.

TRICARE Pharmacy Program Claims Appeals

If you disagree with the determination on your pharmacy claim (*e.g., if your claim is denied*), you or your appointed representative has the right to request a reconsideration. The request (*or appeal*) for reconsideration must be in writing, signed, and postmarked or received by Express Scripts within 90 calendar days after the date of the decision. Your request must state the specific matter you disagree with and include a copy of the claim decision.

Send your signed, written request to the following address no later than 90 days from the date of the notice:

Express Scripts, Inc.
P.O. Box 60903
Phoenix, AZ 85082-0903

You may submit additional documentation in support of your appeal. However, your request should not be delayed because you wish to include additional documentation. In your letter requesting reconsideration, clearly indicate if and when you plan to submit additional documentation.

Host Nation Pharmacy Claims

To file a host nation pharmacy claim, complete and mail *DD Form 2642*, paperwork, and proof of payment to the TOP contractor at the appropriate address for your region. See Figure 6.1 (*for ADSMs*) or Figure 6.2 (*for non-ADSMs*) for mailing addresses. See "Health Care Claims" earlier in this section for information about proof of payment.

Appealing a Decision

If you believe a service or claim was improperly denied, in whole or in part, you (*or another appropriate party*) may file an appeal. An appeal must involve an appealable issue. For example, you have the right to appeal TRICARE decisions regarding the payment of your claims.

You also may appeal the denial of a requested authorization of services, even though no care has been provided and no claim submitted. There are some things you may not appeal. For example, you may not appeal denial of a service provided by a health care provider who is not eligible for TRICARE certification.

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

Appeal Requirements

Your appeal must meet the requirements listed in Figure 6.3.

Filing an Appeal

Appeals must be filed with the TOP contractor within 90 days after the date that appears on the explanation of benefits or denial notification letter. If you are not satisfied with a decision rendered on an appeal, there may be further levels of appeal available to you. For specific information about filing an appeal in your region, contact your TOP Regional Call Center or TAO.

A prior authorization denial appeal may be either expedited or non-expedited, depending on the urgency of the situation. You or an appointed representative must file an expedited review of a prior authorization denial within three calendar days after you receive the initial denial. A non-expedited review of a denial must be filed no later than 90 days after you receive the initial denial. Appeals should contain the following information:

- Beneficiary's name, address, and telephone number

TRICARE Appeal Requirements *Figure 6.3*

1	An appropriate appealing party must submit the appeal. Proper appealing parties include: • You, the beneficiary • Your custodial parent or guardian (*if you are a minor*) • A person you appoint, in writing, to represent you for the purpose of the appeal • An attorney filing on your behalf • Participating non-network host nation providers If a party other than those listed above is going to submit the appeal, you must complete and sign an *Appointment of Appeal Representative and Authorization to Disclose Information* form. You can download the form from the TRICARE Overseas Program Web site at **www.tricare-overseas.com**. Click on "Forms" on the Beneficiaries Web page. Appeals submitted without this form will not be processed. **Note:** Network host nation providers are not appropriate appealing parties unless you appoint them in writing.
2	The appeal must be submitted in writing. See Figure 8.2 for the appeals submission address for your region.
3	The issue in dispute must be an appealable issue. The following are not appealable issues: • Allowable charges • Eligibility • Denial of services from an unauthorized provider • Denial of a treatment plan when an alternative treatment plan is selected • Refusal by a primary care manager to provide services or refer a beneficiary to a specialist • Point-of-service issues, except when services were related to an emergency
4	The appeal must be filed within 90 days of the date on the explanation of benefits or denial notification letter.
5	There must be an amount in dispute to file an appeal. In cases involving an appeal of a denial of an authorization in advance of receiving the actual services, the amount in dispute is deemed to be the negotiated rate for the services requested. There is no minimum amount to request a reconsideration.

Claims Appeals Filing Information *Figure 6.4*

TRICARE Eurasia-Africa	TRICARE Latin America and Canada	TRICARE Pacific
TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992

- Sponsor's Social Security number (SSN)
- Beneficiary's date of birth
- Beneficiary's or appealing party's signature

A description of the issue or concern must include:

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

Send your appeal to the TOP contractor. For appeals filing information, see Figure 6.4.

Third-Party Liability

The Federal Medical Care Recovery Act allows TRICARE to be reimbursed for treatment costs if you are injured in an accident caused by someone else. You will receive a *Statement of Personal Injury—Possible Third Party Liability* (DD Form 2527) form if a claim appears to have third-party liability involvement. You can download *DD Form 2527* at **www.tricare.mil/claims**. Within 35 calendar days, you must complete and sign the form and follow the directions for returning it to the TOP contractor.

TRICARE Explanation of Benefits

A TRICARE explanation of benefits (EOB) is not a bill. It is an itemized statement that shows the action TRICARE took on your claims. Keep EOBs with your health insurance records for reference.

After reviewing the EOB, you have the right to appeal certain decisions regarding your claims. If you wish to appeal, you must do so in writing within 90 days of the date of the EOB notice. For more information about appeals, see the *For Information and Assistance* section later in this handbook.

Debt Collection Assistance Officers

Debt Collection Assistance Officers (DCAOs) are located at MTFs and TRICARE Area Offices to help you resolve health care collection-related issues. Contact a DCAO if you received a negative credit rating or were contacted by a collection agency due to a TRICARE-related issue.

When you visit a DCAO for assistance, you must present or submit documentation associated with a collection action or adverse credit rating, including debt collection letters, EOBs, and medical and/or dental bills from providers. The more information you provide, the faster the cause of the problem can be determined. The DCAO researches your claim, provides you with a written resolution of your collection problem, and informs the collection agency that action is being taken to resolve the issue. DCAOs cannot provide legal advice or repair your credit rating, but they can help by providing documentation for the collection or credit-reporting agency to explain the circumstances relating to the debt. To find a DCAO near you, visit the online DCAO Directory at **www.tricare.mil/bcacdcao**.

Changes to Your TRICARE Coverage

TRICARE continues to provide health coverage for you and your family before, during, and after major life events. You do, however, need to take specific actions to make sure you remain TRICARE-eligible. For each life event listed in this section, the first step is to update your information in the Defense Enrollment Eligibility Reporting System (DEERS).

You have several options for updating and verifying DEERS information. See "Keep Your DEERS Information Current!" in the *Welcome to the TRICARE Overseas Program* section of this handbook for details.

The following provides information about what to do when you get married, have a child, move, retire, and more.

Getting Married or Divorced

Marriage

It is extremely important for sponsors to register new spouses and children in DEERS to ensure TRICARE eligibility. To register a new spouse and children in DEERS, the sponsor needs to provide a copy of the marriage certificate to the nearest uniformed services identification (ID) card-issuing facility (*or DEERS representative, in remote locations*). The new spouse and children are also required to show two forms of ID (*e.g., any combination of Social Security card, driver's license, birth certificate, current uniformed services ID card, or Common Access Card [CAC]*). Once your spouse and children are registered in DEERS, they receive uniformed services ID cards and are eligible for TRICARE Overseas Program (TOP) Standard. If you wish for your new family members to enroll in TOP Prime or TOP Prime Remote, you must apply for command sponsorship, which makes them eligible for enrollment.

When accessing care, your new family members must present their uniformed services ID cards.

New Family Member Enrollment in TRICARE Overseas Program Prime and TRICARE Overseas Program Prime Remote

Registering in DEERS is not the same as enrolling in TOP Prime and TOP Prime Remote. Your new family members are covered under TOP Standard, unless they enroll in TOP Prime or TOP Prime Remote. To enroll, your new family members must have command sponsorship and submit *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876) to the TOP Regional Call Center or local TRICARE Service Center (TSC).

Download the form at **www.tricare.mil/forms**, or contact your local TOP Regional Contractor or TSC to request an enrollment application. Family member enrollments are effective when their applications are received.

Divorce

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

Children

After a divorce, any children who retain eligibility under the sponsor remain TRICARE-eligible up to age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides at least 50 percent of the financial support*), as long as his or her DEERS information is current. To extend benefits for your college student beyond his or her 21st birthday, contact DEERS to verify what documentation is needed. See "Keep Your DEERS Information Current!" in the *Welcome to the TRICARE Overseas Program* section of this handbook for contact information.

Although a child normally does not get his or her own uniformed services ID card until age 10, a child younger than 10 should have an ID card if in the custody of a parent or guardian who is not TRICARE-eligible or who is not the custodial parent. Patient privacy may be a factor for divorced

parents attempting to obtain information about received health care services.

Note: Children with disabilities may remain TRICARE-eligible beyond the normal age limits. Check with DEERS for eligibility criteria.

Former Spouses

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

- Do not remarry (*If a former spouse remarries, the loss of benefits remains applicable even if the remarriage ends in death or divorce.*)
- Are not covered by employer-sponsored health plans
- Are not also former spouses of North Atlantic Treaty Organization or "Partners for Peace" nation members
- Meet the requirements of one of the two situations described in Figure 7.1

TRICARE-eligible former spouses must change their personal information in DEERS so their names and Social Security numbers (SSNs) are listed for the primary contact information. The former spouse's TRICARE eligibility is shown in DEERS under his or her SSN, not the sponsor's.

Having a Baby or Adopting a Child

When your child is born abroad, you need to record the birth with the nearest U.S. Embassy or Consulate, obtain an SSN for the child, and register the child in DEERS to ensure TRICARE eligibility. **Note:** If you are enrolled at a military treatment facility (MTF), contact your MTF personnel department for guidance about recording your child's birth.

Applying for U.S. Citizenship Abroad

Most children born abroad to U.S. citizens acquire U.S. citizenship at birth. To obtain an information packet explaining the requirements for recording your child's birth or adoption, call the nearest U.S. Embassy or Consulate. To locate a U.S. Embassy or Consulate near you, visit **www.usembassy.gov**.

After confirming that your child can acquire U.S. citizenship, the Consulate prepares a *Consular Report of Birth* (FS-240). The Consulate can help obtain a passport and SSN for your child.

There is a fee for the *FS-240*. For cost information, check with the U.S. Embassy or Consulate. Personal checks are not accepted as payment. A money order or cash in the local currency may be required.

Applying for a Social Security Card

To apply for a child's SSN when you and the child live outside of the United States, you must complete and sign an *Application for a Social Security Card* (Form SS-5-FS). This form is available at **www.socialsecurity.gov/online/ss-5fs.html**.

If you are a U.S. military dependent or a U.S. citizen working on an overseas U.S. military post, you may also go to the Post Adjutant or personnel office.

Eligibility Requirements for Former Spouses ***Figure 7.1***

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

1. For divorce decrees, annulments, or dissolutions on or before September 29, 1988, contact DEERS to verify eligibility.

These offices can copy and certify your records so you do not have to send original documents through the mail. If you do not have your records certified at the Post Adjutant or personnel office, you must mail original documents to the Social Security Administration (SSA). Your child's Social Security card will be mailed to you from the United States.

For more information on SSA services overseas, visit **www.ssa.gov/foreign**.

TRICARE Coverage

Overseas, children are automatically covered as TOP Prime or TOP Prime remote beneficiaries for the first 120 days after birth or adoption, as long as one other family member is enrolled in TOP Prime or TOP Prime Remote. In the United States, parents must enroll their children within 60 days after birth or adoption, but the TRICARE Area Offices (TAOs) have extended the time frame to 120 days in all overseas areas.

If you are a new parent, you must take both of the following steps within 120 days after your child's birth or adoption to ensure that your child has continuous TOP Prime or TOP Prime Remote coverage after the first 120 days:

1. Register your child in DEERS at a uniformed services ID card-issuing facility. A birth certificate or certificate of live birth from the hospital is required. If your child is not registered in DEERS within one year after the date of birth or adoption, DEERS shows "loss of eligibility," and the child is no longer TRICARE-eligible until registered in DEERS.
2. Enroll your child in TOP Prime or TOP Prime Remote within 120 days after birth or adoption by submitting *DD Form 2876* to your local TSC or TOP Regional Call Center. On day 121, if you have not enrolled your child, he or she is covered under TOP Standard.

Note: You must complete DEERS registration before you enroll your child in TOP Prime or TOP Prime Remote. Contact the TSC or your TOP Regional Call Center for enrollment assistance.

If no family member is enrolled in TOP Prime or TOP Prime Remote at the time of your child's birth or adoption, he or she is automatically covered by TOP Standard. Coverage is continuous as long as you register your child in DEERS within 365 days after birth or adoption.

Going to College

Any children who retain eligibility under the sponsor remain TRICARE-eligible up to age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides at least 50 percent of the financial support*), as long as his or her DEERS information is current. To extend benefits for your college student beyond his or her 21st birthday, contact DEERS for eligibility criteria. See "Keep Your DEERS Information Current!" in the *Welcome to the TRICARE Overseas Program* section of this handbook for contact information.

After his or her DEERS record is updated, you may reenroll your child in TOP Prime or TOP Prime Remote by submitting *DD Form 2876* to your TOP Regional Call Center or TSC if the child attends a college in your current overseas region. You must take both steps to reenroll, as updating DEERS does not update TOP Prime or TOP Prime Remote enrollment.

TRICARE benefits end when your college student reaches age 23 or when full-time student status ends, whichever comes first. For example, if your child turns 23 on January 3, but does not graduate until May, coverage ends at midnight on January 2.

Note: Some colleges and universities offer student health plans. Student health plans are considered to be other health insurance (OHI), and TRICARE pays after OHI.

TRICARE Overseas Program Prime and TRICARE Overseas Prime Remote

If your child is enrolled in TOP Prime or TOP Prime Remote and attends school in your TRICARE region, your child may request a new primary care manager (PCM) by submitting *DD Form 2876* to the TOP Regional Call Center or TSC.

Command-sponsored children who reside with their sponsors in locations where the Department of Defense does not recognize the schools as approved institutions of higher learning may be sent to another overseas location to attend school. In these cases, sponsors must obtain both of the following to enroll children in TOP Prime or TOP Prime Remote in the school's area:

- Written verification that their children attend school in the other area
- Command-sponsorship verification to enroll in TOP Prime or TOP Prime Remote in the school's area

If the school is in a different overseas region where TOP Prime is available, your child may remain enrolled in TOP Prime using the split enrollment feature. You will need to submit a new *DD Form 2876* for your child's new location.

If your child attends a U.S. school located in a TRICARE Prime Service Area (PSA), an area where TRICARE Prime is available, he or she may submit *DD Form 2876* to the stateside regional contractor to enroll in TRICARE Prime. If the school is not located in a PSA, your child may use TRICARE Standard and TRICARE Extra. See Figure 7.2 later in this section for regional contractor contact information.

TRICARE Overseas Program Standard

TOP Standard provides continuous coverage when your child goes to college, even if it is in a different overseas region. Coverage remains the same, but your child needs to find a new provider.

If your child attends a school in the United States, he or she may use TRICARE Standard and TRICARE Extra or enroll in TRICARE Prime (*if it is available*) by submitting *DD Form 2876* to the appropriate stateside regional contractor.

Advise your child to save all health care receipts in case you need to file claims for reimbursement.

Note: Children with disabilities may remain TRICARE-eligible beyond the normal limits. Contact DEERS for eligibility criteria.

Traveling

Active Duty Service Members*

Active duty service members (ADSMs) traveling or between duty stations must seek all nonemergency care at MTFs, whenever possible. For urgent care, if an MTF is not available, prior authorization from your PCM or TOP contractor is required. Primary care, which includes routine health and dental office visits for treatment and ongoing care, should be handled before you travel or postponed until you return home. ADSMs located overseas should contact the TOP Regional Call Center.

Traveling Overseas

In an emergency, go to the nearest emergency care facility or call the Medical Assistance number for the region where you are located. Contact the TOP Regional Call Center before leaving the facility, preferably within 24 hours or on the next business day. **Note:** Prior authorization is not required for emergency care. If possible, ADSMs traveling overseas should contact the local TOP Regional Call Center before seeking care or before making payments.

* *This guidance also applies to National Guard and Reserve members on orders of 30 days or less, who should follow normal procedures for emergency care and must provide a copy of their orders to the local TOP Regional Call Center to verify TRICARE eligibility.*

Traveling in the United States

In an emergency, call 911 or go to the nearest hospital emergency room. Notify your PCM or TOP Regional Call Center **before leaving the facility**, or within 24 hours or on the next business day. **Note:** Prior authorization is not required for emergency care.

TRICARE Overseas Program Prime (*Non-Active Duty Service Members*)

Traveling Overseas

In an emergency, go to the nearest emergency care facility or call the Medical Assistance line for the region where you are traveling. If you are admitted, you must call your PCM or TOP Regional Call Center **before leaving the facility**, or within

24 hours or on the next business day to coordinate authorization, continued care, and payment.

Traveling in the United States

In an emergency, call 911 or go to the nearest hospital emergency room. If you are admitted, you must notify the TRICARE Latin America and Canada TOP Regional Call Center, which is the nearest call center, **before leaving the facility**, or within 24 hours or on the next business day to coordinate authorization, continued care, and payment. If urgent treatment cannot wait until you return home, you must contact the Latin America and Canada TOP Regional Call Center for assistance before receiving care. Failing to obtain a referral may cause your care to be covered under the point-of-service (POS) option,* resulting in higher out-of-pocket costs.

* *POS cost-sharing does not apply to ADSMs, newborns and adoptees during their first 120 days, the first eight outpatient behavioral health care visits per fiscal year (*October 1–September 30*) to network providers, clinical preventive services from network providers, emergency care, or beneficiaries with OHI.*

TRICARE Overseas Program Standard

Traveling Overseas

You can access your TOP Standard benefits and receive care from any host nation provider when you travel overseas. Before seeking care, contact your TAO to determine if you are required to visit an authorized provider. If you need emergency or urgent care while traveling overseas, go to the nearest emergency facility or call the Medical Assistance line for the overseas area where you are traveling to find a host nation provider.

Traveling in the United States

In an emergency, call 911 or go to the nearest hospital emergency room.

If you seek care from a stateside TRICARE network provider, the provider files the claim with the TOP contractor for you. If you seek care from a TRICARE-authorized non-network provider, expect to pay up front and file a claim with the TOP contractor. Save your receipt as proof of payment, and be sure to put your overseas address on the claim. Always file claims with the TOP contractor in your home region, not with the regional contractor in the area where you are traveling.

Note to all TRICARE Overseas Program beneficiaries: When seeking care from an overseas host nation provider or a stateside non-network provider, be prepared to pay up front for services and file a claim with the TOP contractor for reimbursement in the overseas region where you live.

Filling Prescriptions on the Road

You may use any available TRICARE pharmacy option when traveling, but be sure your DEERS information is current. To fill a prescription, you need a valid uniformed services ID card.

Military Treatment Facility Pharmacies

If you are traveling, you can fill a new prescription at any MTF pharmacy at no cost, if it is on the MTF formulary and in stock. All you need is the written prescription and your uniformed services ID card or CAC. The MTF pharmacy determines if you can obtain a refill of a prescription that was originally filled at another MTF.

Host Nation Pharmacies

You can fill prescriptions at any host nation pharmacy while you are traveling in overseas areas. Expect to pay up front and file claims with the TOP contractor.

TRICARE Retail Network Pharmacies

You can fill prescriptions at any TRICARE retail network pharmacy when traveling in the United States and U.S. territories (*American Samoa,** *Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). To find the nearest TRICARE retail network pharmacy, visit **www.express-scripts.com/TRICARE** or call **+1-866-ASK-4PEC (+1-866-275-4732)**.

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

Mail Order Pharmacy

If you are away from home for an extended period of time, you can plan ahead to receive prescriptions through the Mail Order Pharmacy, if available in the area where you are traveling. Provide Express Scripts, Inc. (Express Scripts), with your temporary address so prescriptions can be mailed to you at your travel destination. The Mail Order Pharmacy is only available in the United States, U.S. territories, and overseas if you have an APO/FPO address.

Visit **www.express-scripts.com/TRICARE** or call **+1-866-ASK-4PEC (+1-866-275-4732)** for assistance.

Non-Network Retail Pharmacies

If there is no other option, you can fill prescriptions at non-network pharmacies in the United States or U.S. territories. You must pay for prescriptions up front and file claims with Express Scripts for reimbursement. See the *Claims* section for details about filing pharmacy claims. ADSMs are fully reimbursed for covered, prescribed medications. If you are a TOP Prime or TOP Prime Remote active duty family member (ADFM), POS fees apply when you visit non-network pharmacies.

Moving

Moving Overseas

TRICARE Overseas Program Prime and TRICARE Overseas Program Prime Remote

TOP Prime and TOP Prime Remote coverage is portable—you can easily transfer your enrollment when you move within your region, to a new TRICARE overseas region, or to the United States. Follow these simple steps to ensure continuous coverage when you move:

1. Do not disenroll from TOP Prime or TOP Prime Remote before you move to your new location.
2. Once you arrive at your new location, update DEERS immediately.
3. Select a new PCM or transfer your enrollment within 60 days after departing your location.

ADFMs who do not enroll or reenroll within 60 days after leaving their overseas areas may be involuntarily disenrolled from TOP Prime or TOP Prime Remote. To prevent disruptions in health care coverage, ADSMs should ensure their enrollments transfer to their new regions within 60 days.

Moving within Your Current Overseas Region

If you move to another area in the same overseas region where your current program (*either TOP Prime or TOP Prime Remote*) is available, contact your current TOP Regional Call Center or TSC. You will only need to change your PCM.

Moving to a New Overseas Region

If you move to an area in another overseas region where your current program (*either TOP Prime or TOP Prime Remote*) is available, contact the TOP Regional Call Center or TSC in your new region to transfer enrollment and select a new PCM. The enrollment transfer is effective when your new TOP Regional Call Center or TSC receives your enrollment application.

Currently enrolled in TOP Prime: If you move to an area where TOP Prime is not available:

- **ADSMs:** Transfer your enrollment to TOP Prime Remote by submitting a new *DD Form 2876*. The transfer is effective when your new TOP Regional Call Center or TSC receives your form.
- **ADFMs:** Your enrollment transfers to TOP Prime Remote if you live with your TOP Prime Remote-enrolled sponsor and are command sponsored at your sponsor's location. Your sponsor can include you on his or her enrollment form. If you choose to disenroll from TOP Prime, you are automatically covered by TOP Standard as long as your DEERS information is current.
- **Transitional survivors:** Transitional survivors are eligible for TOP Prime and TOP Prime Remote as ADFMs during the three-year transitional survivor period. Surviving children remain eligible for TOP Prime and TOP Prime Remote as ADFMs until age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided 50 percent of the financial support*).

Currently enrolled in TOP Prime Remote: If you move to an area where TOP Prime is available, you must submit *DD Form 2876* to transfer your enrollment to TOP Prime. The enrollment transfer is effective when your new TOP Regional Call Center or TSC receives your enrollment application.

ADSMs and their families may transfer TOP Prime enrollment as often as needed. Retired service members and their families, eligible former spouses, and others are not eligible for TOP Prime or TOP Prime Remote.

TRICARE Overseas Program Standard

Whether you move to another area within the same TRICARE overseas region or to a different overseas region, all you need to do is update your personal information in DEERS and continue to receive care when you need it. For a list of providers, visit **www.tricare-overseas.com**.

Moving to the United States

If you make a permanent change of station move to the United States, you remain enrolled in TOP Prime or TOP Prime Remote for a maximum of 60 days from the date you leave your overseas area. Before you move, notify your TOP Regional Call Center or your local TSC that you are moving.

This protects you from incurring unnecessary costs for unexpected health care needs while traveling to your new U.S. location.

TRICARE Regional Contractors

A regional contractor administers the TRICARE program in each stateside TRICARE region. Before you move to your new stateside region, visit your regional contractor's Web site to learn about enrollment, PCMs, covered services, claims, and referral and authorization requirements. Requirements and procedures may differ between regions. Refer to Figure 7.2 for regional contractor contact information.

TRICARE Overseas Program Prime and TRICARE Overseas Program Prime Remote

Once you arrive at your U.S. location, submit *DD Form 2876* to your new regional contractor to transfer your overseas enrollment. If you move to a PSA, your enrollment transfers to TRICARE Prime. If you move to an area that is not part of a PSA, your enrollment transfers to TRICARE Prime Remote (TPR) (*for ADSMs*) or TRICARE Prime Remote for Active Duty Family Members (TPRADFM) (*for ADFMs*). ADFMs must reside with their TPR-enrolled sponsors to be eligible for TPRADFM. Otherwise, they must use TRICARE Standard and TRICARE Extra.

If you do not enroll in stateside TRICARE Prime or TRICARE Prime Remote within 60 days after leaving your overseas area, you are automatically disenrolled, and your coverage converts to TRICARE Standard and TRICARE Extra. Contact your new U.S. regional contractor for help with transferring your enrollment or to obtain *DD Form 2876*.

TRICARE Overseas Program Standard

Update your personal information in DEERS to receive care under the stateside TRICARE Standard program. Contact your new regional contractor for more information before you move.

To find a U.S. provider, visit the online provider locator at **www.tricare.mil/providerdirectory**. The U.S. regional contractors also have network provider directories on their Web sites to help

beneficiaries find local providers. See Figure 7.2 for contact information. You can also call a provider's office to ask if he or she accepts TRICARE.

Separating from the Service

If your active duty sponsor separates from the uniformed services, TRICARE coverage may or may not continue, depending on the circumstances of the separation. TRICARE offers transitional health care options through the Transitional Assistance Management Program (TAMP) and the Continued Health Care Benefit Program (CHCBP). TAMP and CHCBP provide temporary coverage until you have a new health care plan. There are also health care plans that National Guard and Reserve members and retirees may qualify to purchase.

Contact your TAO, TSC, TOP Regional Call Center, or a Beneficiary Counseling and Assistance Coordinator to discuss your family's eligibility for these programs. For more information, visit **www.tricare.mil**.

Transitional Assistance Management Program

TAMP provides 180 days of transitional health care benefits to help certain uniformed services members and their families transition to civilian life. The sponsor and family members may be eligible for TAMP if the sponsor is:

- Involuntarily separating from active duty under honorable conditions
- A National Guard or Reserve member separating from a period of active duty that lasted more than 30 consecutive days in support of a contingency operation
- Separating from active duty following involuntary retention (*stop-loss)* in support of a contingency operation
- Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation
- Separating from active duty with an agreement to become a member of the Selected Reserve of the Ready Reserve of a reserve component
- Separating from active duty due to sole survivorship discharge

If you qualify for coverage under TAMP, you have 180 days of transitional health benefits after the sponsor separates. When you become eligible for TAMP, you and your family members are automatically covered under TOP Standard, regardless of which overseas program option you were enrolled in before separation. During this 180-day period, you may continue to use TOP Standard; you may enroll in TRICARE Prime (*if you reside in or move to a PSA*) or TOP Prime (*if available in your overseas area*); or you may use TRICARE Standard and TRICARE Extra (*in the United States*). Rules and processes for these programs apply. Your costs will be the same as those for ADFMs.

Formerly Enrolled in TRICARE Overseas Program Prime or TRICARE Overseas Program Prime Remote

You are not eligible for TAMP while on terminal leave. During terminal leave, you continue to receive benefits as an ADSM, and your family members remain covered under TOP Prime or TOP Prime Remote. Note that an ADSM is not eligible to change his or her PCM while on terminal leave. You must

U.S. TRICARE Regional Contractor Contact Information *Figure 7.2*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Health Net Federal Services, LLC +1-877-TRICARE (+1-877-874-2273) www.healthnetfederalservices.com	**Humana Military Healthcare Services, Inc.** +1-800-444-5445 www.humana-military.com	**TriWest Healthcare Alliance Corp.** +1-888-TRIWEST (+1-888-874-9378) www.triwest.com.com

Note: *To coordinate behavioral health care, contact your TOP Regional Call Center.*

coordinate all care through your current PCM. If you incurred an injury, illness, or disease while on active duty, contact your unit or service branch for eligibility determination or authorizations for follow-up care.

You may also enroll or reenroll in stateside TRICARE Prime, stateside TRICARE Prime Remote,* TOP Prime, or TOP Prime Remote under the following conditions:

- If you were enrolled in TOP Prime when you separated, you may continue your enrollment with no break in coverage. Complete a reenrollment application before your TAMP coverage ends to continue with TOP Prime. The effective date is the date the sponsor separated from active duty.
- If you were not enrolled in TOP Prime or TOP Prime Remote immediately prior to your change in status, you may choose to enroll in TOP Prime, stateside TRICARE Prime, or stateside TRICARE Prime Remote* while receiving TAMP coverage.

Note: TOP Prime Remote is not available during TAMP. You will be disenrolled and covered by TOP Standard if you were enrolled in TOP Prime Remote. If you move to the United States, you may not enroll in TPR or TPRADFM during TAMP.

* *Stateside TRICARE Prime or stateside TRICARE Prime Remote enrollment is subject to the "20th of the month" rule. If the regional contractor receives your application by the 20th of the month, your coverage begins on the first day of the following month (*e.g., an enrollment received by December 20 becomes effective January 1*). If your application is received after the 20th of the month, your coverage begins on the first day of the month following the next month (*e.g., an enrollment received on December 27 becomes effective February 1*). TOP Prime enrollment is effective when the enrollment application is received.*

Continued Health Care Benefit Program

CHCBP is a premium-based health care program administered by Humana Military Health Care Services, Inc. (Humana Military). CHCBP offers temporary transitional health care coverage (*18–36 months*) after TRICARE eligibility ends. If you qualify, you can purchase CHCBP within 60 days after losing eligibility for either regular TRICARE or TAMP coverage.

CHCBP acts as a bridge between military health care benefits and your new civilian health care plan. CHCBP benefits are similar to TRICARE Standard with the same benefits, providers, and rules. For more information about CHCBP, visit Humana Military's Web site at **www.humana-military.com** or call **+1-800-444-5445**.

National Guard and Reserve Coverage

TRICARE Reserve Select (TRS) is a premium-based health care plan that National Guard and Reserve members (*when not activated for a period of more than 30 consecutive days*) may qualify to purchase. Member-only and member-and-family enrollments are available.

Overseas, TRS coverage works like TOP Standard, with similar benefits, requirements, and costs. TRS beneficiaries receive comprehensive coverage and can obtain care from any host nation provider without a referral. Before seeking care, contact your TAO to determine if you are required to visit an authorized provider. Beneficiaries are responsible for paying monthly premiums, annual deductibles, and cost-shares.

Visit **www.tricare.mil/reserve/reserveselect** for more information about TRS coverage.

Retiring from Active Duty

When you retire from active duty, you and your eligible family members experience a "change in status." After you update information in DEERS, you will receive a new uniformed services ID card that reflects your status as a retiree. After you retire, it is still essential that you keep your DEERS information current.

Until retirement, your sponsor is enrolled in either TOP Prime or TOP Prime Remote. If you are going on terminal leave, **notify your TOP Regional Call Center or TSC before you depart**, so you will not be involuntarily disenrolled 60 days after you leave your overseas area. Eligible retired service members who are entitled to premium-free Medicare Part A must have Part A and Part B to remain TRICARE-eligible, and they receive benefits under

TRICARE For Life (TFL). Retirees who are not entitled to premium-free Medicare Part A may remain TRICARE-eligible under TOP Standard.

Note: TOP Prime and TOP Prime Remote are not available to retirees.

After retiring, TOP Standard beneficiaries can expect differences in covered services and changes in dental coverage. TOP Standard cost-shares, copayments, and catastrophic caps increase to retired family rates. See "Dental Options" in the *Covered Services, Limitations, and Exclusions* section for information about dental coverage. For additional information regarding program costs, visit **www.tricare.mil/costs**.

Becoming Entitled to Medicare

Active Duty Status

ADSMs and ADFMs who are entitled to premium-free Medicare Part A remain eligible for TRICARE Prime and TRICARE Standard programs without signing up for Medicare Part B. To avoid a break in TRICARE coverage, ADSMs and ADFMs must sign up for Medicare Part B before sponsors retire. ADSMs and ADFMs can sign up for Medicare Part B during a special enrollment period without having to pay monthly late-enrollment premium surcharges. The special enrollment period is available any time the sponsor is on active duty or within the first eight months following the month that (1) the sponsor retires, **or** (2) TRICARE coverage ends, whichever is first. Beneficiaries must have both Medicare Part A and Part B to receive benefits under TFL.

For services covered by Medicare and TRICARE in the United States and U.S. territories, Medicare pays for inpatient services first, and TRICARE pays last. In areas where Medicare is not available, TRICARE is the primary payer. If you have OHI, it pays before TRICARE. For services covered by Medicare, your OHI, and TFL, Medicare pays first, your OHI pays second, and TRICARE pays last.

Retired Status

After active duty status ends, beneficiaries who are entitled to premium-free Medicare Part A must have Medicare Part B to remain TRICARE-eligible, regardless of where they live. TFL coverage automatically begins when both Medicare Part A and Part B are effective. TRICARE benefits are terminated for any period of time when you do not have Medicare Part B, and you may have to pay monthly Medicare premium surcharges if you sign up for Part B later.

Survivor Coverage

If your sponsor dies while serving on active duty for a period of more than 30 days, you are automatically eligible for transitional TRICARE survivor benefits as long as your DEERS information is up to date and you are either of the following:

- A surviving spouse and do not remarry (*If you remarry, TRICARE eligibility cannot be regained later, even if you divorce or your new spouse dies.*)
- An unmarried child under age 21 (*or age 23 if enrolled in a full-time course of study at an institution of higher learning, and if the sponsor provided at least 50 percent of the financial support*)

Note: Children with disabilities may remain eligible beyond normal age limits. Check DEERS for eligibility criteria.

Surviving Spouse: You remain eligible as a "transitional survivor" for three years following your sponsor's death and will have ADFM benefits and costs. After three years, you remain TRICARE-eligible as a survivor and will pay retiree rates and enrollment fees.

Surviving Children: Surviving children whose sponsors died on or after October 7, 2001, remain eligible as ADFMs until eligibility ends due to the age limits previously noted or for another reason (*e.g., marriage*).

Upon the death of your sponsor, you will receive a letter from DEERS explaining your program options and how your benefits will change. Transitional survivors are considered command-sponsored ADFMs and remain eligible for TOP Prime and TOP Prime Remote. Visit **www.tricare.mil/DEERS** if you have questions.

Dependent Parent Coverage

If your parents or parents-in-law are dependent on you for support, your local MTF may be able to help with the cost of their health care. Although dependent parents are not eligible for most TRICARE benefits, they may be eligible for MTF care on a space-available basis. Dependent parents may also be able to fill prescriptions at MTF pharmacies and through certain TRICARE Pharmacy Program options once they become entitled to Medicare Part A and purchase Medicare Part B. Your service branch determines MTF care eligibility for your parents or parents-in-law, registers them as dependents in DEERS, and issues their ID cards.

Health care for eligible dependent parents or parents-in-law is available on a space-available basis at certain MTFs. Access to care is subject to change based on MTF capacity and capabilities. Also, enrollment at one MTF does not guarantee that your parents or parents-in-law can receive care at another MTF. When moving, you should check with the MTF at your new location to determine if care is available.

A dependent parent or parent-in-law may be able to participate in TRICARE Plus if the nearest MTF offers it and space permits. TRICARE Plus is a program that allows certain non-Prime beneficiaries to enroll at MTFs and receive primary care within TRICARE Prime access standards. Contact the nearest MTF to find out if TRICARE Plus is available. See "Access Standards" in the *Getting Care* section for information about TRICARE Prime access standards.

Note: Dependent parents and parents-in-law are not eligible for any TRICARE civilian health care services, including emergency care. TRICARE does not pay for services received outside of MTFs. You should consider a private commercial health insurance plan for your parents and/or parents-in-law if they need services that MTFs cannot provide.

Visit **www.tricare.mil** for more information on MTF care eligibility for dependent parents and parents-in-law.

Loss of Eligibility

Upon loss of TRICARE eligibility, each family member automatically receives a certificate of creditable coverage. The certificate of creditable coverage is a document that serves as evidence of prior health care coverage under TRICARE, so that you cannot be excluded from a new health plan for pre-existing conditions. Certificates may be issued in the following circumstances:

- Upon the sponsor's separation from active duty, a certificate is issued to the sponsor listing all eligible family members.
- Upon the loss of eligibility for a dependent child (*age 21, or 23 if enrolled in a full-time course of study at an institution of higher learning, and if the sponsor provides at least 50 percent of the financial support*), a certificate is issued to the dependent child.
- Upon loss of coverage after divorce, a certificate is issued to the former spouse as soon as the information is updated in DEERS.

Certificates reflect the most recent period of continuous TRICARE coverage. Certificates issued upon beneficiary request reflect each period of continuous TRICARE coverage that ended within the 24 months prior to the date of loss of eligibility. Each certificate identifies the name of the sponsor or family member it is issued for, the dates TRICARE coverage began and ended, and the certificate issue date.

Send written requests for certificates of creditable coverage to the Defense Manpower Data Center Support Office at:

Defense Manpower Data Center
Support Office
ATTN: Certificate of Creditable Coverage
400 Gigling Road
Seaside, CA 93955-6771

The request must include:

- Sponsor's name and SSN
- Name of person the certificate is requested for
- Reason for the request
- Name and address the certificate should be sent to
- Requester's signature

Certificates cannot be requested by phone. If there is an urgent need for a certificate of creditable coverage, fax your request to **+1-831-655-8317** and/or request that the certificate be faxed to a particular number.

Additional information is available at **www.tricare.mil/certificate**.

For Information and Assistance

Beneficiary Counseling and Assistance Coordinators

Beneficiary Counseling and Assistance Coordinators (BCACs) can help you with TRICARE and Military Health System inquiries and concerns and can advise you about obtaining health care. BCACs are located at military treatment facilities (MTFs) and at TRICARE Area Offices (TAOs). To locate a BCAC, visit **www.tricare.mil/bcacdcao** to use the online directory.

Medical Service Coordinators

The Medical Service Coordinators, or TRICARE Beneficiary Service Representatives, are located at TRICARE Service Centers and provide the following services:

- Processing enrollments, disenrollments, and transfers for TRICARE Overseas Program (TOP) Prime, TOP Prime Remote, and TRICARE Plus (*if available*)
- Assigning primary care managers (PCMs)
- Handling PCM change requests

Patient Liaison Services

Many MTFs are staffed with Patient Liaisons who can help you navigate your host nation health care system. Liaisons speak fluent English and your host nation language, and they are skilled at handling host nation medical-system procedures.

If you are admitted to a host nation hospital after duty hours or on a weekend, have someone contact your TOP Regional Call Center. Your TOP Regional Call Center will make sure your MTF is notified of the admission.

Your host nation Patient Liaison can:

- Help coordinate care in your host nation medical system
- Translate for you if your host nation medical staff cannot speak English
- Assist with scheduling appointments, consultations, tests, and follow-up exams
- Help with medical bill payments and claims

TRICARE Point of Contact Program

The TRICARE Point of Contact (POC) program is a liaison service that assists beneficiaries and host nation providers in remote overseas locations. POCs assist beneficiaries with TRICARE enrollment and with accessing quality host nation care. They also help beneficiaries and host nation providers file medical and dental claims. To locate a POC, contact your TAO.

U.S. Embassies and Consulates

The U.S. Department of State, the lead federal agency carrying out U.S. foreign policy, provides a list of U.S. Embassies and Consulates on its Web site. Visit **www.usembassy.gov** to locate a U.S. Embassy or Consulate in the area where you live or where you travel.

Filing a Grievance

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

The grievance process allows you to report in writing any concern or complaint regarding health care quality or service. Any TRICARE civilian or military provider; TRICARE beneficiary; sponsor; or parent, guardian, or other representative of an eligible dependent child may file a grievance. International SOS Assistance, Inc. (International SOS), is responsible for investigating and resolving all grievances. Grievances are generally resolved within 60 days of receipt. Following resolution, International SOS notifies the party that submitted the grievance that the review is complete.

Grievances may include such issues as:

- The quality of health care or services (*e.g., accessibility, appropriateness, level of care, continuity, timeliness of care*)
- The demeanor or behavior of providers and their staffs
- The performance of any part of the health care delivery system
- Practices related to patient safety

When filing a grievance, include the following:

- Beneficiary's name, address, and telephone number
- Sponsor's SSN
- Beneficiary's date of birth
- Beneficiary's signature

A description of the issue or concern, must include:

- Date and time of the event
- Name(s) of the provider(s) and/or person(s) involved
- Location of the event (address)
- The nature of the concern or complaint
- Details describing the event or issue
- Any appropriate supporting documents

Mail grievances to International SOS:

International SOS Assistance, Inc.
Reconsideration/Grievances Department
P.O. Box 11570
Philadelphia, PA 19116

Reporting Suspected Fraud and Abuse

Fraud happens when a person or organization takes action to deliberately deceive others to gain an unauthorized benefit. Health care abuse occurs when providers supply services or products that are medically unnecessary or that do not meet professional standards.

Beneficiaries are important partners in the ongoing fight against fraud and abuse. Because an explanation of benefits (EOB) is a tangible statement of services and/or supplies received, it is one of the first lines of defense against health care fraud. Each EOB provides a number to call if you have concerns about services you believe are billed fraudulently. You can also visit the TRICARE Fraud and Abuse Web site at **www.tricare.mil/fraud** for direct links to the International SOS fraud and abuse reporting office. **We strongly encourage you to read your EOBs carefully.**

Write to the customer service department for TRICARE Overseas to report suspected fraud and abuse:

ATTN: TRICARE Program Integrity
1717 W. Broadway
P.O. BOX 7635
Madison, WI 53707

You can also send an e-mail to **reportit@wpsic.com**. Be sure to provide as much information as possible.

To report fraud or abuse regarding the pharmacy program, contact Express Scripts, Inc.:

- **Phone:** +1-800-332-5455, ext. 367079
- **E-mail:** fraudtip@express-scripts.com.

You also can report fraud or abuse issues directly to TRICARE at **fraudline@tma.osd.mil**.

Implied TRICARE Affiliations of Health Care Companies Operating Overseas

The TRICARE Management Activity (TMA) Office of Program Integrity has received several inquiries about health care agencies and companies operating in overseas locations and serving TRICARE beneficiaries. Please be advised that such companies have no official connection with the U.S. Government and its TRICARE program. Health care providers and facilities associated with these companies do not undergo the same TRICARE certification review as those required of providers that are affiliated with the companies. When they meet TRICARE's requirements, all certified providers have equal standing with the TOP contractor as authorized providers and are eligible for reimbursement for TRICARE claims.

In response to complaints received from several overseas beneficiaries, TMA sent an informational letter to health care companies operating overseas to identify inappropriate activities that could constitute fraudulent billings. The letter included the following examples:

- Billing or submitting claims for non-covered or non-chargeable services by disguising them as covered items (*It is fraudulent for billing agencies to include administrative costs on health care claims. Billing agencies may charge providers administrative fees to cover claims submission costs. However, these costs cannot be passed on to the U. S. Government in the form of health care charges.*)
- Billings or claims that involve flagrant and persistent over utilization of services
- Billings for services that were not provided (*e.g., charging for an office visit for a prescription refill when no office visit took place*)
- Arrangements designed to overcharge TRICARE through means used to divert or conceal improper or unnecessary costs or profits (*e.g., commissions, fee-splitting, kickbacks*)
- Unauthorized use of the term "TRICARE" in private business (*Federal statute does not prohibit use of the term "TRICARE," but misrepresentation or description to imply an official connection with the U.S. Government or to defraud may violate federal statute.*)
- Improper billing practices (*These may include charging TRICARE beneficiaries more than what is routinely charged to the general public. For instance, prescription drug charges should not be more than the average drug wholesale price. Other services, both professional and institutional, should not represent excessive charges.*)
- A pattern of claims for services that are not medically necessary or, if medically necessary, not to the extent rendered
- Waiving the deductible or cost-share and/or offering a financial incentive to encourage beneficiaries to receive health care services
- Engaging in a practice that results in a waiver of the deductible or cost-share
- Failing to promptly refund the U.S. Government any payment resulting from inappropriate billing or overpayments

The above fraudulent and/or abusive actions are prohibited by the Code of Federal Regulations (*32 CFR, 199.9*). Those who knowingly participate in these activities may be subject to consequences, including prosecution and denial of future claims for payment by TRICARE.

If you are aware of organizations engaging in these activities, e-mail your concerns to the TRICARE Overseas Program at **reportit@wpsic.com** or write to:

ATTN: TRICARE Program Integrity
1717 W. Broadway
P.O. BOX 7635
Madison, WI 53707

Acronyms

AAP	American Academy of Pediatrics
ADDP	Active Duty Dental Program
ADFM	Active duty family member
ADSM	Active duty service member
BCAC	Beneficiary Counseling and Assistance Coordinator
CAC	Common Access Card
CDC	Centers for Disease Control and Prevention
CFHF	Canadian Forces Health Facility
CHCBP	Continued Health Care Benefit Program
DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DO	Doctor of osteopathic medicine
DoD	Department of Defense
DRG	Diagnosis-related group
ECHO	Extended Care Health Option
EHHC	ECHO Home Health Care
EOB	Explanation of benefits
FY	Fiscal year
HHA	Home Health Agency
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
ID	Identification
MD	Doctor of Medicine
MRI	Magnetic resonance imaging
MTF	Military treatment facility
ODTF	Overseas dental treatment facility
OHI	Other health insurance
PCM	Primary care manager
PHP	Partial hospitalization program
POC	Point of contact
POS	Point of service
PSA	Prime Service Area
RTC	Residential treatment care
SNF	Skilled nursing facility
SSA	Social Security Administration
SSN	Social Security number
TAMP	Transitional Assistance Management Program
TAO	TRICARE Area Office
TDP	TRICARE Dental Program
TDY	Temporary duty
TFL	TRICARE For Life
TMA	TRICARE Management Activity
TOP	TRICARE Overseas Program
TPMRC	Theater Patient Movement Requirements Center
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRDP	Enhanced-Overseas TRICARE Retiree Dental Program
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
WIC	Women, Infants, and Children

Glossary

20th of the Month Rule

Under the "20th of the month" rule, applications for benefits received by your regional contractor by the 20th of the month will become effective at the beginning of the following month (*e.g., an enrollment received by December 20 would become effective January 1*). If your application is received after the 20th of the month, your coverage will become effective on the first day of the month following the next month (*e.g., an enrollment received on December 27 would become effective February 1*).

Beneficiary Counseling and Assistance Coordinator (BCAC)

BCACs are persons at military treatment facilities and TRICARE Area Offices who are available to answer questions, help solve health care-related problems, and assist beneficiaries in obtaining medical care through TRICARE. To locate a BCAC, visit **www.tricare.mil/bcacdcao**.

Catastrophic Cap

The catastrophic cap is the maximum out-of-pocket expenses TRICARE beneficiaries are responsible for in a given fiscal year (*October 1–September 30*). Point-of-service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

Contingency Operation

A contingency operation is "a military operation that results in the call or order to, or retention of, active duty of members of the uniformed services during a war or during a national emergency declared by the President or Congress." Written calls or orders to active duty will specify if they are in support of a contingency operation.

Continued Health Care Benefit Program (CHCBP)

CHCBP is a premium-based health care program you may purchase after loss of TRICARE eligibility if you qualify. CHCBP offers temporary transitional health coverage and must be purchased within 30 days after TRICARE eligibility ends.

Cost-Share

A cost-share is the percentage or portion of costs that the beneficiary will pay for inpatient or outpatient care.

Debt Collection Assistance Officer (DCAO)

DCAOs are persons located at military treatment facilities and TRICARE Area Offices to assist you in resolving health care collection-related issues. Contact a DCAO if you received a negative credit rating or were sent to a collection agency due to an issue related to TRICARE services.

Deductible

A deductible is the annual amount a TRICARE Overseas Program Standard or TRICARE Reserve Select beneficiary must pay for covered outpatient benefits before TRICARE begins to share costs.

Defense Enrollment Eligibility Reporting System (DEERS)

DEERS is a database of uniformed services members (*sponsors*), family members, and others worldwide who are entitled under law to military benefits, including TRICARE. Beneficiaries are required to keep DEERS updated. DEERS is the official record system for TRICARE eligibility.

Explanation of Benefits (EOB)

An EOB is a statement sent to a beneficiary showing that a claim was processed, and it indicates the amount paid to the provider. If denied, an explanation of denial is provided.

Host Nation Provider

A host nation provider is a civilian hospital or individual provider licensed to practice or deliver health care overseas. The TRICARE Overseas Program contractor, International SOS Assistance, Inc., certifies some host nation providers to provide health care services to TRICARE beneficiaries.

Military Treatment Facility (MTF)

An MTF is a medical facility (*e.g., hospital, clinic*) owned and operated by the uniformed services and usually located on or near a military base. Beneficiaries can locate an MTF by visiting **www.tricare.mil/mtf**.

National Guard and Reserve

The National Guard and Reserve includes the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the Coast Guard Reserve.

Negotiated Rate

The negotiated rate is the rate overseas network host nation providers and participating non-network host nation providers agree to accept for covered services.

Network Provider

A TRICARE network provider is a professional or institutional provider who has a contractual relationship with a TRICARE contractor to provide care at a negotiated rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries. A network provider accepts the negotiated rate as payment in full for services rendered.

Non-Network Provider

A non-network provider is a professional or institutional provider who does not have a contractual relationship with a TRICARE contractor but is authorized to provide care to TRICARE beneficiaries. There are two categories of non-network providers—participating and nonparticipating.

Other Health Insurance (OHI)

OHI is any non-TRICARE health insurance that is not considered a supplement. This insurance is acquired through an employer, entitlement program, host nation statutory health care program, or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs or plans as identified by the TRICARE Management Activity.

Point of Service (POS)

The POS option allows a TRICARE Prime option beneficiary to obtain medically necessary services—inside or outside the TRICARE network—from someone other than his or her primary care manager without first obtaining a referral or authorization. Using the POS option results in a deductible and greater out-of-pocket expenses.

Primary Care Manager (PCM)

A PCM is a military treatment facility (MTF) provider or host nation provider who provides routine (*primary*) care to TRICARE beneficiaries. A PCM is either selected by the beneficiary or assigned by an MTF commander or his or her designated appointee.

Prime Service Area (PSA)

A PSA is an area around military treatment facilities and in other predetermined areas as defined by ZIP codes where TRICARE Prime is offered.

Prior Authorization

Prior authorization is the process of reviewing certain medical, surgical, and behavioral health services to ensure medical necessity and appropriateness of care before services are rendered or within 24 hours of an emergency admission. For a list of services that require prior authorization, visit **www.tricare.mil**.

Transitional Assistance Management Program (TAMP)

TAMP provides transitional health care for certain uniformed services members (*and eligible family members*) who separate from active duty.

TRICARE-Allowable Charge

The TRICARE-allowable charge (*also called the allowable charge*) is the maximum amount TRICARE will pay for services rendered in the United States or Puerto Rico.

TRICARE-Authorized Provider

A TRICARE-authorized provider meets TRICARE's licensing and certification requirements and has been certified by TRICARE to provide care to TRICARE beneficiaries. If you see a provider who is not TRICARE-authorized and can never be certified, you are responsible for the full cost of care. TRICARE-authorized providers include doctors, hospitals, ancillary providers (*laboratories and radiology centers*), and pharmacies. There are two types of authorized providers—network and non-network.

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Notes

Notes

Patient Bill of Rights and Responsibilities

As a patient in the military health system, you have the right to:

- Receive accurate, easy-to-understand information to help you make informed decisions about TRICARE programs, medical professionals, and facilities.
- Have a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.
- Access emergency health care services when and where the need arises.
- Receive and review information about diagnosis, treatment, and the progress of your condition, and to fully participate in all decisions related to your health care, or to be represented by family members, conservators, or other duly appointed representatives.
- Receive considerate, respectful care from all members of the health care system without discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Communicate with health care providers in confidence and to have the confidentiality of your health care information protected. You also have the right to review, copy, and request amendments to your medical records.
- Have a fair and efficient process for resolving differences with your health plan, health care providers, and the institutions that serve them.
- For more information about your rights, visit **www.tricare.mil/patientrights/default.cfm**.

As a patient in the military health system, you have the responsibility to:

- Maximize healthy habits, such as exercising, not smoking, and maintaining a healthy diet.
- Be involved in health care decisions, which means working with providers in developing and carrying out agreed-upon treatment plans, disclosing relevant information, and clearly communicating your wants and needs.
- Be knowledgeable about TRICARE coverage and program options.

You also have the responsibility to:

- Show respect for other patients and health care workers.
- Make a good-faith effort to meet financial obligations.
- Use the disputed claims process when there is a disagreement.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

Please provide feedback on this handbook at:
www.tricare.mil/evaluations/booklets

TRICARE Overseas
(*TRICARE Eurasia-Africa, TRICARE Latin America and Canada, and TRICARE Pacific*)
www.tricare.mil/overseas
1-888-777-8343

TRICARE North Region
Health Net Federal Services, LLC
www.healthnetfederalservices.com
1-877-TRICARE (1-877-874-2273)

TRICARE South Region
Humana Military Healthcare Services, Inc.
www.humana-military.com
1-800-444-5445

TRICARE West Region
TriWest Healthcare Alliance Corp.
www.triwest.com
1-888-TRIWEST (1-888-874-9378)

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