OVERSEAS

TRICARE® Overseas Program Handbook

Your guide to program benefits in the TRICARE Overseas Program

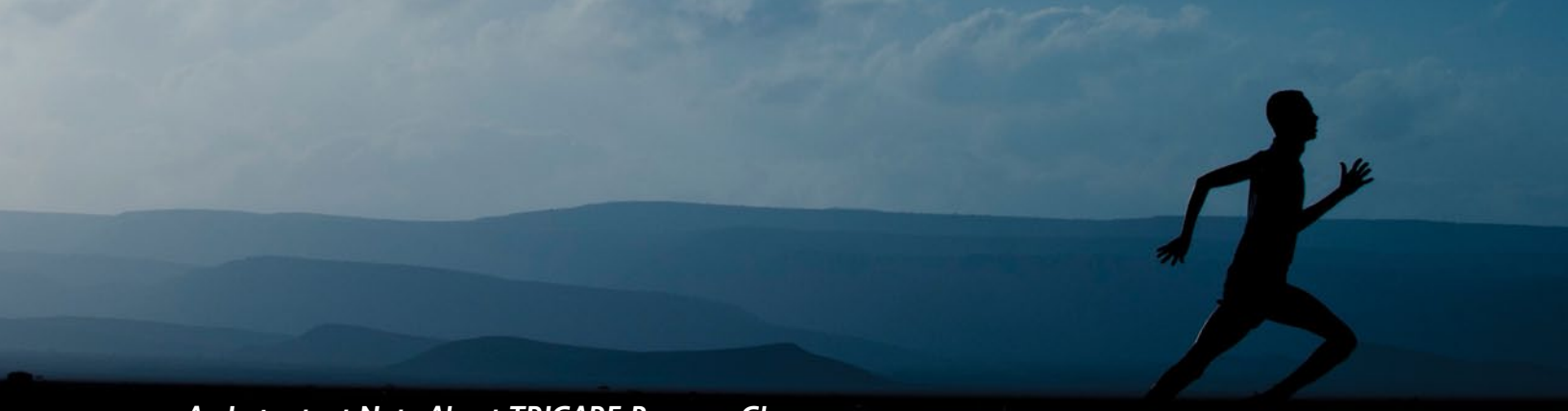
TRICARE®

November 2012

Important Information

TRICARE Web site:	www.tricare.mil
TRICARE Overseas Program contractor:	International SOS Assistance, Inc.
Overseas Web site:	www.tricare-overseas.com
TRICARE Eurasia-Africa	
TOP Regional Call Center:*	+44-20-8762-8384 (*overseas*) 1-877-678-1207 (*stateside*) tricarelon@internationalsos.com
Medical Assistance Number:*	+44-20-8762-8133
TRICARE Latin America and Canada	
TOP Regional Call Center:*	+1-215-942-8393 (*overseas*) 1-877-451-8659 (*stateside*) tricarephl@internationalsos.com
Medical Assistance Number:*	+1-215-942-8320
TRICARE Pacific	
TOP Regional Call Center*/Singapore:	+65-6339-2676 (*overseas*) 1-877-678-1208 (*stateside*) sin.tricare@internationalsos.com
TOP Regional Call Center*/Sydney:	+61-2-9273-2710 (*overseas*) 1-877-678-1209 (*stateside*) sydtricare@internationalsos.com
Medical Assistance*/Singapore Number:	+65-6338-9277
Medical Assistance*/Sydney Number:	+61-2-9273-2760

** For toll-free contact information, visit www.tricare-overseas.com. Toll-free lines may not be available for all mobile phone carriers overseas. Only call Medical Assistance numbers to coordinate overseas emergency care.*



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 overseas 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) and in many remote locations as well.

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/subscriptions** 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

International SOS Assistance, Inc. (International SOS) administers the TOP benefit; visit the TOP 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 the Medical Assistance number for your area in an emergency. TOP Regional Call Centers provide Medical Assistance numbers for each overseas area, as well as stateside numbers for use in the United States. The TOP Regional Call Centers are available 24 hours a day, seven days a week, and you may call collect, if available. For toll-free contact information, visit **www.tricare-overseas.com**.

TRICARE Overseas Program Regional Call Centers

TOP Regional Call Centers help coordinate care for TOP Prime and TOP Prime Remote 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.

Global TRICARE Service Center

The Global TRICARE Service Center (GTSC) helps beneficiaries understand TOP and assists with enrollments, transfers, general inquiries, and customer service. It is staffed 24 hours a day, seven days a week by beneficiary service representatives.

When you call your TOP Regional Call Center, you will be prompted with the following menu of options; the GTSC is available at option 4:

Option 1: Medical Assistance (*directs you to the Medical Assistance team at your TOP Regional Call Center*)

Option 2: Claims issues (*connects you to a claims customer service specialist*)

Option 3: Health care finder/authorization assistance (*helps you find health care at an MTF overseas or find a local host nation provider in your community*)

Option 4: GTSC (*connects you to the 24-hour customer service assistance center*)

Option 5: Provider concerns (*this option is for TOP providers only and should not be used by beneficiaries*)

Option 6: TOP Prime Remote Wellness Program (*designed to help TOP Prime Remote beneficiaries manage chronic health conditions and improve overall health and well-being*)

Medical Assistance

International SOS provides a Medical Assistance line for areas throughout the 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 or TOP Regional Call Center for urgent care assistance or for referrals and authorizations.

TRICARE Area Offices

A TRICARE Area Office is located in each overseas area to assist beneficiaries living or traveling overseas.

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[1] +44-20-8762-8384 (*overseas*) 1-877-678-1207 (*stateside*) tricarelon@internationalsos.com **Medical Assistance**[1] +44-20-8762-8133	**TOP Regional Call Center**[1] +1-215-942-8393 (*overseas*) 1-877-451-8659 (*stateside*) tricarephl@internationalsos.com **Medical Assistance**[1] +1-215-942-8320	**TOP Regional Call Centers**[1] Singapore: +65-6339-2676 (*overseas*) 1-877-678-1208 (*stateside*) sin.tricare@internationalsos.com Sydney: +61-2-9273-2710 (*overseas*) 1-877-678-1209 (*stateside*) sydtricare@internationalsos.com **Medical Assistance**[1] Singapore: +65-6338-9277 Sydney: +61-2-9273-2760
TRICARE Area Office +49-6302-67-6314 314-496-6314 (*DSN*) teoweb@europe.tricare.osd.mil www.tricare.mil/eurasiaafrica	**TRICARE Area Office** +1-210-292-8520 94-554-8520 (*DSN*) taolac@tma.osd.mil www.tricare.mil/tlac	**TRICARE Area Office** +81-6117-43-2036 315-643-2036 (*DSN*) tpao.csc@med.navy.mil www.tricare.mil/pacific

*1. For toll-free contact information, visit **www.tricare-overseas.com**. Toll-free lines may not be available for all mobile phone carriers overseas. Only call Medical Assistance numbers to coordinate overseas emergency care.*

TRICARE Service Centers

TRICARE Service Centers (TSCs) are located throughout the overseas areas, typically at MTFs, where beneficiary 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 grievances. To locate a TSC near you, visit **www.tricare.mil/contacts**.

Keep Your DEERS Information Up To Date!

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 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 (*TDD/TTY*)
Fax[2]	• +1-831-655-8317
Mail[2]	• Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771 USA
Online[2]	• milConnect Web site **http://milconnect.dmdc.mil**

1. *Only sponsors (*or sponsor-appointed individuals with valid power 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. The service member's service personnel office determines eligibility for pre-activation benefits. Contact the unit personnel office regarding eligibility. Activation orders should contain the 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.

Important Note for Beneficiaries Living in the Philippines

If you live in the Philippines, you are required to visit a certified provider. A certified provider has been verified to meet required TOP contract standards and is allowed to bill TRICARE for TRICARE beneficiary claims. You are also required to use only certified pharmacy providers. For more information on certified providers in the Philippines, please visit **www.tricare.mil/pacific**. Individuals in other locations should check if restrictions on certified providers apply in their area. For the most up-to-date information on accessing care in the Philippines, visit **www.tricare.mil**.

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See the inside back cover of this handbook for “TRICARE Expectations for Beneficiaries.”

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 U.S. Public Health Service
- National Oceanic and Atmospheric Administration

Your beneficiary category and location determine which overseas 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 reaching age 21 (*or age 23 if enrolled in a full-time course*

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

Beneficiary Type	Program Options
Active duty service members	• TRICARE Overseas Program (TOP) Prime • TOP Prime Remote • TRICARE Active Duty Dental Program (ADDP)[1]
Active duty family members and transitional survivors	• TOP Prime • TOP Prime Remote • TOP Standard • TRICARE Young Adult (TYA) • TRICARE For Life (TFL) (*if entitled to Medicare Part A and have Part B*)[2] • TRICARE Dental Program
Retired service members and family members, survivors, Medal of Honor recipients, certain unremarried former spouses, and others	• TOP Standard • TYA • TFL (*if entitled to Medicare Part A and have Part B*)[2] • Enhanced-Overseas TRICARE Retiree Dental Program • TRICARE Plus (*depending on military treatment facility availability*)

1. *The ADDP 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*).*
2. *Most beneficiaries who are entitled to Medicare Part A must have Medicare Part B to remain TRICARE-eligible. ADFMs who have Medicare Part A are not required to have Medicare Part B to remain eligible for TRICARE. However, once the sponsor reaches age 65, Medicare Part B must be in effect no later than the sponsor's retirement date to avoid a break in TRICARE coverage.*

of study at an approved institution of higher learning, and if the sponsor provides over 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 are one of the following:

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

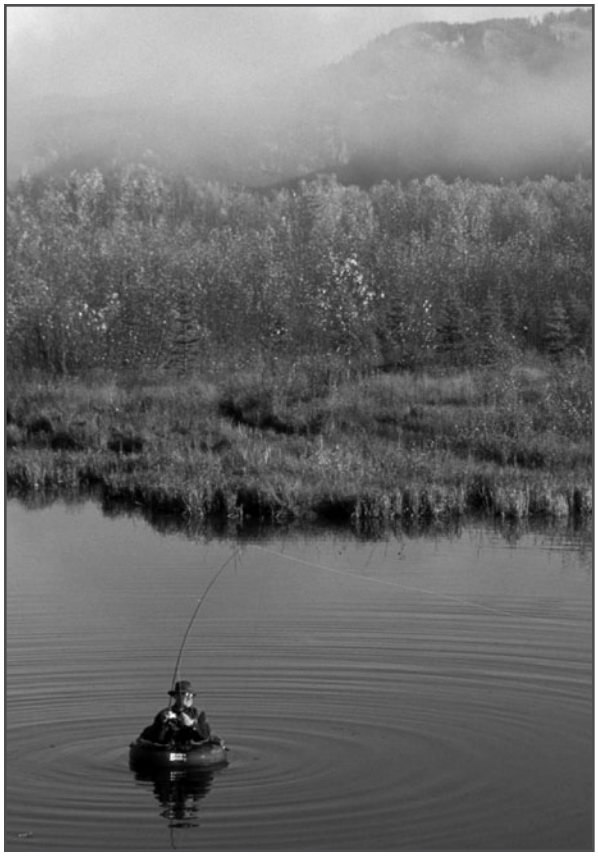
Note: Command sponsorship is an authorization entitling family members to travel overseas at the government's expense. Command-sponsored family members are included on their sponsors' change-of-station orders.

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

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

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, depending on individual MTF availability. Eligible Retired Reserve members under age 60 may qualify to purchase TRICARE Retired Reserve (TRR) coverage. Medicare-eligible retirees and family members who have both Medicare Part A and Part B receive benefits



under TRICARE For Life (TFL). See the *TRICARE Overseas Program Options* section of this handbook for more information.

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 Consecutive 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 entitled to Medicare Part A and have Part B*)

Pre-Activation Benefit

National Guard and Reserve members who are issued delayed-effective-date active duty orders for more than 30 consecutive 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 or TRR.

If you do not meet the pre-activation eligibility requirements, your coverage 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 (LOD) care through your uniformed service. Additionally, you may seek emergency and urgent care while serving on your orders. Visit **www.tricare.mil/lod** for more information on LOD care.

TRICARE 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 significantly 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), TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA), and the Continued Health Care Benefit Program (CHCBP)—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 stateside 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 or TOP Prime Remote, or they may use TOP Standard.

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 stateside 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 (DEERS) and you are not enrolled 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. For more information, see the *Getting Care* section of this handbook. 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 worldwide to TRICARE beneficiaries who are entitled to Medicare Part A and have Medicare Part B. If your sponsor is retired and you are entitled to premium-free Medicare Part A on your record or your spouse's record, you must have Medicare Part B to remain TRICARE-eligible. This rule applies to all TRICARE beneficiaries even though Medicare generally does not cover health care obtained outside of the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

Unless you have other health insurance (OHI), TRICARE is the primary payer for covered care you receive in areas where Medicare is not available. You are responsible for paying the TRICARE Standard annual deductible and cost-shares. When obtaining health care from host nation providers, expect to pay for your care at the time of service. You are responsible for filing claims 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. For more information about OHI, see "Other Health Insurance" in the *Claims* section of this handbook.

Note: Medicare may pay for services you receive on board a ship in the territorial waters adjoining the land areas of the United States and its territories. In these locations, TFL works exactly as it does in the United States.

To learn more about TFL, visit **www.tricare.mil/tfl** and **www.TRICARE4u.com**.

TRICARE Reserve Select

TRS is a premium-based health plan that stateside and overseas members of the Selected Reserve of the Ready Reserve 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, unless local TOP restrictions require only certified providers. However, certain services, including inpatient nonemergency behavioral health care, require prior authorization. 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 claims processor for reimbursement. For a list of providers, visit **www.tricare-overseas.com**.

TRICARE Retired Reserve

TRR is a premium-based health plan that stateside and overseas Retired Reserve members may qualify to purchase until reaching age 60. Qualifying members may purchase TRR member-only or member-and-family coverage and pay monthly premiums. Overseas, TRR works like TOP Standard for retirees, with the same retiree benefits, requirements, and costs. You may receive care from any host nation provider without a referral, unless local TOP restrictions require only certified providers. However, certain services, including inpatient nonemergency behavioral health care, require prior authorization. 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**.

TRICARE Young Adult

TYA is a premium-based program available to eligible young adults who have "aged out" of TRICARE benefits. The TYA program allows eligible young adults to purchase TRICARE coverage worldwide. If you are an adult-age dependent, you may purchase TYA coverage based on the eligibility established by your uniformed service sponsor and where you live.

TYA includes medical and pharmacy benefits, but excludes dental coverage. All TYA enrollees are eligible for TRICARE Standard and MTF care on a space-available basis. If eligible for TYA Prime, enrollees have TRICARE Prime access to care through their assigned military or civilian PCMs. TYA is only available for individuals and is not offered as a family plan.

Note: Special eligibility conditions may exist.

You may generally purchase TYA coverage if you are all of the following:

- A dependent of a TRICARE-eligible uniformed service sponsor
- Unmarried
- At least age 21 (*or age 23 if previously enrolled in a full-time course of study at an approved*

institution of higher learning and if the sponsor provided over 50 percent of the financial support), but have not yet reached age 26

You may **not** purchase TYA coverage if you are:

- Eligible to enroll in an employer-sponsored health plan as defined in TYA regulations
- Otherwise eligible for TRICARE program coverage
- Married

Note: Command sponsorship is required for TYA Prime enrollment overseas.

TYA offers open enrollment, so, if you qualify, you may purchase coverage at any time. Visit **www.tricare-overseas.com** for more information.

Children of National Guard and Reserve Members

If you are an adult child of a non-activated member of the Selected Reserve of the Ready Reserve or the Retired Reserve, your sponsor must be enrolled in TRS or TRR for you to be eligible to purchase TYA coverage.

Continued Health Care Benefit Program

CHCBP is a premium-based health care program administered by 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 Transitional Assistance Management Program coverage. CHCBP acts as a bridge between military health care benefits and your new civilian health care plan. CHCBP is similar to TRICARE Standard with the same benefits, providers, and rules. For more information about CHCBP, visit Humana Military's Web site at **Humana-Military.com** or call **+1-800-444-5445**.

Note: CHCBP enrollees are not legally entitled to space-available care at MTFs.

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 you have 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 Retired Reserve (TRR)
- TRICARE Young Adult (TYA)
- TRICARE Plus*
- Continued Health Care Benefit Program (CHCBP)

** TRICARE Plus is a military treatment facility (MTF) primary care option that requires enrollment if offered at specific MTFs.*

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), or call your Global TRICARE Service Center (*Option 4 off the TOP Regional Call Center menu*). 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 active duty family members (ADFMs) may enroll in stateside TRICARE Prime in the regions where they live. If they are currently enrolled in TRICARE Prime Remote for Active Duty Family Members (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.

Note: TRICARE Extra is not available overseas.

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 7.3 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 or TOP Prime Remote 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 or TOP Prime Remote 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 (*select Option 4*) 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 (*E-5 and above*) may change their enrollment status twice in an enrollment year before a one-year enrollment lockout applies.
- **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. You may also qualify to purchase CHCBP, which is the TRICARE Standard benefit without access to military treatment facility care on a space-available basis. The Defense Manpower Data Center sends you a certificate of creditable coverage when TRICARE eligibility ends. See "Loss of Eligibility" in the *Changes to Your TRICARE Coverage* section of this handbook 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 members of the Selected Reserve of the Ready Reserve 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. Annual deductibles and cost-shares apply. Visit **www.tricare.mil/trs** information about TRS coverage.

TRICARE Retired Reserve Enrollment

TRR requires enrollment. TRR is a premium-based health care plan that qualifying Retired Reserve members may purchase. TRR offers coverage similar to TRICARE Standard for retirees, but a monthly premium is charged. You will receive comprehensive coverage and can obtain care from any TRICARE-authorized provider. Annual deductibles and cost-shares apply. Visit **www.tricare.mil/trr** for information about TRR coverage.

TRICARE Young Adult Enrollment

The TYA program is a premium-based health care plan available for purchase by qualified dependents. Adult-age dependents until reaching age 26 may purchase TYA coverage based on the eligibility established by their uniformed service sponsor and where they live. Command sponsorship is required for TYA Prime enrollment overseas. TYA includes medical and pharmacy benefits, but excludes dental coverage. Visit **www.tricare.mil/tya** for information about TYA coverage. To purchase TYA coverage, submit a *TRICARE Young Adult Application* (DD Form 2947) 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 Call Center or TSC to request a form.

Note: Special eligibility conditions may exist.

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, 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 TRICARE Plus[1]
3	Non-TOP Prime and non-TOP Prime Remote ADFMs TRICARE Reserve Select for members of the Selected Reserve of the Ready Reserve and their families
4	Retired service members, their families, and all others not enrolled in TOP Prime or TOP Prime Remote TRICARE Retired Reserve for Retired Reserve members and their families

1. TRICARE Plus enrollees have access to primary care, but not specialty care, at the TRICARE Prime level. Otherwise, they have access on a space-available basis.

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. (International SOS). Check with your TOP Regional Call Center before visiting host nation providers. Local TOP restrictions may require you to see only certified providers in your location.

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. You must submit proof of payment with overseas claims. TRICARE nonparticipating non-network providers may charge up to 115 percent of the TRICARE-allowable amount in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). However, there is **no limit** to the amount that nonparticipating non-network providers may bill in overseas locations, and you are responsible for paying any amount that exceeds the TRICARE-allowable amount. 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 and then call the Medical Assistance number for your region. Prior authorization is not required. However, continued care must be coordinated to include

subsequent authorizations and payment. TOP Prime beneficiaries must contact their MTF primary care managers (PCMs) and TOP Prime Remote beneficiaries must contact International SOS before leaving the facility, preferably within 24 hours or on the next business day.

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. You can also call 911 or your civilian insurance company.

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 care 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 TRICARE Overseas Program Prime Remote Active Duty Service Members" later in this section.

TRICARE Overseas Program Prime and TRICARE Overseas Program 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. 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 for a medically diagnosed and covered condition per fiscal year (FY) (*October 1–September 30*)
- Beneficiaries with other health insurance

The POS option results in higher out-of-pocket costs. TRICARE 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.

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 for a medically diagnosed and covered condition to a network host nation 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 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 a host nation provider without a PCM referral, you are using the POS option, resulting in higher out-of-pocket costs.

TOP Prime Remote beneficiaries should contact the TOP Regional Call Center to coordinate care. 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 a Canadian Forces Health Facility (CFHF) 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 care 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 TOP Regional 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. For TOP Prime Remote beneficiaries, your PCM or the specialist must contact your TOP Regional Call Center to obtain authorization for additional specialty care, if necessary. For TOP Prime beneficiaries, your MTF will issue a referral for care.

Specialty Care for TRICARE Overseas Program Prime Remote Active Duty Service Members

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 TRICARE Area Office (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 of this handbook or visit **www.tricare-overseas.com**.

Fitness-for-Duty Appointments

The local TRICARE point of contact (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, unless local TOP restrictions require seeing certified providers. 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 TOP Regional Call Center for assistance.

You do not need a referral for care. Prior authorization is required for certain services, including nonemergency inpatient behavioral health care admissions.

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

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, and family counseling.

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

- Adjunctive dental services
- Nonemergency care received in the continental United States
- 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 may have 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 proposed 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, or TOP Regional Call Center to explain your situation and ask questions about the first specialist's suggested care. Then you, your PCM, or your primary care provider can request a referral to another specialist by working with your TSC 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. 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.

Behavioral Health Care Services

Please see *Appendix B* of this handbook for details on covered 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, 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 care facility and then 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 for the first eight outpatient behavioral health care visits to network host nation providers for medically diagnosed and covered conditions per fiscal year (FY) (*October 1–September 30*). If you need non-medical counseling not covered under TRICARE, you may be eligible for services through a military family support center or counseling services in your community. After the eighth visit, your behavioral health care provider must obtain prior authorization. Point-of-service (POS) fees apply to care received from a non-network host nation provider without a referral and prior authorization.

TRICARE Overseas Program Standard Behavioral Health Care

TOP Standard beneficiaries do not need prior authorization for the first eight outpatient behavioral health care visits to host nation providers for medically diagnosed and covered conditions per FY. However, prior authorization is required for additional visits.

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 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.
- **Certified psychiatric nurse specialists** are licensed, master's-level psychiatric nurses with an additional American Nurses Association certification in behavioral health care. Certified psychiatric nurse specialists include both psychiatric nurse specialists and psychiatric nurse practitioners. Psychiatric clinical nurse specialists mainly perform psychotherapy while psychiatric nurse practitioners generally provide medication management.
- **Clinical psychologists** have doctoral-level degrees in philosophy or in psychology. They perform psychotherapy, psychological testing, and counseling services, but usually 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.
- **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).
- **Psychiatrists** are physicians who have general medical degrees (*MDs or DOs*) and have completed advanced residency training in psychiatry. Most psychiatrists treat patients 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 **www.tricare.mil/mentalhealth** for more information.

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.

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. You may fill prescriptions at military treatment facility (MTF) pharmacies, through TRICARE Pharmacy Home Delivery, at retail pharmacies, or at host nation pharmacies. Host nation pharmacies are non-network; therefore, when filling a prescription at host nation pharmacies, you will pay the full cost up front and file a claim for reimbursement with International SOS Assistance, Inc. (International SOS).

You need a prescription and a valid uniformed services identification (ID) card or Common Access Card to fill prescriptions in overseas locations, including the U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa.

Visit **www.tricare.mil/pharmacy** for pharmacy costs and for information about the TRICARE pharmacy benefit administered by Express Scripts, Inc. (Express Scripts) in the United States and U.S. territories.

Note: Beneficiaries residing in the Philippines must use a certified pharmacy in the Philippines. For more information about getting care in the Philippines, **visit www.tricare.mil**.

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. Most MTF pharmacies accept prescriptions written by both civilian and military providers, regardless of whether you are enrolled at the MTF. 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.

TRICARE Pharmacy Home Delivery

Outside of the United States and U.S. territories, you can only use TRICARE Pharmacy Home Delivery 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. TRICARE Pharmacy Home Delivery is your least expensive option when not using an MTF. There is no cost-share for home delivery for ADSMs. For all other beneficiaries, there is no cost-share to receive up to a 90-day supply of formulary generic medications. Copayments apply for formulary brand-name

and non-formulary medications. Additionally, prescriptions are delivered to you with free standard shipping, and refills can be easily ordered online, by phone, or by mail.

TRICARE Pharmacy Home Delivery 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 TRICARE Pharmacy Home Delivery by using any of the options in Figure 5.1.

Note: Beneficiaries residing in Germany cannot use the home delivery option due to country-specific legal restrictions. If you live in Germany, you should fill prescriptions at MTF pharmacies or host nation pharmacies.

For faster processing of your home delivery prescription, register for TRICARE Pharmacy Home Delivery 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 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 TRICARE Pharmacy Home Delivery if your OHI does not cover the medication you need or if you exceed the OHI's coverage dollar limit.

Note: Diabetic supplies (*e.g., syringes and needles, blood and urine test strips, lancets*) are also available through TRICARE Pharmacy Home Delivery.

TRICARE Pharmacy Home Delivery Contact Information ***Figure 5.1***

Online	Visit **www.express-scripts.com/TRICARE**
Phone	Dial your toll-free in-country access code: • **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 52132 Phoenix, AZ 85082 USA

TRICARE Retail Network Pharmacy

TRICARE retail network pharmacies are only available in the United States and the U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa. You must present your prescription and your uniformed services ID card to the pharmacist.

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 **+1-866-ASK-4PEC (+1-866-275-4732)** 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 use host nation pharmacies. TOP Standard deductibles and cost-shares apply when non-TOP Prime and non-TOP Prime Remote beneficiaries use 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 reimbursed if International SOS confirms 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.

Call your TOP Regional Call Center with pharmacy questions.

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. For a general list of TRICARE-covered prescription drugs with quantity limits, visit **www.pec.ha.osd.mil/formulary_search.php**.

Prior Authorization

Some drugs require prior authorization. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics (P&T) Committee, brand-name medications with generic equivalents, medications with age limitations, and medications prescribed for quantities exceeding normal limits. Visit **www.pec.ha.osd.mil/formulary_search.php** for a general list of TRICARE-covered prescription drugs that require prior authorization. Call **+1-866-ASK-4PEC (+1-866-275-4732)** to inquire about a specific drug.

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. Prescribers may call the Express Scripts Prior Authorization line at **+1-866-684-4488** to submit a request for a brand-name drug to be dispensed instead of a generic, or a completed *Brand over Generic Prior Authorization Request Form* may be faxed to **1-866-684-4477**. This form may be found at **http://pec.ha.osd.mil/forms_criteria.php**.

Non-Formulary Drugs

The DoD P&T 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 TRICARE Pharmacy Home Delivery 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 **+1-866-ASK-4PEC (+1-866-275-4732)**.

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 TRICARE Pharmacy Home Delivery or at retail network pharmacies at no cost. Overseas ADSMs must have APO/FPO addresses to use TRICARE Pharmacy Home Delivery, unless they live in U.S. territories. Refrigerated medications cannot be shipped to APO/FPO addresses. Retail network pharmacies are only located in the United States and the U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa.

Visit the TRICARE Formulary Search Tool at **www.pec.ha.osd.mil/formulary_search.php** 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 TRICARE Pharmacy Home Delivery. 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 TRICARE Pharmacy Home Delivery, and participation is voluntary. If you or your provider orders a specialty medication from TRICARE Pharmacy Home Delivery, Express Scripts sends you additional information about the Specialty Medication Care Management program and how to get started.

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, TRICARE Pharmacy Home Delivery ships your specialty medication to your U.S. Postal Service or APO/FPO address. For your convenience and safety, TRICARE Pharmacy Home Delivery contacts you to arrange delivery before the medication is shipped.

Note: Some specialty medications may not be available through TRICARE Pharmacy Home Delivery because the medication's manufacturer limits the drug's distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, TRICARE Pharmacy Home Delivery either forwards your prescription to a pharmacy of your choice that can fill it or provides you with instructions about where to have it filled. Visit

www.pec.ha.osd.mil/formulary_search.php to determine if your specialty medication is available through TRICARE Pharmacy Home Delivery.

Dental Options

Overseas ADSMs receive dental care at military overseas dental treatment facilities (ODTFs). For all other beneficiaries, TRICARE offers two dental programs—the TRICARE Dental Program (TDP) and the Enhanced-Overseas TRICARE Retiree Dental Program (TRDP). Each benefit is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

Active Duty Dental Care

Most overseas ADSMs receive dental care at military ODTFs. International SOS coordinates dental care services for ADSMs in remote overseas locations.

When ADSMs enrolled in TOP Prime or TOP Prime Remote are in the United States or U.S. territories for duty or leave, they may receive emergency care from civilian providers through the TRICARE Active Duty Dental Program (ADDP). This care is limited to emergency care and should be coordinated with the contractor, United Concordia Companies, Inc., to ensure prompt payment.

ADDP phone number: **+1-866-984-ADDP** (**+1-866-984-2337**)

ADDP Web site: **www.addp-ucci.com**

Note: Treatment plans that exceed $750 per episode or $1,500 per calendar year require prior authorization and approval from the TRICARE Area Office (TAO) Dental Consultant (*or designee*), even for routine care.

TRICARE Dental Program

The TDP benefit, administered by MetLife, is a voluntary dental insurance program available worldwide 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 higher cost-shares for certain services.

Visit **https://mybenefits.metlife.com/tricare** or call MetLife at **+1-855-MET-TDP2 (+1-855-638-8372)** 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 benefit 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 you are strongly encouraged 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:

- Anesthesia for pain management during labor and delivery
- Hospitalization for labor, delivery, and postpartum care
- Management of high-risk or complicated pregnancies
- Medically necessary caesarean section
- Medically necessary fetal ultrasounds
- Obstetric visits throughout your pregnancy

Newborns are covered separately. See "Having a Baby or Adopting a Child" in the *Changes to Your TRICARE Coverage* section of this handbook 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

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

TRICARE Overseas Program Prime and TRICARE Overseas Program Prime Remote

If you are a TOP Prime beneficiary, visit your PCM or primary care provider as soon as you think you may be pregnant. If you are a TOP Prime Remote beneficiary, your TOP Regional Call Center will assist you with coordinating care. 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, or TRICARE Service Center (TSC).

Active Duty Family 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. For CHCBP details, visit **Humana-Military.com**. To learn more about TAMP, visit **www.tricare.mil/tamp**.

TRICARE Overseas Standard

If you are a TOP Standard beneficiary, visit a provider that arranges or provides obstetrical services as soon as you think you may be pregnant. The TOP Regional Call Center can assist you with finding a provider.

Maternity care services for TOP Standard beneficiaries do not require referrals or prior authorizations. For more information, contact the TOP Regional Call Center or a TSC.

Women, Infants, and Children Overseas Program

DoD offers the Women, Infants, and Children (WIC) Overseas Program to eligible participants living overseas, including ADSMs and their family members; DoD civilian employees and their family members; and DoD contractors and their family members. The WIC Overseas Program supplements the food that participants usually buy with additional nutritious foods. Program staff members provide ideas for meal planning and food preparation. Your WIC Overseas Program 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 age 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 MTF 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 **only** available in the United States and 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**.

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

For ADFMs with an autism spectrum disorder diagnosis who are registered in ECHO, TRICARE covers applied behavior analysis (ABA) through the DoD Enhanced Access to Autism Services Demonstration.

Note: Active duty sponsors with family members seeking ECHO registration must enroll in their service's Exceptional Family Member Program (*unless waived in specific situations*) and register for ECHO with International SOS in order to be eligible for ECHO benefits.

ECHO provides coverage for the following products and services:

- ABA (*which includes the DoD Enhanced Access to Autism Services Demonstration*), and other services that are not available through schools or other local community resources
- Assistive services (*e.g., those from a qualified interpreter or translator*)
- Durable equipment, including adaptation and maintenance equipment
- 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 and limited to the 50 United States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands*)
- ECHO respite care: up to 16 hours of care per month when another ECHO service is rendered
- EHHC respite care: up to eight hours per day, five days per week (*for those who qualify*)
- Training to use special education and assistive technology devices
- Institutional care when a residential environment is required
- Transportation to and from institutions or facilities in 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**.

TRICARE Overseas Program Prime and TRICARE Overseas Prime Remote Department of Defense Aeromedical Evacuation

When medical care is not available at your location, you may be eligible for DoD 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), TRICARE Reserve Select, and TRICARE Retired Reserve 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 coordinate 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 TOP Regional Call Center coordinates with the Joint Patient Movement Requirements Center and the Theater Patient Movement Requirements Center (TPMRC) Eurasia-Africa and arranges for an accepting physician to meet you at your destination. TOP Prime Remote beneficiaries should call International SOS and TOP Prime beneficiaries should call TPMRC. Your unit's medical liaison, TRICARE point of contact (POC), or International SOS 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 5.2 on the following page*).

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.

For information about evacuating from your current location, see *Appendix B* of this handbook.

Eurasia-Africa Evacuation Contacts *Figure 5.2*

Theater Patient Movement Requirements Center	+49-6371-47-8040 +49-6371-47-2235 +49-6371-47-2264 314-480-8040 (*DSN*) 314-480-2235 (*DSN*) 314-480-2264 (*DSN*) tpmrc.europe@ramstein.af.mil
Joint Patient Movement Requirements Center	+974-458-9555, ext. 436 4418/4417 318-436-4418 (*DSN*)
TOP Regional Call Center	+44-20-8762-8384 Medical Assistance +44-20-8767-8133

If you are evacuating to Germany, see Figure 5.3 for emergency contact details.

Germany Evacuation Contacts *Figure 5.3*

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 5.4 lists aeromedical evacuation contact information for Latin America and Canada.

Latin America and Canada Evacuation Contacts *Figure 5.4*

Canada (*for beneficiaries enrolled in Canada*)	Contact your Canadian Forces Health Information Line. • **Locate a Canadian Forces Health Facility:** +1-613-945-6653
Other areas and for TRICARE Prime and TRICARE Prime Remote active duty service members and family members visiting Canada[1]	• **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 TRICARE 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 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 arranges emergency

and urgent medical evacuation and care. See Figure 5.5 for medical evacuation contact details for the Pacific area.

Pacific Evacuation Contacts *Figure 5.5*

Singapore	• **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 are enrolled in TOP Prime or TOP Prime Remote, and do not coordinate urgent or routine care in advance with your PCM, you may use the POS option, resulting in 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

Please see *Appendix B* of this handbook for a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist.

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

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.

For a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist, please see *Appendix B* of this handbook. For more information, visit **www.tricare-overseas.com**.

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 certain other countries are reimbursed based on government-provided foreign fee schedules.

Claims for care received overseas must be filed within three years of the date of service or within three years of the date of an inpatient discharge. **Note:** Claims for separately billed professional charges incurred during an inpatient admission must be submitted within three years of the **date the service was received**, even if that date is before the date you were discharged.

In the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), claims must be filed within one year of service or the date of inpatient discharge.

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., (International SOS) 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/contacts**.

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) or Department of Defense Benefit Number (DBN) (*Eligible former spouses should use their SSNs or DBNs, 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 delays.

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 may apply for TRICARE For Life (TFL) claims. TFL beneficiaries should visit **www.tricare.mil/tfl** for more information.

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 USA	**Send claims to:** TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 USA	**Send claims to:** TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 USA

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 Program P.O. Box 8976 Madison, WI 53708-8976 USA	**Send claims to:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 USA	**Send claims to:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 USA

Figures 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
USA

Filing Claims Online

You can file claims online or using paper forms. To file a claim online, you must register on **www.tricare-overseas.com**. Once you register and log in to the "Beneficiary Portal" landing page, click "Send/View Secured Message" in the "Contact Customer Service" section. To submit a claim, click the "New Message" button. After the "New Message" screen appears, choose "Other" as the subject for your message. You should enter "New Claim" as your message subject description.

Enter claim details in the fields that appear and input your provider's name, claim's total billed amount, and dates of service (*dates the procedures or services appearing on the claim were performed*). Then, scan and attach your claim documents and bills to the message in the "Attachment" field.

To learn more about how to file claims through the secured message claim submission portal, visit **www.tricare-overseas.com** and access the International SOS online training course. To access the course, launch the Computer-Based Training Module at the bottom left-hand side of the Beneficiary landing page at **www.tricare-overseas.com/beneficiaries.htm**. For more information on the claims-filing process, visit **www.tricare.mil/claims**.

Proof-of-Payment Requirements Overseas

You must submit proof of payment with all claims. Proof of payment is necessary for TRICARE to validate claims and safeguard benefit dollars.

When submitting your *DD Form 2642*, you should also include an itemized bill or invoice, diagnosis describing why you received medical care, and/or an explanation of benefits from your other health insurance, if applicable. A canceled check or credit card receipt showing payment for medical supplies or services often satisfies the proof-of-payment requirement. If you paid for care or supplies in cash, TRICARE may ask for proof of cash withdrawal from your bank or credit union along with a receipt from your provider.

If you have questions regarding proof-of-payment requests, claims submissions, or the status of a submitted claim, contact your TOP Regional Call Center, and press Option 2 for claims assistance.

Other Health Insurance

For those beneficiaries with other health insurance (OHI), TRICARE is always the second payer. Beneficiaries should visit **www.tricare-overseas.com** and click on the "Beneficiary Forms" page to download the *OHI Questionnaire*. Overseas claims cannot be properly processed if OHI has not been properly declared. Conversely, if a beneficiary formerly had OHI and it was terminated, he or she needs to fill out this form to declare termination of OHI.

Foreign Currency or U.S. Dollar Reimbursement

The TOP contractor issues reimbursements to beneficiaries in USD unless the beneficiary specifically requests 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., USD, 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 TRICARE Pharmacy Home Delivery. 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. For more information, refer to "Host Nation Pharmacy Claims" later in this section.

TRICARE Pharmacy Program Claims

When visiting non-network retail pharmacies in the United States and U.S. territories of 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.

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

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
USA

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
USA

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 active duty service members [ADSMs]*) or Figure 6.2 (*for non-ADSMs*) earlier in this section 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 on the following page.

Filing an Appeal

Appeals must be filed in writing with the TOP contractor within 90 days after the date that appears on the explanation of benefits (EOB) 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.

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
- Sponsor's SSN or DBN
- 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 written appeal to the TOP contractor. For appeals filing information, see Figure 6.4 on the following page.

TRICARE Appeal Requirements *Figure 6.3*

1	An appropriate appealing party must submit the appeal. Proper appealing parties include: • You, the beneficiary • Non-network participating providers If a party other than those listed above submits the appeal, you will generally be required to complete and sign an *Appointment of Representative* form, which is available on your regional contractor's Web site. Appeals submitted without this form will not be processed, except in the following cases: • A custodial parent submits an appeal on behalf of a minor beneficiary • An attorney files an appeal without specific appointment by the proper appealing party **Note:** Network providers are not appropriate appealing parties, but may be appointed as representatives, in writing, by you.
2	The appeal must be submitted in writing. See Figure 6.4 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 USA	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992 USA	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992 USA

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) 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 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 of 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 Up To Date!" 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 the spouse and children are registered in DEERS, they receive uniformed services ID cards and are eligible for TRICARE Overseas Program (TOP) Standard. Sponsors who wish for new family members to enroll in TOP Prime or TOP Prime Remote 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.

Conversely, when children of a sponsor marry, they lose TRICARE eligibility. The sponsor must report the marriage of a dependent child to the nearest uniformed services ID card-issuing facility (*or DEERS representative, in remote locations*).

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. The new family members are covered under TOP Standard, unless they enroll in TOP Prime or TOP Prime Remote. To enroll, new family members must have command sponsorship and submit a *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876) or *TRICARE Young Adult Application* (DD Form 2947) 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 until reaching 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 over 50 percent of the financial support*), as long as his or her DEERS information is current. To extend benefits for your college student beyond age 21, contact DEERS to verify what documentation is needed. See "Keep Your DEERS Information Up To Date!" in the *Welcome to the TRICARE Overseas Program* section of this handbook for contact information.

TRICARE Young Adult (TYA) is a premium-based program available to young adults who

have "aged out" of TRICARE benefits. The TYA program allows eligible young adults to purchase TRICARE Prime or TRICARE Standard coverage worldwide. For more information on TYA, see "TRICARE Young Adult" in the *Overseas Program Options* section of this handbook or visit **www.tricare.mil/tya**.

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 before the age of 55 (*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 name and Social Security number (SSN) or Department of Defense Benefits Number (DBN) 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

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, dissolutions, or annulments on or before September 29, 1988, contact DEERS to verify eligibility.

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 Social Security card 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. 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.

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 until reaching 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 over 50 percent of the financial support*), as long as his or her DEERS information is current. To extend benefits for your college student beyond age 21, contact DEERS for eligibility criteria. See "Keep Your DEERS Information Up To Date!" 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 under the sponsor's plan 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.

Qualified dependents who are no longer eligible for TRICARE benefits under their sponsor's plan may qualify to purchase health care coverage through TYA. For more information on TYA, see "TRICARE Young Adult" in the *Overseas Program Options* section of this handbook.

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 Program Prime Remote

If your child is enrolled in TOP Prime 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

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.

Attending School in the United States

If your child is eligible for TRICARE Prime and 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. See Figure 7.3 later in this section for regional contractor contact information. If the school is not located in a PSA or your child is not eligible for TRICARE Prime, he or she may use TRICARE Standard and TRICARE Extra.

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 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.

Note: Failure to receive prior authorization for care that requires it may result in the claim being denied.

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 greater than 30 consecutive days, who should follow normal procedures for emergency care, which may include providing a copy of their orders to the local TOP Regional Call Center to verify TRICARE eligibility.*

TRICARE Overseas Program Prime (*Active Duty Family Members*)

Traveling Overseas

In an emergency, go to the nearest emergency care facility or call the Medical Assistance number 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. Beneficiaries based in the United States who seek health care while traveling overseas should file their claims with the TOP contractor.

Note: TRICARE Prime enrollees need a PCM referral for urgent or routine care received on board a ship; otherwise the care may be covered under the point-of-service (POS) option at a higher out-of-pocket cost.

Traveling in the United States

Emergency Care

Emergency care in the United States does not require a referral or authorization. In an emergency, call 911 or go to the nearest emergency room. If you are admitted, you must notify your 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.

Urgent Care

If you are a TOP Prime Remote beneficiary and urgent treatment cannot wait until you return home, you must contact your TOP Regional Call Center for assistance before receiving care.

Generally, a TRICARE Prime enrollee needs a PCM referral if the PCM is not providing the services. If you are an active duty family member (ADFM) and you do not coordinate urgent care with your PCM or regional contractor, the care will be covered under the POS option,* resulting in higher out-of-pocket costs.

Note: TRICARE Prime enrollees need a PCM referral for urgent or routine care received on board a ship; otherwise the care may be covered under the POS option at a higher out-of-pocket cost.

* *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 for a medically diagnosed and covered condition, clinical preventive services from network providers, emergency care, or beneficiaries with OHI.*

Emergency Care vs. Urgent Care — *Figure 7.2*

Emergency Care	Urgent 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 and the absence of immediate medical attention would result in a threat to life, limb, or sight. It also includes 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. Examples of emergencies include: • No pulse • Severe bleeding • Spinal cord or back injury • Chest pain • Severe eye injury • Broken bone • Inability to breathe	TRICARE defines urgent care as medically necessary treatment for an illness or injury that would not result in further disability or death if not treated immediately but that requires professional attention within 24 hours. Examples of urgent care situations include: • Minor cuts • Migraine headache • Urinary tract infection • Sprain • Earache • Rising fever

Routine Care

To receive routine care in the United States, TOP Prime beneficiaries are required to obtain a referral from their PCM before leaving the host nation or TOP area where enrolled. If already in the United States, you should contact your PCM to request the referral.

Note: Your PCM is required to provide a referral with justification for receiving routine care while in the United States. Your TOP Regional Call Center will then issue an authorization for you to receive routine care while in the United States.

TOP Prime Remote beneficiaries should call the TOP Regional Call Center for the TOP area where enrolled to obtain a prior authorization before traveling. If already in the United States, you should contact the TOP Regional Call Center for the area where you are enrolled using the international direct dial or stateside toll-free numbers. Your TOP Regional Call Center will then issue an authorization to receive routine care while in the United States if appropriate care is not available at the remote location where you reside.

Note: TOP Prime and TOP Prime Remote beneficiaries are encouraged to seek care from a U.S. MTF if one is located nearby. If this is not possible, you should seek care from a TRICARE-approved provider in the United States to ensure access to quality care. Please visit the regional contractors' Web sites listed in Figure 7.3 later in this section to find an MTF or TRICARE-approved provider in the United States region where you are located.

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, unless local TOP restrictions require seeing a certified provider. When seeking care from an overseas host nation 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.

If you need emergency care while traveling overseas, go to the nearest emergency care facility or contact the TOP Regional Call Center for the overseas area where you are traveling to find a host nation provider.

If you need urgent care while traveling overseas, you do not need a referral, but you can call the TOP Regional Call Center for assistance.

Beneficiaries based in the United States who seek health care while traveling overseas should file their claims with the TOP contractor.

Traveling in the United States

In an emergency, call 911 or go to the nearest emergency room. If you seek care from a TRICARE network provider in the United States, the provider files the claim with the TOP claims processor for you. If you seek care from an authorized non-network provider, expect to pay up front and file a claim with the TOP claims processor.

Save your receipt as proof of payment, and be sure to put your overseas address on the claim. Always file claims with the TOP claims processor using the mailing addresses assigned for your home region, not with the stateside regional contractor in the area where you are traveling. Submitting your claim to a stateside regional contractor may result in your payment being delayed. For additional claims-filing information, see the *Claims* section of this handbook.

Note: 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 claims processor in the overseas region where you live.

Filling Prescriptions on the Road

You may use any available TRICARE Pharmacy Program 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 the U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa. To find the nearest TRICARE retail network pharmacy, visit **www.express-scripts.com/TRICARE** or call **+1-866-ASK-4PEC (+1-866-275-4732)**.

TRICARE Pharmacy Home Delivery

If you are away from home for an extended period of time, you can plan ahead to receive prescriptions through TRICARE Pharmacy Home Delivery, 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. TRICARE Pharmacy Home Delivery is only available in the United States, U.S. territories, and overseas if you have an APO/FPO address or are assigned to a U.S. Embassy or State Department.

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 for reimbursement. See the *Claims* section of this handbook for details about filing pharmacy claims. ADSMs are fully reimbursed for covered, prescribed medications. If you are a TOP Prime or TOP Prime Remote ADFM, POS fees apply when you visit non-network pharmacies.

Moving

TOP Prime, TOP Prime Remote, and TOP Standard coverage is portable. You can easily transfer your TOP Prime or TOP Prime Remote enrollment when you move within your overseas area, to a new TRICARE overseas area, or to the United States.

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

TOP Prime and TOP Prime Remote

If you are an ADSM or ADFM moving to a new location, the easiest way to transfer your TRICARE Prime enrollment is to call your current TOP Regional Call Center to begin the process. If you are moving to a new region (*either overseas or stateside*), your information will be sent to your new TOP Regional Call Center or stateside regional contractor, who will follow up with you to complete the enrollment transfer after you arrive at your new location. Your new region will also assign a PCM best suited to your needs and the location of your work or home. If you are moving within your current overseas region, your TOP Regional Call Center will help you transfer to a new PCM.

If you need care before your transfer is processed, contact the TOP Regional Call Center or regional contractor for the region you are moving from for authorization and referral information. If you prefer to call your new TOP Regional Call Center or regional contractor upon arrival at the new location, then your new region can also transfer your TRICARE Prime enrollment at that time.

Note for beneficiaries moving to the United States: ADFMs who make a permanent change-of-station move to the United States remain enrolled in TOP Prime or TOP Prime Remote for a maximum of 60 days from the date you leave your overseas area. 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. 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.

Note: This enrollment transfer option is only available to ADSMs and ADFMs with TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TOP Prime, or TOP Prime Remote.

TOP Standard

Moving Overseas

Whether you move to another area within the same TRICARE overseas area or to a different area, 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

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. See Figure 7.3 for contact information.

U.S. TRICARE Regional Contractor Contact Information ***Figure 7.3***

TRICARE North Region	TRICARE South Region	TRICARE West Region
Health Net Federal Services, LLC +1-877-TRICARE (+1-877-874-2273) www.hnfs.com	**Humana Military, a division of Humana Government Business** +1-800-444-5445 Humana-Military.com	**UnitedHealthcare Military & Veterans** +1-888-571-4829 (*overseas*) 1-877-988-WEST (1-877-988-9378) (*stateside*) www.uhcmilitarywest.com

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. Transitional health care options include 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 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 service 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
- 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.

Note: Under TAMP, 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. An ADSM is not eligible to change his or her PCM while on terminal leave. You must 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 TOP Prime or stateside TRICARE Prime* 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 period 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 or stateside TRICARE Prime during the TAMP period.

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 enrollment is subject to the "20th of the month" rule. For more information, visit **www.tricare.mil/enroll**.*

Continued Health Care Benefit Program

CHCBP is a premium-based health care program administered by 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 is similar to TRICARE Standard with the same benefits, providers, and rules. For more information about CHCBP, visit Humana Military's Web site at **Humana-Military.com** or call **+1-800-444-5445**. **Note:** CHCBP enrollees are not legally entitled to space-available care at MTFs.

National Guard and Reserve Coverage

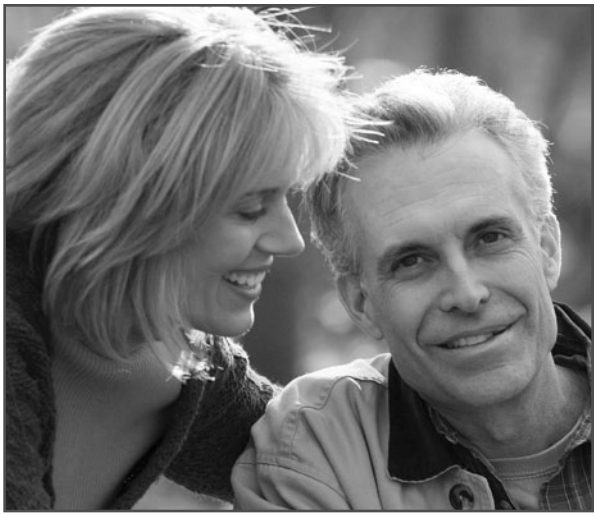
TRICARE Reserve Select (TRS) is a premium-based health care plan that Selected Reserve of the Ready Reserve members (*when not activated for a period of more than 30 consecutive days*) may qualify to purchase. Member-only and member-and-family enrollments are available. Overseas, TRS coverage works like 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, unless local TOP restrictions require only certified providers. Beneficiaries are responsible for paying monthly premiums, annual deductibles, and cost-shares. For more information about TRS coverage, visit **www.tricare.mil/trs**.

TRICARE Retired Reserve (TRR) is a premium-based health care plan that Retired Reserve members may qualify to purchase. Member-only and member-and-family enrollments are available. Overseas, TRR coverage works like TOP Standard for retirees, with similar benefits, requirements, and costs. TRR beneficiaries receive comprehensive coverage and can obtain care from any host nation provider without a referral, unless local TOP restrictions require only certified providers. However, some services require prior authorization. Beneficiaries are responsible for paying monthly premiums, annual deductibles, and cost-shares. For more information about TRR coverage, visit **www.tricare.mil/trr**.

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 rates. See "Dental Options" in the *Covered Services, Limitations, and Exclusions* section of this handbook 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 (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), Medicare pays for 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.

Eligibility for TRICARE and Veterans Affairs Benefits

Certain beneficiaries are eligible for both TRICARE and U.S. Department of Veterans Affairs (VA) benefits programs, and they may choose which benefits they want to use. Further, a beneficiary can seek TRICARE-covered services even if he or she received treatment through the VA for the same medical condition during a previous episode of care. However, TRICARE does not duplicate payments made or authorized by VA for service-connected disability care.

Note: Eligibility for VA health care for service-connected disabilities is not considered double coverage.

Veterans Affairs Benefits as OHI

If you are entitled to VA benefits, and a VA provider is available near where you live, you may choose whether you see a TRICARE or VA provider. If

you are not Medicare-eligible, VA coverage is considered OHI and TRICARE pays second to any out-of-pocket costs for VA services.

If you are entitled to Medicare Part A due to age or another reason, you are considered Medicare-eligible, and must generally have Medicare Part B to keep your TRICARE benefit, even though Medicare does not cover overseas care.* TRICARE beneficiaries with Medicare Part A and Part B are covered by TFL, TRICARE's Medicare-wraparound coverage. Under TFL, Medicare acts as your primary insurance, and TRICARE acts as your last payer. VA care is not covered by Medicare, so if you seek care from a VA provider while you are using your TRICARE benefit, TFL pays first and Medicare pays nothing. In this situation, you pay the TRICARE Standard fiscal year deductible, cost-shares, and remaining billed charges. Alternatively, you may choose to use your VA benefit when seeing VA providers. To minimize your out-of-pocket costs once you are covered by TFL, you should seek care from providers who participate in both TRICARE and Medicare.

* *Certain beneficiaries may not need Medicare Part B to keep their TRICARE benefit. For more information, visit* ***www.tricare.mil/tfl****.*

Survivor Coverage

If you live in a TOP Prime location and your sponsor dies while serving on active duty for a period of more than 30 consecutive 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 before age 55 (*If you remarry, TRICARE eligibility cannot be regained later, even if you divorce or your new spouse dies.*)
- An unmarried child until reaching 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 over 50 percent of the financial support*)

Qualifying survivor children may purchase TYA coverage to continue receiving TRICARE benefits until reaching age 26. Visit **www.tricare.mil/tya** for more information.

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.

Dental Options for Survivors

TRICARE Dental Program Survivor Benefit Plan

When a sponsor dies while on active duty for a period of more than 30 consecutive days, surviving family members are eligible for TRICARE Dental Program (TDP) benefits. The TDP Survivor Benefit also applies to family members of the Selected Reserve of the Ready Reserve and the Individual Ready Reserve, regardless of whether the sponsor was on active duty orders at the time of his or her death. Eligible survivors do not need to be enrolled in the TDP at the time of the sponsor's death to receive the TDP Survivor Benefit.

The surviving spouse is eligible to receive survivor benefits for up to three years from the sponsor's date of death, regardless of the Survivor Benefit enrollment coverage start date.

Surviving children are eligible to receive survivor benefits until reaching 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 over 50 percent of the financial support*).

Eligible surviving family members enrolled at the time of their sponsor's death will be automatically enrolled in a TDP Survivor Benefit plan. Survivors will be notified of this enrollment change and the terms of the TDP Survivor Benefit.

Eligible surviving family members **not** enrolled in the TDP at the time of the sponsor's death will be notified of their TDP eligibility. The surviving spouse, parent, or legal guardian must elect to enroll in the TDP Survivor Benefit.

Visit **www.tricare.mil/dental** for more information.

TRICARE Retiree Dental Program

When your TDP Survivor Benefit plan ends, you may be eligible for the TRICARE Retiree Dental Program. For more information, visit **www.trdp.org**.

Dependent Parent Coverage

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-TRICARE 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 of this handbook for information about TRICARE Prime access standards. Visit **www.tricare.mil** for more information on MTF care eligibility for dependent parents and parents-in-law.

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.

Loss of Eligibility

Upon loss of TRICARE eligibility, each family member automatically receives a certificate of creditable coverage from the Defense Manpower Data Center. 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 preexisting 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 (*until reaching age 21, or 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support*), a certificate will be issued to the dependent child. (*At this point, if the child qualifies, he or she may choose to continue TRICARE coverage by purchasing TYA.*)
- 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
USA

The request must include:

- Sponsor's name and SSN or DBN
- Name of person the certificate is requested for
- Reason for the request
- Name and address on the certificate
- 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 MTF after-hours care number or 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 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 Social Security number or Department of Defense Benefits Number
- 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

Visit **www.tricare-overseas.com** to file grievances online. You may also print and sign the *TRICARE Overseas Program–Universal Grievance and Complaint Form* and mail it to International SOS:

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

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 TOP Fraud and Abuse Web site at **www.tricare-overseas.com/fraud.htm** to file a report. You can also report suspected fraudulent or abusive behavior by phone or e-mail. You can report any fraudulent or abusive behavior anonymously; all reports are kept strictly confidential.

- **Phone:** +1-877-342-2503 (*toll-free*)
  +1-215-354-5020 (*direct*)
- **E-mail:**
  TOPProgramIntegrity@internationalsos.com

We strongly encourage you to read your EOBs carefully.

Write to the TOP customer service department to report suspected fraud and abuse:

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

You can also e-mail **reportit@wpsic.com** or report fraud or abuse issues directly to TRICARE at **fraudline@tma.osd.mil**. 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

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 overutilization 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 local or U.S. average drug wholesale price, whichever is the lesser of the two amounts. 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 federal law. 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 individuals or organizations engaging in these activities, e-mail your concerns to TOP at **reportit@wpsic.com** or **TOPProgramIntegrity@internationalsos.com**.

Acronyms

AAP	American Academy of Pediatrics
ABA	Applied Behavior Analysis
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
ECHO	Extended Care Health Option
EHHC	ECHO Home Health Care
EOB	Explanation of benefits
FDA	U.S. Food and Drug Administration
FY	Fiscal year
GTSC	Global TRICARE Service Center
HIV	Human immunodeficiency virus
HNPCC	Hereditary nonpolyposis colorectal cancer
HPV	Human papillomavirus
ID	Identification
LOD	Line-of-duty
MD	Doctor of Medicine
MRI	Magnetic resonance imaging
MTF	Military treatment facility
ODTF	Overseas dental treatment facility
OHI	Other health insurance
P&T	Pharmacy and Therapeutics
PCM	Primary care manager
PHP	Partial hospitalization program
POC	Point of contact
POS	Point of service
PSA	Prime Service Area
RTC	Residential treatment care
SSA	Social Security Administration
SSN	Social Security number
SUDRF	Substance use disorder rehabilitation facility
TAMP	Transitional Assistance Management Program
TAO	TRICARE Area Office
TDP	TRICARE Dental Program
TDY	Temporary duty
TFL	TRICARE For Life
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
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TYA	TRICARE Young Adult
USD	U.S. dollars
WIC	Women, Infants, and Children

Appendix A

TRICARE Overseas Program Provider Types *Figure 10.1*

Provider Type	Description	Key Characteristics
Network Provider	Provider enters into a formal agreement with International SOS Assistance, Inc. (International SOS) to provide medical care or services to TRICARE Overseas Program (TOP) beneficiaries.	• Assurance that you are receiving quality care, because network providers' credentials have been reviewed and institutions site audited at least once every three years • Guarantee that provider can directly or indirectly communicate in English • Cashless/claimless services for TOP Prime and TOP Prime Remote beneficiaries • Network provider performance is monitored on an ongoing basis to help ensure beneficiary satisfaction and quality of care
Participating Non-Network Provider	Professional or institutional provider who does not have a contractual relationship with International SOS, but agrees to provide cashless/claimless care to TRICARE Prime beneficiaries	• Has undergone a verification that the provider is licensed to practice in the country in which he or she operates • Has not undergone the full International SOS credentialing process
Certified Provider (*Philippines*)	As the TOP contractor, International SOS is responsible for performing provider certification through on-site visits and license/credential validation in the Philippines. The Department of Defense may expand this requirement to other locations.[1]	• Verified to meet required TOP contract standards • Allowed to invoice TRICARE for TRICARE beneficiary claims • For the most up-to-date information about provider choice in the Philippines, visit **www.tricare.mil**
Nonparticipating Non-Network Provider[2]	Has not agreed to participate in TOP	• May not provide cashless/claimless service; beneficiaries may be required to pay up front and file a claim for reimbursement

May file claims for beneficiaries

1. *Individuals in other locations should check if restrictions on certified providers apply in their area. For more information, call your TOP Regional Call Center.*
2. *TRICARE nonparticipating non-network providers may charge up to 115 percent of the TRICARE-allowable amount in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). However, there is no limit to the amount that nonparticipating non-network providers may bill in overseas locations, and you are responsible for paying any amount that exceeds the TRICARE-allowable charge.*

Appendix B

TRICARE covers most care that is medically necessary and considered proven. Some types of care are not covered at all, and there are special rules and limits for certain types of care. The following figures are **not** all-inclusive. TRICARE policies are very specific about which services are covered and which are not. It is in your best interest to take an active role in verifying coverage.

Outpatient Services

Figure 11.1 provides coverage details for outpatient services. **Note:** This figure is **not** all-inclusive.

Outpatient Services: Coverage Details *Figure 11.1*

Service	Description
Ambulance Services	The following ambulance services are covered: • Emergency transfers from a beneficiary's home, accident scene, or other location to a hospital • Transfers between hospitals • Ambulance transfers from a hospital-based emergency room to a hospital more capable of providing the required care • Transfers between a 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 conveyances transporting patients to and from their medical appointments **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.
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 includes: • DMEPOS that are medically necessary and appropriate and prescribed by a physician for a beneficiary's specific use • Duplicate DMEPOS items 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 item. For example, a portable oxygen concentrator may be covered as a backup for a stationary oxygen generator.*) **Note:** Prosthetic devices must be U.S. Food and Drug Administration-approved.
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. However, most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE.

Outpatient Services: Coverage Details (continued)

Service	Description
Home Health Care[1]	Covers part-time or intermittent skilled nursing services and home health care services for those confined to the home (*All care must be provided by a participating home health care agency and be authorized in advance by the regional contractor.*)
Individual 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.
Active Duty Service Member (ADSM) Respite Care	Covers respite care for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty; available if the ADSM's plan of care includes frequent[2] interventions by the primary caregiver. The following respite care limits apply: • Five days per calendar week • Eight hours per calendar day **Note:** Respite care must be provided by a TRICARE-authorized home health care agency and requires prior authorization from your regional contractor and the ADSM's approving authority (*i.e., Military Medical Support Office or referring military treatment facility*). The ADSM is not required to be enrolled in the TRICARE Extended Care Health Option program to receive the respite benefit.

1. *Home health care services 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*).*
2. *More than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.*

Inpatient Services

Figure 11.2 provides coverage details for inpatient services. **Note:** This figure is **not** all-inclusive.

Inpatient Services: Coverage Details *Figure 11.2*

Service	Description
Hospitalization (*semiprivate 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; 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[1] (*semiprivate room*)	Covers skilled 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:** TRICARE does not cover purely custodial care.

1. *Skilled nursing facility care is 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*).*

Figure 11.3 provides coverage details for clinical preventive services. **Note:** This figure is **not** all-inclusive.

Clinical Preventive Services: Coverage Details *Figure 11.3*

Service	Description
Comprehensive Health Promotion and Disease Prevention Examinations	A comprehensive clinical preventive examination 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. Beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without receiving an immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening (*one examination 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 examination. The intent is to maximize preventive care.

Cancer Screenings	• **Colonoscopy:**
	  • Average risk: Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50.
	  • Increased risk: Once every five years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second-degree relatives.
	  • High risk: Once every one to two years for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20–25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.
	• **Fecal occult blood testing:** Conduct testing annually starting at age 50.
	• **Breast Cancer:**
	  • **Clinical Breast Examination:** For women under age 40, a clinical breast examination may be performed during a preventive health visit. For women age 40 and older, a clinical breast examination should be performed annually.
	  • **Mammograms:** Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15 percent or greater lifetime risk of breast cancer (*according to risk-assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model*), or who have any of the following risk factors:
	  • History of breast cancer, ductal carcinoma in situ, lobular carcinoma in situ, atypical ductal hyperplasia, or atypical lobular hyperplasia
	  • Extremely dense breasts when viewed by mammogram
	  • Known BRCA1 or BRCA2 gene mutation[1]

1. Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

Clinical Preventive Services: Coverage Details (continued)

Service	Description
Cancer Screenings (*continued*)	• First-degree relative (*parent, child, sibling*) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves[1] • Radiation therapy to the chest between ages 10 and 30 • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes[1] • **Breast Screening Magnetic Resonance Imaging (MRI):** Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20 percent or greater lifetime risk of breast cancer (*according to risk-assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model*), or who have any of the following risk factors: • Known BRCA1 or BRCA2 gene mutation[1] • First-degree relative (*parent, child, sibling*) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves[1] • Radiation to the chest between ages 10 and 30 • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes[1] • **Proctosigmoidoscopy or sigmoidoscopy:** • Average risk: Once every three to five years beginning at age 50. • Increased risk: Once every five years beginning at age 40 for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer. • High risk: Annual flexible sigmoidoscopy beginning at age 10–12 for individuals with known or suspected familial adenomatous polyposis. • **Prostate cancer:** Perform a digital rectal examination 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*). Human papillomavirus (HPV) DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women age 30 and older. • **Skin cancer:** Examinations 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 (*non-fasting*):** 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 (*up to age 3*): Conduct one eye and vision screening at birth and at 6 months. • Children (*ages 3–6*): Conduct a routine eye examination every two years. Active duty family member (ADFM) children are covered for one routine eye examination annually. • **Adults and children (*over age 6*):** Conduct a routine eye examination every two years. Active duty service members (ADSMs) and ADFMs receive one eye examination each year. • **Diabetic patients (*any age*):** Eye examinations are not limited. One eye examination per year is recommended.

1. Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

Clinical Preventive Services: Coverage Details (continued)

Service	Description
Eye Examinations (*continued*)	**Note:** ADSMs enrolled in TRICARE Prime 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 a network provider is not available. ADSMs enrolled in TRICARE Prime Remote may obtain periodic eye examinations from network providers without authorizations as needed to maintain fitness-for-duty status.
Hearing	Preventive hearing examinations are only allowed under the well-child care benefit. A newborn audiology screening should be performed on newborns before hospital discharge or within the first month after birth. Evaluative hearing tests may be performed at other ages during routine exams.
Immunizations	Age-appropriate doses of vaccines, including annual influenza vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). The HPV vaccine is a limited benefit and may be covered when the beneficiary has not been previously vaccinated or completed the vaccine series. • Females: The HPV vaccine Gardasil (HPV4) or Cervarix (HPV2) is covered for females ages 11–26. The series of injections must be completed prior to age 27 for coverage under TRICARE. • Males: The HPV vaccine Gardasil (HPV4) is covered for all males ages 11–21 and is covered for males ages 22–26 who meet certain criteria. A single dose of the shingles vaccine Zostavax® is covered for beneficiaries age 60 and older. 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. Immunizations for personal overseas travel are not covered.
Infectious Disease Screening	TRICARE covers screening for infectious diseases, including hepatitis B, rubella antibodies, and HIV, and screening and/or prophylaxis for tetanus, rabies, hepatitis A and B, meningococcal meningitis, and tuberculosis.
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.

Outpatient Behavioral Health Care Services

Figure 11.4 provides coverage details for outpatient behavioral health care services. **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Outpatient Coverage Details ***Figure 11.4***

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:** Up to 60 minutes per visit (*Collateral visits are counted as individual psychotherapy sessions. Beneficiaries have the option of combining collateral visits with other individual or group psychotherapy visits.*)

Psychoanalysis	Psychoanalysis differs from psychotherapy and requires prior authorization. After prior authorization is obtained, treatment must be given by approved providers.
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 (FY).[1] Any testing beyond six hours 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 • Testing to determine whether a beneficiary has a learning disability • 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. Medication-management appointments are medical appointments and do not count against the first eight outpatient behavioral health care visits per FY.[1]

1. October 1–September 30.

Inpatient Behavioral Health Care Services

Prior authorization is required for all nonemergency inpatient behavioral health care services. Psychiatric emergencies do not require prior authorization for inpatient admissions, but authorization is required for continued stay. Admissions resulting from psychiatric emergencies should be reported to your regional contractor within 24 hours of admission or the next business day, and must be reported within 72 hours of an admission. Authorization for continued stay is coordinated between the inpatient unit and the regional contractor.

Note: Active duty service members who receive care at military treatment facilities do not require prior authorization.

Figure 11.5 provides coverage details for inpatient behavioral health care services. **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Inpatient Coverage Details ***Figure 11.5***

Service	Description
Acute Inpatient Psychiatric Care	May be covered on an emergency or nonemergency basis. Prior authorization from your regional contractor 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 for acute inpatient psychiatric care. (*Limitations may be waived if determined to be medically or psychologically necessary.*)
Psychiatric Partial Hospitalization Program (PHP)	Psychiatric PHPs provide interdisciplinary therapeutic services at least three hours a day, five days a week, in any combination of day, evening, night, and weekend treatment programs. The following rules apply: • Prior authorization from your regional contractor is required. PHP admissions are not considered emergencies. • Facilities must be TRICARE-authorized. • PHPs must have participation agreements with TRICARE. **Limitations:** PHP care is limited to 60 treatment days (*whether full- or partial-day treatment*) per FY.[1] These 60 days are not offset by or counted toward the 30- or 45-day limit for acute inpatient psychiatric care. (*Limitations may be waived if determined to be medically or psychologically necessary.*)

1. October 1–September 30.

Behavioral Health Care Services: Inpatient Coverage Details (continued)

Service	Description
Residential Treatment Center (RTC) Care	RTC care provides extended care for children and adolescents with psychological disorders that 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 continued care of the patient through either direct involvement at the facility or geographically distant family therapy. • Prior authorization from your regional contractor is always required. RTC admissions are not considered emergencies. • RTC care is considered elective and will not be covered for emergencies. • Admission primarily for substance use rehabilitation is not authorized for psychiatric RTC care. • 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 until reaching age 21. • RTC care does not count toward the 30- or 45-day inpatient limit.

1. October 1–September 30.

Substance Use Disorder Services

Figure 11.6 provides coverage details for covered substance use disorder services (*up to three benefit periods per beneficiary, per lifetime*). **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Substance Use Disorder Services ***Figure 11.6***

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 or substance use disorder rehabilitation facility (SUDRF). **Limitations:** • Diagnosis-related group-exempt facility: Seven days per episode • Services count toward 30- or 45-day limit for acute inpatient psychiatric care • Services do not count toward the 21-day rehabilitation limit
SUDRF Rehabilitation	Rehabilitation of a substance use disorder may occur in an inpatient (*residential*) or partial hospitalization setting. TRICARE covers 21 days of rehabilitation per benefit period in a TRICARE-authorized facility, whether in an inpatient or partial hospitalization facility or a combination of both.[1] **Limitations:** • 21-day rehabilitation limit per episode • Three episodes per lifetime • Days for inpatient rehabilitation count toward the 30- or 45-day limit for acute inpatient psychiatric care (*Limitations may be waived if determined to be medically or psychologically necessary.*)
SUDRF Outpatient Care	Outpatient substance use care must be provided by an approved SUDRF. **Limitations:** • **Individual or group therapy:** 60 visits per benefit period[1] • **Family therapy:** 15 visits per benefit period[1] • **Partial hospitalization care:** 21 treatment days per fiscal year[2] (*Limitations may be waived if determined to be medically or psychologically necessary.*)

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

2. October 1–September 30.

Services or Procedures with Significant Limitations

Figure 11.7 is a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist. **Note:** This figure is **not** all-inclusive.

Services or Procedures with Significant Limitations *Figure 11.7*

Service	Description
Botulinum Toxin Type A Injections	Botulinum toxin type A injections for cosmetic procedures, myofascial pain, and fibromyalgia are not covered. Cost-sharing may apply for injections to treat severe primary axillary hyperhidrosis, dystonia-related blepharospasm or strabismus, cervical dystonia, cerebral palsy-related spasticity, or for the treatment of sialorrhea associated with Parkinson's disease. Botulinum toxin type A injections may also be cost-shared for prophylaxis of headaches in adult patients with chronic migraines, which is defined as 15 days or more per month with headache lasting four hours a day or longer. TRICARE may also consider off-label cost-sharing for Botox® injections used to treat chronic anal fissure (*if unresponsive to conservative therapeutic measures*).
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*). Prior authorization is required for adjunctive dental care.
Education and Training	Education and training are only covered under the TRICARE Extended Care Health Option (ECHO) and diabetic outpatient self-management training programs. Diabetic outpatient self-management training programs must be accredited by the American Diabetes Association®. The provider's accreditation certificate must accompany the claim for reimbursement.
Eyeglasses or Contact Lenses	Active duty service members may receive eyeglasses at a military treatment facility 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, cleaning, and repairs for eyeglasses are not covered.

Services or Procedures with Significant Limitations (continued)

Service	Description
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	Medically necessary nutrition formulas 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. Vitamins may be cost-shared only when used as a specific treatment of a medical condition. Additionally, prenatal vitamins that require a prescription may be cost-shared, but are covered for prenatal care only.
Gastric Bypass	This procedure is covered for the treatment of morbid obesity under certain limited circumstances. For more information, contact your regional contractor or visit **www.tricare.mil/coveredservices**.
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 semiprivate 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 beneficiaries with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered.

Limitations and Exclusions

The following specific services **are excluded under any circumstance. Additionally, medical services that result from excluded services are also excluded. This list is not all-inclusive.** Check your regional contractor's Web site for additional information.

- Acupuncture (*may be offered at some military treatment facilities and approved for certain active duty service members, but is not covered for care received by civilian providers*)
- Alterations to living spaces
- Artificial insemination, including in vitro fertilization (IVF), gamete intrafallopian transfer, and all other such reproductive technologies
- Autopsy services or post-mortem examinations
- Birth control/contraceptives (*non-prescription*)
- Camps (*e.g., for weight loss*)
- Charges that providers may apply to missed or rescheduled appointments
- Counseling services that are not medically necessary for the treatment of a diagnosed medical condition (*e.g., educational, vocational, and socioeconomic counseling; stress management; 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 (*unless authorized under specific exceptions in the TRICARE regulations*)
- 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
- 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; or 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 and other tests allowed under the clinical preventive services benefit

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Notes

TRICARE Expectations for Beneficiaries

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

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

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

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

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