TRICARE For Life

TRICARE® For Life Handbook

TRICARE®

November 2012

Important Information

Medicare:	1-800-MEDICARE (1-800-633-4227)
Social Security Administration:	1-800-772-1213
TRICARE Web Site:	www.tricare.mil
TRICARE For Life Contractor	
Wisconsin Physicians Service:	1-866-773-0404
TRICARE For Life Web Site:	www.TRICARE4u.com
TRICARE North Region Contractor	
Health Net Federal Services, LLC:	1-877-TRICARE (1-877-874-2273)
Health Net Web Site:	www.hnfs.com
TRICARE South Region Contractor	
Humana Military, a division of Humana Government Business:	1-800-444-5445
Humana Military Web Site:	Humana-Military.com
TRICARE West Region Contractor	
UnitedHealthcare Military & Veterans:	1-877-988-WEST (1-877-988-9378)
UnitedHealthcare Web Site:	www.uhcmilitarywest.com

An Important Note About TRICARE Program Changes

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

Important Contact Information

Use this page as a guide for the most important resources available to you.

TRICARE's Web Site: www.tricare.mil

TRICARE's official Web site is your first stop for the most up-to-date information about your benefit. Go to **www.tricare.mil** for information about eligibility and TRICARE-covered services; answers to frequently asked questions; information on your TRICARE pharmacy benefit; to download claims forms and instructions; to locate a TRICARE Service Center or military treatment facility; to find a TRICARE Debt Collection Assistance Officer; and to answer questions about survivor coverage, loss of eligibility, and program option information, among other things. Subscribe to TRICARE For Life (TFL) program updates at **www.tricare.mil/subscriptions**.

General Contact Information	Grievances	Claims
Phone: **1-866-773-0404** Web: **www.TRICARE4u.com** Written Correspondence: WPS/TRICARE For Life P.O. Box 7889 Madison, WI 53707-7880 TRICARE Overseas Program* P.O. Box 7992 Madison, WI 53707-7992	E-mail: **reportit@wpsic.com** WPS/TFL (*stateside*) P.O. Box 8974 Madison, WI 53708-8974 TRICARE Overseas Grievances P.O. Box 7992 Madison, WI 53707-7992	WPS/TRICARE For Life (U.S.) P.O. Box 7890 Madison, WI 53707-7890 TRICARE Overseas (*Eurasia-Africa*) P.O. Box 8976 Madison, WI 53707-7992 USA TRICARE Overseas (*Latin America and Canada*) P.O. Box 7985 Madison, WI 53707-7985 USA TRICARE Overseas (*Pacific*) P.O. Box 7985 Madison, WI 53707-7985 USA

* *Use this address for overseas appeals and grievances as well as general inquiries.*

Defense Enrollment Eligibility Reporting System (DEERS)

DEERS is a database of uniformed service members (*sponsors*), family members, and others worldwide who are entitled under law to military benefits, including TRICARE. Sponsors are required to keep DEERS updated, including their residential and mailing address for themselves and eligible dependents.

You have several options for updating and verifying DEERS information:

In Person	Phone or Fax
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.	**1-800-538-9552** (*phone*) **1-866-363-2883** (*TDD/TTY*) **1-831-655-8317** (*fax*)
Online	**Mail**
milConnect: **http://milconnect.dmdc.mil** Beneficiary Web Enrollment: **www.dmdc.osd.mil/appj/bwe/**	Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771

TRICARE Regional Contractors

Regional contractors provide health care services and support in the TRICARE regions and can help TFL beneficiaries with prior authorizations, but do not provide referrals for TFL beneficiaries. Wisconsin Physicians Service administers the TFL program and should be your primary contact for TRICARE-related customer service needs in the United States or U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). Go to **www.medicare.gov** and click on "Facilities & Doctors" for help finding providers. Overseas, contact your TRICARE Overseas Program (TOP) Regional Call Center.

***Regional Contractors* (Stateside)**

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** 1-877-988-WEST (1-877-988-9378) www.uhcmilitarywest.com

***Regional Contractor* (Overseas)**

TRICARE Eurasia-Africa	TRICARE Latin America and Canada	TRICARE Pacific
TRICARE Overseas Program (TOP) Regional Call Center +44-20-8762-8384 (*overseas*) 1-877-678-1207 (*stateside*) tricarelon@internationalsos.com	**TOP Regional Call Center** +1-215-942-8393 (*overseas*) 1-877-451-8659 (*stateside*) tricarephl@internationalsos.com	**TOP Regional Call Centers** *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

Other Contact Information

For More Information	Resource Numbers	Web Sites
Medicare	**1-800-633-4227**	**www.medicare.gov**
Social Security Administration	**1-800-772-1213**	**www.ssa.gov**
TRICARE Pharmacy Program	**1-877-363-1303**	**www.tricare.mil/pharmacy** **www.express-scripts.com/TRICARE**
Prescription Drug Formulary Search	**1-877-363-1303**	**www.pec.ha.osd.mil/formulary_search.php**
TRICARE Dental Program	**1-855-638-8371** (*stateside*) **1-855-638-8372** (*overseas*) **1-855-638-8373** (*TDD/TTY*)	**https://mybenefits.metlife.com/tricare**
TRICARE Retiree Dental Program	**1-888-838-8737**	**www.trdp.org**
Office of Personnel Management	**1-888-767-6738** **1-800-582-3337**	**www.opm.gov/forms** **www.opm.gov/insure/ltc**
Find a Debt Collection Assistance Officer or a Beneficiary Counseling and Assistance Coordinator	**See Web site**	**www.tricare.mil/bcacdcao**
Find a military treatment facility	**See Web site**	**www.tricare.mil/mtf**
Toll-free overseas contact information	**See chart above**	**www.tricare-overseas.com**

Welcome to TRICARE For Life

TRICARE For Life (TFL) is the Medicare-wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B, regardless of age or place of residence.

TFL provides comprehensive health care coverage. You have the freedom to seek care from any Medicare-participating or nonparticipating provider, or military treatment facility on a space-available basis. Medicare-participating providers file your claims with Medicare. After paying its portion, Medicare automatically forwards the claim to TRICARE for processing (*unless you have other health insurance [OHI]*). TRICARE pays after Medicare and OHI for covered health care services.

This handbook will help you make the most of your TFL coverage. You will find information about eligibility requirements, getting care, and claims. This handbook also provides details about your pharmacy and dental coverage options.

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

How TRICARE For Life Works

Eligibility

TRICARE For Life (TFL) is available to TRICARE beneficiaries, regardless of age and place of residence, if you have Medicare Part A and Medicare Part B. You are eligible for TFL on the first date that you have both Medicare Part A and Medicare Part B.

TRICARE Eligibility Requirements

When you are entitled to premium-free Medicare Part A:

- Medicare Part B coverage is required to remain TRICARE-eligible if you are a:
  - Retired service member (*including retired National Guard and Reserve members drawing retirement pay*)
  - Family member of a retired service member
  - Medal of Honor recipient or eligible family member
  - Survivor of a deceased sponsor
  - Qualifying former spouse
- Medicare Part B coverage is **not** required to remain TRICARE-eligible if:
  - You are an active duty service member (ADSM) or active duty family member (ADFM) (*ADSMs and ADFMs remain eligible for TRICARE Prime and TRICARE Standard and TRICARE Extra options while the sponsor is on active duty. However, when the sponsor retires, you must have Medicare Part B to remain TRICARE-eligible. See "Medicare Part B [*Medical Insurance*]" on the following page for information about the Medicare Part B special enrollment period for ADSMs and ADFMs.*)

Note: Regardless of age, ADFMs who have Medicare Part A may enroll in TRICARE Prime if they live in a TRICARE Prime Service Area (PSA). The TRICARE Prime enrollment fee is waived for retiree family members with Medicare Part B coverage.

Understanding Medicare

TFL is managed by the Department of Defense. Medicare is managed by the Centers for Medicare & Medicaid Services (CMS). The two agencies work together to coordinate benefits.

Medicare is a federal entitlement health insurance program for people:

- Age 65 or older
- Under age 65 with certain disabilities
- Any age with end-stage renal disease (ESRD)

Medicare Part A (*Hospital Insurance*)

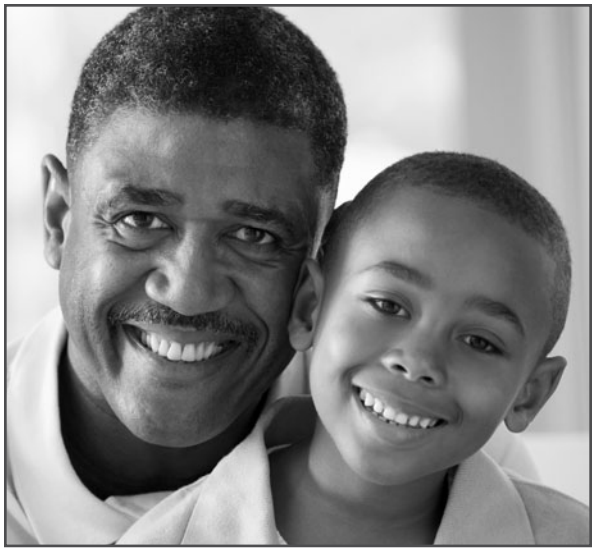
Medicare Part A covers inpatient hospital care, hospice care, inpatient skilled nursing facility care, and some home health care. The Social Security Administration (SSA) determines your entitlement to Medicare Part A based on your work history or your spouse's work history. You are eligible for premium-free Medicare Part A at age 65 if you or your spouse has 40 quarters or 10 years of Social Security-covered employment.

If, when you turn 65, you are not eligible for premium-free Medicare Part A under your own Social Security number (SSN), you must file for benefits under your spouse's (*this includes divorced or deceased spouses*) SSN, if he or she is 62 or older. If your spouse is not yet 62, you should enroll in Medicare Part B at age 65 to avoid paying a surcharge for late enrollment, and you should file for Part A benefits under your spouse's record when he or she turns 62.

Medicare Part B (*Medical Insurance*)

Medicare Part B covers provider services, outpatient care, preventive care, home health care, and durable medical equipment. Medicare Part B has a monthly premium, which may change annually and varies based on income. If you sign up after your initial enrollment period for Medicare Part B, you may have to pay a monthly premium surcharge for as long as you have Medicare Part B. The surcharge is 10 percent for each 12-month period that you were eligible for Medicare Part B but did not enroll.

Medicare allows ADSMs and ADFMs who are entitled to Medicare based on age or disability (*does not apply to those with ESRD*) to delay Part B enrollment and sign up during a special enrollment period, which waives the late enrollment surcharge. The special enrollment period for ADSMs and ADFMs is available any time the sponsor is on active duty or within eight months following either (1) the sponsor's retirement or (2) the end of TRICARE coverage, whichever comes first. To avoid a break in



coverage, ADSMs and ADFMs must sign up for Medicare Part B before sponsors retire.

Note: If you have ESRD, sign up for Medicare Part A and Part B as soon as you are eligible to avoid a break in TRICARE coverage and the Medicare Part B late-enrollment premium surcharge.

Medicare Entitlement Based on a Disability

If you receive disability benefits from the SSA, you are entitled to Medicare in the 25th month of receiving disability payments. The CMS will notify you of your Medicare entitlement date.

If you return to work and your Social Security disability payments are suspended, your Medicare entitlement continues for up to eight years and six months. When your disability payments are suspended, you will receive a bill every three months for your Medicare Part B premiums. You must continue to pay your Medicare Part B premiums to remain eligible for TRICARE coverage.

Medicare Entitlement Based on Age

The Medicare entitlement age is 65. If you already receive benefits from the SSA or the Railroad Retirement Board, you will automatically receive Part A and be enrolled in Part B at age 65.

If you are age 65 or older and do not receive Social Security or Railroad Retirement Board benefits, you must apply for Medicare benefits. Your Medicare initial enrollment period is a seven-month period.

- If your birthday falls on the first of the month, your initial enrollment period begins four months before the month you turn 65. Enroll no later than two months before the month you turn 65 to avoid a break in TRICARE coverage. You are eligible for Medicare coverage on the first day of the month before you turn 65.
- If your birthday falls on any day other than the first of the month, your initial enrollment period begins three months before the month you turn 65. Enroll no later than one month before your birth month to avoid a break in TRICARE coverage. You are eligible for Medicare on the first day of the month you turn 65.

Enroll in Medicare Part B when first eligible to avoid a break in TRICARE coverage. If you sign up after your initial enrollment period, you may have to pay a premium surcharge for as long as you have Part B. The Medicare Part B surcharge is 10 percent for each 12-month period that you were eligible to enroll in Part B but did not.

Your Part B premiums are automatically taken out of your Social Security or Railroad Retirement Board checks. If you are not receiving these types of payments, Medicare bills you every three months for Part B premiums.

Frequently Asked Questions: Medicare

I will be 65 soon and will become entitled to Medicare. I work full time and have employer group health plan coverage, and I don't plan on retiring for a few more years. Medicare says I can delay my Part B enrollment if I have employer group health plan coverage. How does this affect my TRICARE benefit?

Medicare allows individuals with group health plan coverage based on current employment to delay Part B enrollment and sign up during a special enrollment period, which waives the late-enrollment premium surcharge. If you or your spouse still works and has group health plan coverage through current employment, you may sign up for Medicare Part B during the special enrollment period, which is available within the eight months following either (1) retirement or (2) the end of the group health plan coverage, whichever comes first.

If you are entitled to premium-free Medicare Part A, you must also have Part B to remain TRICARE-eligible, even if you have group health plan coverage based on current employment. Sign up for Part B before you retire or lose group health plan coverage to ensure your TRICARE coverage under TFL will begin immediately following the end of your group health plan coverage. Your TFL coverage begins on the first day you have both Medicare Part A and Part B coverage.

If I am not entitled to premium-free Medicare Part A when I turn 65, can I still use TFL?

Because you are not entitled to premium-free Medicare Part A, you do not need Medicare Part B to keep your TRICARE benefit. You do not transition to TFL. You may continue enrollment in TRICARE Prime if you live in a PSA, or use TRICARE Standard and TRICARE Extra. For information about TRICARE program options, visit the TRICARE Web site at **www.tricare.mil**.

If you are not eligible for premium-free Medicare Part A under your own SSN when you turn 65, you must file for benefits under your spouse's (*this includes divorced or deceased spouses*) SSN if he or she is 62 or older. If your spouse is not yet 62, you must file for benefits under his or her SSN when he or she turns 62.

If you will be eligible under your spouse's SSN in the future, you should sign up for Medicare Part B during your initial enrollment period to avoid paying a Part B premium surcharge for late enrollment. Even if you are not entitled to premium-free Medicare Part A, you are eligible for Part B at age 65. See "Medicare Entitlement Based on Age" earlier in this section for more information.

If you sign up for Medicare and are not eligible for premium-free Part A under your or your spouse's (*this includes divorced or deceased spouses*) SSN, you receive a "Notice of Award" or "Notice of Disapproved Claim" from SSA. To keep your TRICARE coverage, take the "Notice(s) of Award" or "Notice(s) of Disapproved Claim" to a uniformed services identification (ID) card-issuing facility to have your Defense Enrollment Eligibility Reporting System (DEERS) record updated and receive a new ID card. This allows you to keep your eligibility for TRICARE Prime or TRICARE Standard and TRICARE Extra after you turn 65. To confirm that your TRICARE coverage will continue without a break, contact Wisconsin Physicians Service (WPS) after you update your DEERS record.

Note: A *Report of Confidential Social Security Benefit Information* (SSA-2458) from the SSA is not accepted as proof of non-entitlement to premium-free Part A to keep TRICARE eligibility.

How TRICARE For Life Works with Medicare

Medicare and TFL work together to minimize your out-of-pocket expenses. However, there are instances when some health care costs may not be covered by Medicare and/or TFL.

Health Care Services Covered by Medicare and TRICARE

When you see a participating or nonparticipating Medicare provider, you have no out-of-pocket costs for services covered by both Medicare and TFL. Most health care services fall into this category. After Medicare pays its portion of the claim, TFL pays the remaining amount and you pay nothing.

As the primary payer, Medicare approves health care services for payment. If Medicare

does not pay because it determines that the care is not medically necessary, TFL also does not pay. You may appeal Medicare's decision, and if Medicare reconsiders and provides coverage, TFL also reconsiders coverage.

If a health care service is covered by both Medicare and TFL, but Medicare does not pay because you have used up your Medicare benefit, TFL becomes the primary payer. In this case, you are responsible for your TFL deductible and cost-shares.

If a health care service is normally covered by both Medicare and TFL, but you receive the service from a provider who has opted out of Medicare, the provider cannot bill Medicare and, therefore, Medicare will pay nothing. When you see an opt-out provider, TFL will process the claim as the second payer, unless you have other health insurance (OHI). TFL pays the amount it would have paid if Medicare had processed the claim (*normally 20 percent of the TRICARE-allowable charge*) and you are responsible for the remainder of the billed charges.

Opt-out providers establish private contracts with patients. Under a private contract, there are no limits on what the provider can charge for health care services.

Health Care Services Covered by Medicare but Not by TRICARE

When you receive care that is covered by Medicare only (*e.g., chiropractic care*), Medicare processes the claim as the primary payer. TFL makes no payment, regardless of any action Medicare takes. You are responsible for the Medicare deductible and copayments.

Health Care Services Covered by TRICARE but Not by Medicare

When you receive care that is covered only by TFL (*e.g., TRICARE-covered services received overseas*), TRICARE processes the claim as the primary payer. You are responsible for the applicable TFL deductible, cost-shares, and remaining billed charges.

TFL claims are normally filed with Medicare first; however, when a health care service is not covered by Medicare, your provider may file the claim directly with WPS, unless you have OHI. See the *Claims* section of this handbook for additional information.

Health Care Services Not Covered by Medicare or TRICARE

When you receive care that is not covered by Medicare or TFL (*e.g., cosmetic surgery*), neither makes a payment on the claim. You are responsible for the entire bill.

For more information on covered services, visit **www.medicare.gov** or **www.tricare.mil** or contact WPS.

See Figure 1.1 on the following page for TFL out-of-pocket costs.

Coordinating TRICARE For Life with Other Health Insurance

How Medicare coordinates with OHI depends on whether or not the OHI is based on current employment. In either case, TFL is the last payer.

OHI Not Based on Current Employment

If you have OHI that is not based on your or a family member's current employment, Medicare pays first, the OHI pays second, and TFL pays last.

OHI Based on Current Employment

Generally, if you have an employer-sponsored health plan based on current employment, that health plan pays first, Medicare pays second, and TFL pays last. If there are fewer than 20 employees in the employer-sponsored plan, Medicare pays first, the employer plan pays second, and TFL pays last.

When your OHI processes the claim after Medicare, you need to submit a claim to WPS for any remaining balance. See the *Claims* section of this handbook for additional information.

Note: TRICARE pays after most insurance plans with the exception of Medicaid, TRICARE supplements, the Indian Health Service, and other programs and plans as identified by the TRICARE Management Activity.

How TRICARE For Life Works Overseas

Medicare provides coverage in the United States and U.S. territories, which are:

- American Samoa
- Guam
- Northern Mariana Islands
- Puerto Rico
- U.S. Virgin Islands

Medicare also covers health care services received on board ships in U.S. territorial waters. In these locations, TFL works exactly as it does in the United States. Unless you have OHI, TFL is the second payer after Medicare for most health care services. Your provider files the claim with Medicare first. Medicare pays its portion and automatically forwards the claim to WPS for processing.

TRICARE For Life Out-of-Pocket Costs ***Figure 1.1***

Type of Service	Medicare Pays	TRICARE Pays	You Pay
Covered by TRICARE and Medicare	Medicare-authorized amount	Remaining amount	Nothing
Covered by Medicare only	Medicare-authorized amount	Nothing	Medicare deductible and cost-share
Covered by TRICARE only	Nothing	TRICARE-allowable amount	TRICARE deductible and cost-share
Not Covered by TRICARE or Medicare	Nothing	Nothing	Billed charges (*which may exceed the Medicare amount or balance-billing cap*)

Medicare does not provide coverage outside of the United States, U.S. territories, and ships in territorial waters. Therefore, TFL is your primary payer for health care received in all other overseas locations, unless you have OHI. TFL provides the same coverage as TRICARE Standard and has the same cost-shares and deductibles for beneficiaries who live or travel overseas. When seeking care from a host nation provider, region- or country-specific requirements may also apply. You should be prepared to pay up front for services and submit a claim to the TRICARE Overseas Program (TOP) claims processor. Claims for care received overseas are submitted directly to the TOP claims-processing address for the region where you received care. See the *Claims* section of this handbook for more information.

Frequently Asked Questions: How TRICARE For Life Works

Does TFL pay for the Medicare Part B premium and deductible?

The Part B monthly premium is your responsibility. TFL covers the Medicare Part B deductible as long as the health care service is covered by both Medicare and TRICARE.

Using TFL seems so easy. Should I cancel my Medicare supplement, Medicare Advantage Plan, or OHI?

You should carefully evaluate your health insurance needs to determine if you should continue any OHI plans, Medicare supplements, and Medicare Advantage Plans. You may contact your local State

Health Insurance Assistance Program for free health insurance counseling and assistance.

Note: If you drop your OHI coverage, you must notify WPS.

I am a TFL beneficiary and a retired federal employee. Can I suspend my Federal Employees Health Benefits (FEHB) program coverage to use TFL?

Yes. You may suspend your FEHB coverage and premium payments at any time. Visit **www.opm.gov/forms** to get a *Health Benefits Election Form* (SF 2809). Eligible unremarried former spouses can get the form from the employing offices or retirement system maintaining their enrollments.

Is a referral or TRICARE prior authorization required for health care services?

A referral or TRICARE prior authorization is not required under TFL when Medicare is the primary payer. However, when TFL becomes the primary payer, TRICARE authorization requirements apply as they would for a TRICARE Standard beneficiary.

I was enrolled in TRICARE Prime at a military treatment facility (MTF). I received a letter from the MTF telling me I was no longer eligible for enrollment in TRICARE Prime. What does that mean?

Once you become entitled to premium-free Medicare Part A because you are age 65, you are eligible for TFL when you also have Medicare Part B. You are no longer eligible for enrollment in TRICARE Prime, unless you have an active duty sponsor.

You may continue to seek care at an MTF on a space-available basis, but will likely need to seek care from civilian Medicare providers. When you visit civilian Medicare providers, you have no out-of-pocket costs for services covered by both Medicare and TRICARE. Contact Medicare for assistance with finding Medicare-certified providers.

You may be able to sign up for TRICARE Plus. TRICARE Plus is a program that allows beneficiaries who normally are only able to get MTF care on a space-available basis to enroll and receive primary care appointments at the MTF within the same primary care access standards as beneficiaries enrolled in a TRICARE Prime option. Beneficiaries should contact their local MTFs to determine if they may participate in TRICARE Plus.

Enrollment in TRICARE Plus at one MTF does not automatically extend TRICARE Plus enrollment to another MTF. The MTF is not responsible for any costs when a TRICARE Plus enrollee is referred outside the MTF for additional civilian care.

Getting Care

Finding a Provider

You may receive health care services from Medicare-participating and nonparticipating providers, as well as from providers who have opted out of Medicare. If TRICARE For Life (TFL) is the primary payer, you must visit TRICARE-authorized providers and facilities. You will incur higher out-of-pocket costs when you obtain care from opt-out providers or Veterans Affairs (VA) providers. Costs vary according to the type of provider you see (*i.e., participating, nonparticipating, opt-out, VA*).

Medicare-Participating Providers

Medicare-participating providers agree to accept the Medicare-approved amount as payment in full.

Medicare Nonparticipating Providers

Nonparticipating providers do not accept the Medicare-approved amount as payment in full. They may charge up to 115 percent of the Medicare-approved amount. TFL pays up to the 115-percent limiting charge.

Opt-Out Providers

Providers who opt out of Medicare enter into private contracts with patients and are not allowed to bill Medicare. Therefore, Medicare does not pay for health care services you receive from opt-out providers. When you see an opt-out provider, TFL pays the amount it would have paid if Medicare had processed the claim (*normally 20 percent of the allowable charge*) and you are responsible for paying the remainder of the billed charges. In cases where access to medical care is limited (*i.e., underserved areas*), TFL may waive the second-payer status for Medicare opt-out providers and pay the claim as the primary payer.

Veterans Affairs Providers

Medicare cannot pay for services received from VA. Therefore, TRICARE is the primary payer for VA claims and you will be responsible for the TRICARE annual deductible and cost-shares. Alternatively, you may choose to use your VA benefit.

Military Treatment Facilities

A military treatment facility (MTF) is a military hospital or clinic usually located on or near a military base. You may receive care at an MTF on a space-available basis. See Figure 2.1 for MTF appointment priorities.

MTF Appointment Priorities — *Figure 2.1*

1	Active duty service members
2	Active duty family members (ADFMs) enrolled in TRICARE Prime
3	Retired service members, their families, and all others enrolled in TRICARE Prime or TRICARE Plus
4	ADFMs not enrolled in TRICARE Prime TRICARE Reserve Select members and their families
5	Retired service members, their families, TRICARE Retired Reserve members and their families, and all others not enrolled in TRICARE Prime

Overseas Providers

With TFL overseas, you may generally use any host nation provider and receive care at MTFs on a space-available basis, unless region- or country-specific requirements apply. When seeking care from a host nation provider, you should be prepared to pay up front for services and submit a claim to the TRICARE Overseas Program (TOP) claims processor. For more information about getting care overseas, call your TOP Regional Call Center or visit **www.tricare-overseas.com**.

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. The TRICARE health care benefit covers adjunctive dental care (*i.e., dental care that is medically necessary to treat a covered medical—not dental—condition*). The TRICARE health care benefit does not cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontic, or emergency dental care that is not related to a medical condition. Eligible TRICARE beneficiaries may receive non-adjunctive dental services if enrolled in the TRICARE Dental Program or the TRICARE Retiree Dental Program.

If you need emergency care, call 911 or go to the nearest emergency room. Make sure you present your Medicare card so that your claim is filed with Medicare.

If traveling or living overseas, first attempt to seek care from the nearest MTF. If an MTF is not available, seek care from the nearest emergency room. You can contact the TOP Regional Call Center for your region for assistance in finding a host nation provider.

Note: Most dental conditions that may be considered emergencies are **not** covered under Medicare or TFL.

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 does require professional attention within 24 hours. You could require urgent care for conditions 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.

Behavioral Health Care

Medicare helps cover visits with the following types of health care providers:

- A psychiatrist or other doctor
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician's assistant

Medicare only covers these visits when they are provided by health care providers who accept Medicare payment. To pay even less, you should also ask your health care providers if they accept assignment, which means they accept the Medicare-approved amount as payment in full, before you schedule an appointment.

For more information on Medicare's behavioral health care coverage, visit **www.medicare.gov**.

Prior Authorization for Care

When TFL becomes the primary payer (*e.g., if your Medicare benefits are exhausted*), TRICARE prior authorization requirements apply.

Prior authorization is a review of the requested health care service to determine if it is medically necessary at the requested level of care. If you have an authorization from a TRICARE regional contractor (*Health Net Federal Services, LLC; Humana Military; UnitedHealthcare Military & Veterans; or International SOS Assistance, Inc.*) that covers the dates on your claim, Wisconsin Physicians Service (WPS) will honor those authorizations and no TFL authorization is required. The *TRICARE For Life Authorization Request* form is available on the WPS Web site. Providers should fill out the *TRICARE For Life Authorization Request* form and submit it to the fax number provided in the top right corner of the form.

If you have questions about authorization requirements, contact WPS.

The following services require prior authorization:

- Adjunctive dental services
- All outpatient behavioral health care after the first eight sessions in a fiscal year (*October 1–September 30*) from an authorized, independent behavioral health provider
- Dental anesthesia and institutional care
- Hospice care
- Inpatient behavioral health care services
- Organ and stem cell transplants
- Partial hospitalization
- Psychoanalysis

Note: This list is **not** all-inclusive.

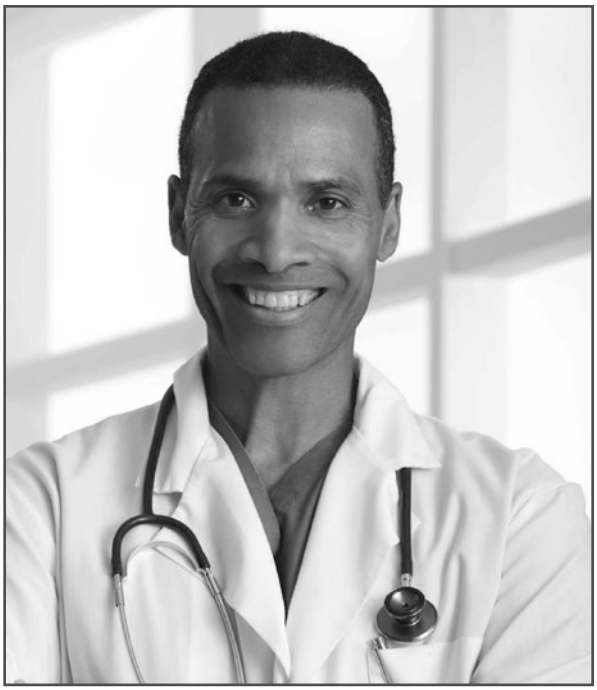
TRICARE For Life Coverage

TRICARE Medical Coverage

TRICARE For Life (TFL) and Medicare cover proven, medically necessary, and appropriate care. TFL has special rules and limitations for certain types of care, and some types of care are not covered at all. 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.

Note: Medicare also has limits on the amount of care it covers and, in some cases, TFL may cover these health care services after your Medicare benefits have been exhausted.

To determine if Medicare covers a specific service or benefit, visit **www.medicare.gov** or call **1-800-633-4227**. To determine if TFL covers the service or benefit, visit the TRICARE Web site at **www.tricare.mil** or contact Wisconsin Physicians Service (WPS) at **1-866-773-0404**. See Figure 1.1 in the *How TRICARE For Life Works* section of this handbook for more information on your out-of-pocket costs.



Examples of services that are generally not reimbursable by either program include:

- Acupuncture
- Experimental or investigational services (*in most cases*)
- Eye examinations (*routine*)
- Hearing aids*

Note: This list is **not** all-inclusive.

* *Retired sponsors may be eligible for the Retiree-At-Cost Hearing Aid Program. If you are a retired service member and you need a hearing aid, you should call a participating military treatment facility. For more information, visit* ***www.militaryaudiology.org/rachap/state.html****.*

Dental Coverage

TRICARE offers two voluntary dental insurance programs, the TRICARE Dental Program (TDP) and the TRICARE Retiree Dental Program (TRDP).

TRICARE Dental Program

The TDP provides worldwide dental coverage for family members of all active duty service members and National Guard and Reserve members and their families. For more information about the TDP, visit the TDP Web site at **https://mybenefits.metlife.com/tricare** or call MetLife at **1-855-638-8371**.

TRICARE Retiree Dental Program

The TRDP is available to retired service members and their eligible family members, including retired National Guard and Reserve members who are entitled to retirement pay but do not begin receiving it until age 60, their eligible family members, certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. For information about the TRDP, including possible restrictions, visit the TRDP Web site at **www.trdp.org** or call Delta Dental® of California toll-free at **1-888-838-8737**.

Frequently Asked Questions: TRICARE For Life Coverage

Does TFL cover long-term care?

No. Long-term care (*or custodial care*) is not a covered benefit. However, you may qualify to purchase long-term care insurance through commercial insurance programs or through the Federal Long Term Care Insurance Program. For more information about the Federal Long Term Care Insurance Program, visit **www.opm.gov/insure/ltc** or call **1-800-582-3337**.

Does TRICARE cover skilled nursing care?

TFL covers reasonable and necessary skilled nursing care and rehabilitative therapies, including semiprivate rooms; regular nursing services; meals (*including special diets*); physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Skilled nursing care is typically provided in a skilled nursing facility (SNF).

For TFL and Medicare to cover SNF admission, you must have had a medical condition that was treated in a hospital for at least three consecutive days, and you must be admitted to a Medicare-certified, TRICARE-participating SNF within 30 days of discharge from the hospital (*with some exceptions for medical reasons*). Your doctor's plan of care must demonstrate your need for skilled nursing services.

Note: TFL is the primary payer for SNF care beyond Medicare's 100-day limit as long as the patient continues to require skilled nursing services and no other health insurance is involved. SNF care requires prior authorization on day 101, when TRICARE is the primary payer. TFL covers an unlimited number of days as medically necessary. SNF care is not covered outside the United States and U.S. territories.

Pharmacy

Prescription Drug Coverage

TRICARE offers several options for filling your prescriptions. TRICARE covers proven, medically necessary, and appropriate prescription medication. To fill a prescription, you need the prescription and a valid uniformed services identification (ID) card or a Common Access Card. When traveling overseas, be prepared to pay up front for medications and file a claim for reimbursement for non-military treatment facility (MTF) and non-network pharmacy services. TRICARE For Life recommends that you fill all of your prescriptions before traveling overseas.

In certain overseas locations, region-specific or country-specific requirements may require using a TRICARE-certified pharmacy. For more information, contact your TRICARE Overseas Program (TOP) Regional Call Center or visit **www.tricare-overseas.com**.

Note: You do not need a Medicare Part D prescription drug plan to keep your TRICARE prescription drug coverage.

Filling Prescriptions

Military Treatment Facility Pharmacy

An MTF pharmacy is the least expensive option for filling prescriptions. At an MTF pharmacy, 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 or not you are enrolled at the MTF.

Non-formulary medications are generally not available at MTF pharmacies. To check the availability of a particular drug, contact the nearest MTF pharmacy.

TRICARE Pharmacy Home Delivery

TRICARE Pharmacy Home Delivery is your least expensive option when not using an MTF pharmacy. There is no cost for home delivery for ADSMs. For all other beneficiaries, there is no cost to receive up to a 90-day supply of generic medications. Copayments apply for 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 24 hours a day, seven days a week to talk confidentially with you.

For faster processing of your mail-order prescriptions, register before placing your first order. Once you are registered, your provider can fax or call in your prescriptions. Express Scripts, Inc. (Express Scripts) sends your medications directly to your home within about 14 days of receiving your prescription.

Note: Overseas beneficiaries must have an APO/FPO or embassy address to use TRICARE Pharmacy Home Delivery,

and the prescription must be from a U.S.-licensed provider.

If you have prescription drug coverage through other health insurance (OHI), you can use TRICARE Pharmacy Home Delivery only if the medication is not covered under your OHI or if you exceed the OHI's coverage limit. Register for TRICARE Pharmacy Home Delivery using any of the options in Figure 4.1.

Member Choice Center

The Member Choice Center makes it easy to reduce your out-of-pocket costs by transferring your current maintenance medication prescriptions to TRICARE Pharmacy Home Delivery.

Note: To use the Member Choice Center, you must have a maintenance prescription from a retail pharmacy or MTF. The Member Choice Center contacts your provider to get new written prescriptions for home delivery.

TRICARE Retail Network Pharmacies

Another option for filling your prescriptions is through TRICARE retail network pharmacies. You may fill prescriptions (*one copayment per 30-day supply*) when you present your written prescription and uniformed services ID card to the pharmacist. This option allows you to fill prescriptions at TRICARE network pharmacies without submitting claims. You have access to approximately 56,000 retail network pharmacies in the United States and U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. TRICARE retail network pharmacies are only located in the United States and U.S. territories. Currently, there are no TRICARE retail network pharmacies in American Samoa.

Visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303** for customer service, including finding the nearest TRICARE retail network pharmacy.

Non-Network Pharmacies

When visiting non-network pharmacies, you pay the full price of your medication up front and file a claim for reimbursement. Reimbursements are subject to deductibles, out-of-network cost-shares, and TRICARE-required copayments. All deductibles must be met before any reimbursement can be made. For details about filing a claim, see the *Claims* section of this handbook.

TRICARE Pharmacy Home Delivery Registration Methods ***Figure 4.1***

Online	Visit **www.express-scripts.com/TRICARE**
Phone	Call **1-877-363-1433** (*Member Choice Center*) or **1-877-540-6261** (*TDD/TTY*)
Mail	Download the registration form from **www.express-scripts.com/TRICARE**, and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954

Pharmacy Policy

Quantity Limits

TRICARE has established quantity limits on certain medications, which means the Department of Defense (DoD) pays for a specified, limited amount of medication each time you fill a prescription. Quantity limits are often applied to ensure medications are safely and appropriately used.

Exceptions to established quantity limits may be made if the prescribing provider can justify medical necessity, or, in cases of natural disasters, as approved by TRICARE.

Prior Authorization

Some drugs require prior authorization from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics (P&T) Committee, brand-name medications with generic equivalents, medications with age limitations, and medications prescribed for quantities exceeding normal limits. If you do not have Internet access, call **1-877-363-1303** to inquire about a specific drug.

Generic Drug-Use Policy

Generic drugs are medications approved by the U.S. Food and Drug Administration and are clinically equivalent to brand-name medications. Generic drugs provide the same safe, effective treatment as brand-name drugs. 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 physician completes a clinical assessment indicating the brand-name drug is medically necessary and after Express Scripts grants approval. Prescribers may call **1-866-684-4488** to submit a request for a brand-name drug to be dispensed instead of a generic, or a completed form may be faxed to: **1-866-684-4477**. The *Brand over Generic Prior Authorization Request Form* may be found at **www.pec.ha.osd.mil/forms_criteria.php**. If a generic-equivalent drug does not exist, the brand-name drug is dispensed at the brand-name copayment.

If you fill a prescription with a brand-name drug that is not considered medically necessary and when a generic equivalent is available, you are responsible for paying the entire cost of the prescription.

Non-Formulary Drugs

The DoD P&T Committee may recommend to the director of TRICARE Management Activity that certain drugs be placed in the third, "non-formulary" tier. These medications include any drug in a therapeutic class determined to be less relatively clinically effective or cost-effective than other drugs in the same class. For an additional cost, third-tier drugs are available through TRICARE Pharmacy Home Delivery or retail network pharmacies. You may be able to fill non-formulary prescriptions at formulary costs if your provider can establish medical necessity by completing and submitting the appropriate TRICARE pharmacy medical-necessity form for the non-formulary medication. Call Express Scripts at **1-877-363-1303** or visit

www.pec.ha.osd.mil/forms_criteria.php for forms and medical-necessity criteria.

For information on how to save money and make the most of your pharmacy benefit, visit **www.tricare.mil/pharmacy** or **www.express-scripts.com/TRICARE**.

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 structured to improve your health through continuous health evaluation, ongoing monitoring, assessment of educational needs, and medication-use management. 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 specified locations
- 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. 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.

Using TRICARE Pharmacy Home Delivery to fill specialty medication prescriptions provides you with access to the Specialty Medication Care Management program benefits previously described. With specific mailing instructions from you or your provider, TRICARE Pharmacy Home Delivery ships your specialty medication to your home. 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 send the prescription to have it filled.

Pharmacy Claims

You do not need to file pharmacy claims for prescriptions filled at MTF pharmacies, through TRICARE Pharmacy Home Delivery, or at TRICARE retail network pharmacies. However, if you fill a prescription at a non-network pharmacy in the United States or U.S. territories

(*American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), you must pay the full price of your prescription up front and file a claim for reimbursement.

If you live in the Philippines, you are required to visit a certified pharmacy. A certified pharmacy has been verified to meet required TOP contract standards and is allowed to invoice TRICARE for TRICARE beneficiary claims.

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

To file a claim:

1. Download *TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment* form (DD Form 2642) at **www.tricare.mil/claims**.
2. Complete the form and attach the required paperwork as described on the form.
3. Mail the form and paperwork to:

   Express Scripts, Inc.
   TRICARE Claims
   P.O. Box 52132
   Phoenix, AZ 85082

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

Contact Express Scripts at **1-877-363-1303** with questions about filing pharmacy claims.

Pharmacy Claims Appeals

If you disagree with the determination on your pharmacy claim (*i.e., 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 from the date of the decision and must include a copy of the claim decision.

Your signed, written request must state the specific matter you disagree with and must be sent 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

Additional documentation in support of the appeal may be submitted; however, because the request for reconsideration must be postmarked or received within 90 calendar days of the date of the decision, do not delay the request for reconsideration for the sake of additional documentation. If additional documentation will be submitted at a later date, the letter requesting reconsideration must state that additional documentation will be submitted and specify the expected date of submission. Upon receiving your request, all TRICARE claims related to the entire course of treatment are reviewed.

Claims

Health Care Claims

In most cases, your provider files your health care claims with Medicare first. Medicare pays its portion and, unless you have other health insurance (OHI), forwards the claim to TRICARE For Life (TFL) for processing.

However, when TFL is the primary payer (*e.g., if Medicare does not cover the health care service*), your provider may be required to file your claim directly with Wisconsin Physicians Service (WPS)/TFL. If you have OHI, you must file the claim with your OHI before filing with TFL.

You are responsible for making sure your claims are filed within one year of either the date of service or the date of an inpatient discharge. To file a claim with TFL, fill out a *TRICARE DoD/ CHAMPUS Medical Claim—Patient's Request for Medical Payment* form (DD Form 2642). You can download forms and instructions from TRICARE at **www.tricare.mil/claims** or the WPS Web site at **www.TRICARE4u.com**. You can also obtain forms and instructions at a TRICARE Service Center (TSC) or a military treatment facility (MTF). Fill out the form completely and sign it. Visit **www.tricare.mil/contactus** to locate a TSC or MTF.

When filing a claim with TFL, include your *Medicare Summary Notice* and OHI explanation of benefits (EOB), if applicable.

Attach a readable copy of the provider's bill to the claim form, making sure it contains the following:

- Patient's name
- Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN) (*Eligible former spouses should use their own SSNs or DBNs, not their sponsors'.*)
- Provider's name and address (*If more than one provider's name is on the bill, circle the name of the person who provided the service for which the claim is filed.*)
- Date and place of each service
- Description of each service or supply furnished
- Charge for each service
- Diagnosis (*If the diagnosis is not on the bill, be sure to complete block 8a on the form.*)

Unlike other TRICARE beneficiaries, TFL beneficiaries should file claims in the regions where they received care. Send claims to the appropriate mailing address provided in "Important Contact Information" at the beginning of this handbook.

Appealing a Claim or Authorization Denial

You may appeal authorization denials of requested services or decisions regarding claims payments. Medicare and TFL have separate appeals processes. Medicare-related appeals should be submitted to Medicare. You should only submit appeals to WPS if TFL is the primary payer.

Third-Party Liability

If TRICARE is the primary payer, 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. *The Statement of Personal Injury—Possible Third-Party Liability* form (DD Form 2527) is sent to you if a claim appears to have third-party liability involvement. Within 35 calendar days, you must complete and sign this form and follow the directions for returning it to the appropriate claims processor. Visit **www.tricare.mil/claims** to download *DD Form 2527.*

Explanation of Benefits

A TRICARE EOB is not a bill. It is an itemized statement that shows the action TRICARE has taken on your claims. An EOB is for your information and files.

After reviewing the EOB, you have the right to appeal certain decisions regarding your claims and must do so in writing within 90 days of the date of the EOB notice. You should keep EOBs with your health insurance records for future reference.

For more information about appeals, visit **www.TRICARE4u.com** or see the *For Information and Assistance* section of this handbook.

Debt Collection Assistance Officers

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

When you visit a TRICARE DCAO for assistance, you must take 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. Visit the DCAO directory online at **www.tricare.mil/bcacdcao** to find a TRICARE DCAO near you.

TRICARE DCAOs can only assist you with TFL-related issues. Contact Medicare for assistance with Medicare-related issues.

Life Changes: Update Your DEERS Record

TRICARE For Life (TFL) continues to provide health care coverage for you and your family as your life changes. However, you need to take specific actions to make sure you remain TRICARE-eligible. It is essential that you keep information in the Defense Enrollment Eligibility Reporting System (DEERS) current for you and your family. DEERS is a 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 key to receiving timely, effective TFL benefits.

Maintaining your TRICARE eligibility is your responsibility. It is essential to verify your information in DEERS any time you have a life-changing event. You have several options for updating and verifying DEERS information. See "Important Contact Information" at the beginning of this handbook.

Note: Only sponsors (*or those appointed power of attorney*) can add or delete a family member. Family members age 18 and older may update their own contact information.

Using milConnect to Update Information in DEERS

Active duty service members, retirees, and eligible family members can use the milConnect Web site to access health care eligibility and personnel information,

uniformed services identification (ID) cards and information on other benefits, including Servicemembers' Group Life Insurance.

You can log on to milConnect's secure site using a Common Access Card (CAC), Defense Finance and Accounting Services user name and password or Department of Defense (DoD) Self-Service Logon (DS Logon). You may visit a TRICARE Service Center or a Veterans Affairs Regional Office to complete an in-person proofing process to request a DS Logon, or you may go online for a remote-proofing process. For more information, visit **www.dmdc.osd.mil/identitymanagement**. If you need a new ID card, you can visit a uniformed services ID card-issuing facility and request a DS Logon at the same time.

Getting Married or Divorced

Marriage

It is extremely important for sponsors to register new spouses in DEERS to ensure they are eligible for TRICARE programs, including TFL. To register a new spouse in DEERS, the sponsor needs to provide a copy of the marriage certificate to the nearest uniformed services ID card-issuing facility. The new spouse is also required to show two forms of ID (*e.g., any combination of Social Security card, driver's license, birth certificate, current military ID card, or CAC*). Once your spouse is registered in DEERS, he or she receives a uniformed services ID card and is eligible for TFL. Your spouse must show his or her ID card to access care.

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.

Former Spouse Coverage

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

- Do not remarry (*If a former spouse remarries, the loss of benefits remains applicable even if the remarriage ends in death or divorce.*)
- Are not covered by employer-sponsored health plans
- Are not also former spouses of North Atlantic Treaty Organization or Partners for Peace nation members
- Meet the requirements of one of the two situations described in Figure 6.1

Former spouses who are TFL-eligible must change their personal information in DEERS so their name and Social Security number (SSN) or DoD 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 or DBN, not the sponsor's.

Eligibility Requirements for Former Spouses — *Figure 6.1*

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.

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

Children

Your dependent's coverage does not change because you are entitled to TFL. 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 coverage beyond your child's 21st birthday, contact DEERS to verify what documentation is needed.

At age 21 (*or 23*), adult children may be eligible for the TRICARE Young Adult (TYA) program, and later for the Continued Health Care Benefit Program (CHCBP). For more information on TYA, visit **www.tricare.mil/tya**. For more information on CHCBP, visit **www.tricare.mil/chcbp**.

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

Moving

Whether you are moving across the street or overseas, moving with TFL is easy. Just update your personal information in DEERS, find a provider who is Medicare-certified (*in the United States and U.S. territories [*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*]*) and TRICARE-authorized, and continue to receive care when you need it. See "Finding a Provider" in the *Getting Care* section of this handbook.

Survivor Coverage

If your TFL sponsor dies, you remain TRICARE-eligible and will continue to receive TFL benefits as long as your DEERS information is up to date and you are either of the following:

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

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

Upon the death of your sponsor, you will receive a letter from DEERS telling you about your program options and how your benefits will eventually change. If you have any questions, visit **www.tricare.mil/deers**.

Loss of Eligibility

Upon loss of TRICARE eligibility, each family member automatically receives a certificate of creditable coverage. The certificate of creditable coverage is a document that serves as evidence of prior health care coverage under TRICARE so that you cannot be excluded from a new health plan for 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 (*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*), a certificate is issued to the dependent child.
- Upon loss of coverage after divorce, a certificate is issued to the former spouse once information is updated in DEERS.

Certificates automatically reflect the most recent period of continuous coverage under TRICARE. Certificates issued upon a 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:

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

The request must include:

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

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

Suspension of Social Security Disability Insurance

Medicare coverage may continue up to eight years and six months following suspension of Social Security Disability Insurance payments. When Social Security Disability Insurance payments are suspended because you have returned to work, you will receive quarterly bills for the Medicare Part B premium. As long as you remain entitled to premium-free Medicare Part A, you must pay the Part B premium to maintain your TRICARE coverage.

For Information and Assistance

Beneficiary Counseling and Assistance Coordinators

TRICARE Beneficiary Counseling and Assistance Coordinators (BCACs) can help you with TRICARE For Life (TFL) questions and concerns, and they can advise you about obtaining health care. BCACs are located at military treatment facilities and TRICARE Regional Offices. To locate a BCAC, visit the online directory at **www.tricare.mil/bcacdcao**.

Your Right to Appeal a Decision

If you believe a service or claim was denied improperly, 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 Medicare or TFL decisions regarding claims payments.

Medicare and TFL have separate claims processes. For most services, Medicare is your primary payer. If you want to appeal a Medicare decision, you must contact Medicare. Contact Wisconsin Physicians Service (WPS) to appeal TFL decisions.

Medicare Denials

Any services or supplies denied payment by Medicare and appealable under Medicare are not considered for coverage by TFL. However, if a Medicare appeal results in some payment by Medicare, TRICARE considers coverage as the second payer. For more information on Medicare appeals, read the back of your *Medicare Summary* notice or contact Medicare.

TRICARE For Life Appeals Requirements

You may appeal a TFL denial of a requested authorization of services even if no care was provided and no claim was submitted. There are some things you may not appeal. For example, when TFL is the primary payer, you may not appeal the denial of care from a provider who is not TRICARE-authorized.

When services are denied based on medical necessity or a 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.

Filing TRICARE For Life Appeals

TFL appeals must be filed with WPS within 90 days from the date that appears on the explanation of benefits or denial notification letter. If you are not satisfied with a decision rendered on an appeal, there may be further levels of appeal available to you. Your TFL appeal must meet the requirements listed in Figure 7.1 on the following page. For specific information about filing a TFL appeal, contact WPS.

Prior authorization denial appeals may be either expedited or non-expedited, depending on the urgency of the situation. You or an appointed representative must file for an expedited review of a prior authorization denial within three calendar days of receipt of the initial denial. A non-expedited denial review must be filed no later than 90 days after receipt of the initial denial.

Appeals should contain the following:

- Beneficiary's name, address, and telephone number
- Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (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

TRICARE For Life Appeals Requirements ***Figure 7.1***

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.
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 treatment plan when an alternative treatment plan is selected
4	An 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 estimated TRICARE-allowable charge for the services requested. There is no minimum amount to request a reconsideration.

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 TFL health care delivery team, including TRICARE-authorized providers or military providers, to provide appropriate and timely health care services, access, or quality, or to deliver the proper level of care or service.

The TFL grievance process provides the opportunity to report, in writing, any concern or complaint regarding health care quality or service. Any TFL civilian or military provider; TFL beneficiary; sponsor; or parent, guardian, or other representative of an eligible dependent child may file a grievance. WPS is responsible for the investigation and resolution of all grievances.

Grievances are generally resolved within 60 days of receipt. Following resolution, the party that submitted the grievance is notified of the review completion.

Grievances may include such issues as:

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

When filing a grievance, include the following information:

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

A description of the issue or concern must include the following:

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

Contact Medicare to file Medicare-related grievances.

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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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TRICARE West Region
UnitedHealthcare Military & Veterans
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HA6551BET11123