PRIME

TRICARE® Prime and TRICARE Prime Remote Handbook

Your guide to program benefits

TRICARE®

November 2012

Important Information

TRICARE Web Site:	www.tricare.mil
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
*TRICARE Overseas Program**	
TRICARE Overseas Program Contractor:	International SOS Assistance, Inc.
TRICARE Eurasia-Africa:	1-877-678-1207
TRICARE Latin America and Canada:	1-877-451-8659
TRICARE Pacific:	1-877-678-1208 (*Singapore*)
	1-877-678-1209 (*Sydney*)
International SOS TRICARE Overseas Program Web Site:	www.tricare-overseas.com

** For overseas contact information, visit www.tricare-overseas.com.*

An Important Note About TRICARE Program Changes

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

Welcome to TRICARE Prime®, TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members

Your decision to enroll in TRICARE Prime, TRICARE Prime Remote (TPR), or TRICARE Prime Remote for Active Duty Family Members (TPRADFM) was an important one. To make the best use of your benefits, please read this *TRICARE Prime and TRICARE Prime Remote Handbook*. There are many resources listed throughout the handbook to help you if you have questions or need more information.

TRICARE Prime offers enhanced benefits and personalized care. Look in the mail and on your regional contractor's Web site for the *TRICARE Health Matters* newsletter, a regular publication for all TRICARE Prime beneficiaries. This publication will highlight covered services, customer service options, news, and other important updates. You can also sign up for more regular updates via e-mail at **www.tricare.mil/subscriptions**.

Note: TRICARE Overseas Program (TOP) Prime and TOP Prime Remote are distinct from and should not be confused with TRICARE Prime, TPR, or TPRADFM in the United States. International SOS Assistance, Inc. provides health care services and pays claims for TRICARE beneficiaries who are enrolled in these overseas programs. For more information about TOP, visit **www.tricare.mil/overseas**.

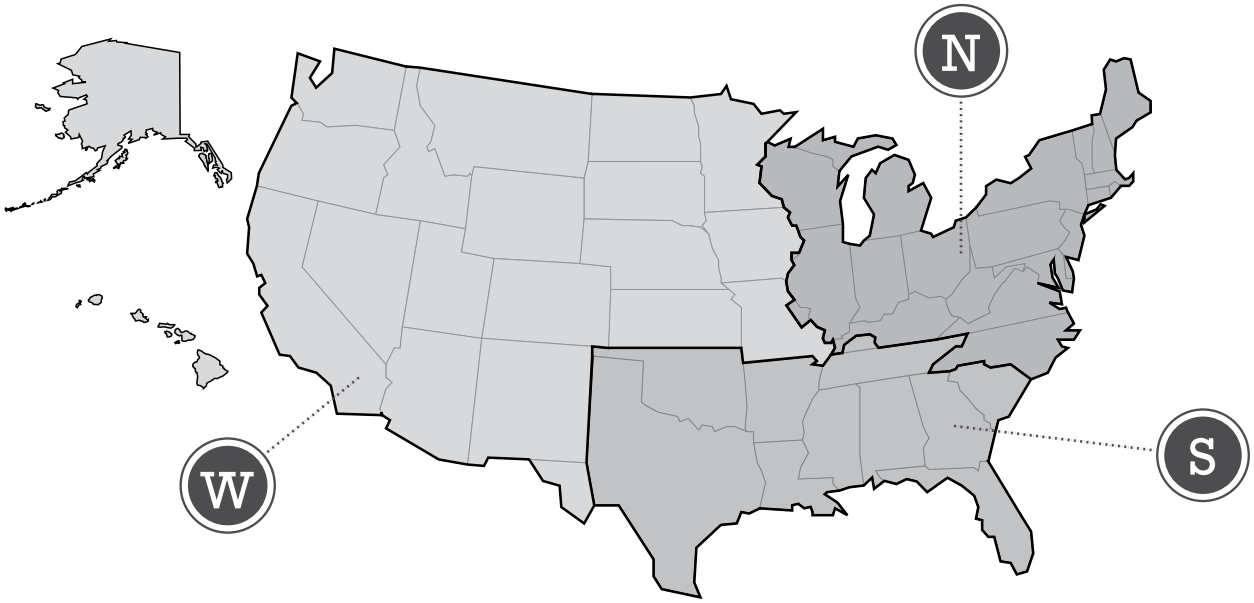
Health Care Services

With TRICARE Prime, you will receive most of your care from a primary care manager (PCM) that you select or are assigned. If you are a TRICARE Prime enrollee, your PCM can be either a military treatment facility (MTF) provider or a civilian TRICARE network provider. If you are a TPR or TPRADFM enrollee, your PCM can be either a civilian TRICARE network provider or a civilian non-network authorized provider (*if a network provider is not available*). PCMs and other provider types are described in the *Getting Started* section of this handbook.

A TRICARE Prime enrollment card and letter have been, or will be, sent to you. Write your PCM's name and telephone number on your enrollment card, and refer to this information when you need to make an appointment.

Your TRICARE Regional Contractor

Regional contractors administer the TRICARE medical benefit in each TRICARE region. This handbook refers regularly to your regional contractor and describes differences among the regions. In cases where there are differences, refer to the information specific to your region. TRICARE encourages you to visit your regional contractor's Web site, which includes information about how to change PCMs, how to enroll a child, covered services, referral and prior authorization requirements, and other helpful information. You can call your regional contractor toll-free for assistance at the numbers provided on the following page. Additionally, your regional contractor has TRICARE Service Centers located throughout the region, typically at MTFs, that have customer service representatives to assist you. You may also seek assistance from Beneficiary Counseling and Assistance Coordinators, who are located at MTFs and at the TRICARE Regional Offices.



TRICARE North Region

The TRICARE North Region includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky (*excluding the Fort Campbell area*), Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, portions of Iowa (*Rock Island Arsenal area*), and Missouri (*St. Louis area*).

Regional Contractor	Health Net Federal Services, LLC
Phone	1-877-TRICARE (1-877-874-2273)
Web Site	www.hnfs.com

TRICARE South Region

The TRICARE South Region includes Alabama, Arkansas, Florida, Georgia, Kentucky (*Fort Campbell area only*), Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (*excluding the El Paso area*).

Regional Contractor	Humana Military, a division of Humana Government Business
Phone	1-800-444-5445 1-877-249-9179 (*TRICARE Prime Remote and Supplemental Health Care Program*)
Web Site	Humana-Military.com

TRICARE West Region

The TRICARE West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (*excluding the Rock Island Arsenal area*), Kansas, Minnesota, Missouri (*excluding the St. Louis area*), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (*the southwestern corner only, including El Paso*), Utah, Washington, and Wyoming.

Regional Contractor	UnitedHealthcare Military & Veterans
Phone	1-877-988-WEST (1-877-988-9378)
Web Site	www.uhcmilitarywest.com

Service Point of Contact for Active Duty Service Members Enrolled in TRICARE Prime Remote

The service point of contact (SPOC) coordinates civilian health care for TPR-enrolled active duty service members (ADSMs) of the uniformed services. Department of Defense SPOCs are located at the Military Medical Support Office (MMSO). U.S. Public Health Service SPOCs are located at the Beneficiary Medical Program Office. National Oceanic and Atmospheric Administration SPOCs are available through the Commissioned Personnel Center.

The SPOC reviews requests for specialty and inpatient care to determine how it might affect your fitness for duty. If the care affects fitness for duty, then the SPOC will decide if you should receive that care at an MTF or from a civilian provider. The SPOC will make this determination based on current service-specific guidelines and clinical standards and will ensure your medical care related to your fitness-for-duty condition is covered. If the SPOC determines there is no impact on fitness for duty, he or she will refer you to a civilian specialist for the care.

Service Branch	SPOC Contact Information
U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, and U.S. Coast Guard	1-888-MHS-MMSO (1-888-647-6676)
U.S. Public Health Service	Medical Affairs Branch 1-800-368-2777
National Oceanic and Atmospheric Administration	Commissioned Personnel Center 1-800-224-6622

Important Note for National Guard and Reserve Members and Their Families

National Guard and Reserve members who are ordered to active duty for more than 30 consecutive days become eligible for TRICARE as ADSMs, and their family members become eligible for TRICARE as active duty family members (ADFMs).

Family members may choose TRICARE Prime, TPRADFM, or TRICARE Standard and TRICARE Extra, depending on the programs available at your location. Your service personnel office determines eligibility for pre-activation benefits. Contact your unit personnel office regarding your eligibility. Your activation orders should contain your unit personnel office address and contact information.

Throughout this *TRICARE Prime and TRICARE Prime Remote Handbook*, when we refer to ADSMs and ADFMs, we are also referring to activated National Guard and Reserve members and their families enrolled in TRICARE Prime, TPR, or TPRADFM. If you have any questions about any of these programs, contact your regional contractor.

Keep Your DEERS Information Up To Date!

It is essential to 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*) worldwide, their family members, and others who are eligible for military benefits, including TRICARE. Proper and current registration in DEERS is key to receiving timely, effective TRICARE benefits including doctors' appointments, prescriptions, payment of health care expenses, authorization letters, and explanations of benefits. Failure to update DEERS to accurately reflect the sponsor's or family member's residential address and/or the ineligibility of a former dependent could be considered fraud and a basis for administrative, disciplinary, and/or other appropriate action.

You have several options for updating and verifying DEERS information:

In Person[1] (*add 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
Online[3]	• milConnect Web site: **http://milconnect.dmdc.mil**

1. *Only sponsors (*or those appointed power of attorney*) can add family members. Family members age 18 and older may update their own contact information.*
2. *Use these methods to change contact information only.*
3. *Please see "Beneficiary Web Enrollment" in the* Getting Started *section of this handbook for more information about online tools.*

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Eligibility and Enrollment

TRICARE Prime

Eligibility for TRICARE Prime

For active duty service members (ADSMs) located in areas where TRICARE Prime is available, enrollment in TRICARE Prime is mandatory. Active duty family members (ADFMs) and retirees and their family members may also enroll in TRICARE Prime if they live in Prime Service Areas (PSAs). A PSA is a geographic area where TRICARE Prime benefits are offered. It is typically an area around a military treatment facility (MTF) or other predetermined areas.

Please note that enrollment in TRICARE Prime is not automatic. An enrollment action must be taken to ensure Defense Enrollment Eligibility Reporting System (DEERS) enrollment data is current and claims are processed correctly. Within PSAs, TRICARE Prime is available to:

- ADFMs
- Transitional survivors
- Certain unremarried former spouses
- Retirees, retiree family members, and survivors
- National Guard and Reserve members who are ordered to active duty for more than 30 consecutive days and their eligible family members
- Medal of Honor recipients and their families

For more information about these beneficiary categories, visit **www.tricare.mil/eligibility**.

Your DEERS information, including your residential address and, if applicable, a separate mailing address, must be accurate and current. Only sponsors (*or sponsor-appointed individuals with valid power of attorney*) can add family members. Family members age 18 and older may update their own contact information.

Regardless of your status, if your DEERS information is incorrect or outdated, you may not be eligible to enroll. Failure to update DEERS to accurately reflect the ineligibility of former dependents could be considered fraud and a basis for administrative, disciplinary, and/or other appropriate action.

Enrolling in TRICARE Prime

Eligible beneficiaries must be registered in DEERS and submit a *TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form* (DD Form 2876) to their regional contractors or local TRICARE Service Centers. Beneficiaries may also enroll online by visiting the Beneficiary Web Enrollment (BWE) Web site at **www.dmdc.osd.mil/appj/bwe/**. Enrollment is open year-round. Visit **www.tricare.mil/forms** to download forms.

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

Active Duty Service Members

Eligibility for TRICARE Prime Remote

To be eligible for TRICARE Prime Remote (TPR), you must be an ADSM in the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, U.S. Public Health Service, or National Oceanic and Atmospheric Administration. Additionally, your DEERS information must be accurate and current. Regardless of your status, if your DEERS information is incorrect or outdated, you may not be eligible to enroll. Finally, your residential and work ZIP codes must be designated as TPR ZIP codes to indicate that you live and work more than 50 miles (*or approximately a one-hour drive*) from the closest MTF.

To determine your eligibility for TPR, visit **www.tricare.mil/tpr/default_zip.aspx** and type in your residential and work ZIP codes. You can also contact your regional contractor.

Exceptions to Eligibility Requirements

If you live or work within 50 miles of an MTF, you will generally not be eligible for TPR. You may submit a *TPR Determination of Eligibility Enrollment Request Form* if you believe geographic boundaries cause you to drive more than one hour to an MTF. The request must be directed through your unit commander to the TRICARE Regional Office in your area. Visit **www.tricare.mil/tpr** for the request form for your region to submit your request online.

Enrolling in TRICARE Prime Remote

TPR enrollment for TPR-qualified ADSMs is mandatory, unless there is a service-specific requirement for MTF enrollment, or if you waive your access standards to enroll at an MTF. If you are not qualified to enroll in TPR, you must enroll in TRICARE Prime.

Complete and submit *DD Form 2876* to your regional contractor. Follow the instructions on the form or contact your regional contractor for guidance.

If you do not have *DD Form 2876*, visit **www.tricare.mil/forms** or your regional contractor's Web site to download one. You can also contact your regional contractor to get a form.

To enroll online, visit the BWE Web site at **www.dmdc.osd.mil/appj/bwe/**. For more information about BWE, see the *Getting Started* section of this handbook.

Active Duty Family Members

Eligibility for TRICARE Prime Remote for Active Duty Family Members

To be eligible for TRICARE Prime Remote for Active Duty Family Members (TPRADFM), you must reside at your TPR-enrolled sponsor's qualifying TPR location. A TPR-enrolled sponsor lives and works more than 50 miles (*or approximately a one-hour drive*) from the closest MTF. Additionally, your DEERS information must be accurate and current. Regardless of status, if your DEERS information is incorrect or outdated, you may not be eligible to enroll in TPRADFM.

Note: The DEERS address information listed for you and your sponsor is used to determine residency. If your sponsor is stationed in a remote location and you live with your sponsor, then you are eligible for TPRADFM as long as your DEERS information is accurate.

Additionally, you remain eligible for TPRADFM as long as your sponsor is enrolled in TPR and you reside in the same TPR-qualifying location, or if

your sponsor receives a subsequent unaccompanied permanent change of assignment and you continue to reside in the same TPR location. If you choose not to enroll in TPRADFM, you will receive care under TRICARE Standard and TRICARE Extra, with applicable cost-shares and deductibles.

To determine your eligibility for TPRADFM, visit **www.tricare.mil/tpr/default_zip.aspx** and type in your sponsor's residential and work ZIP codes. You can also contact your regional contractor.

Exceptions to Eligibility Requirements

If your sponsor lives or works within 50 miles of an MTF, you will generally not be eligible for TPR. Your sponsor may submit a *TPR Determination of Eligibility Enrollment Request Form* if he or she believes geographic boundaries cause you to drive more than one hour to an MTF. The request must be directed through his or her unit commander to the TRICARE Regional Office in your area. Visit **www.tricare.mil/tpr** for the request form for your region to submit the request online.

Enrolling in TRICARE Prime Remote for Active Duty Family Members

Your sponsor can include all eligible family members on his or her *DD Form 2876*. The enrollment application must be completed and submitted to your regional contractor. Follow the instructions on the form or contact your regional contractor for guidance.

If you do not have *DD Form 2876*, visit **www.tricare.mil/forms** or your regional contractor's Web site to download one. You can also contact your regional contractor to get a form.

To enroll online, visit the BWE Web site at **www.dmdc.osd.mil/appj/bwe/**. For more information about BWE, see the *Getting Started* section of this handbook.

National Guard and Reserve Members

Eligibility for TRICARE Prime Remote

To be considered an ADSM and eligible for TRICARE active duty coverage, you must be a National Guard or Reserve member on orders to active duty for more than 30 consecutive days or within 180 days of mobilization based on early activation orders. In the case of early eligibility, the effective date is the later of either: (a) the date of issuance of the delayed-effective active duty order, or (b) 180 days before the date on which the period of active duty is to begin. Until then, you should coordinate care with your unit. If eligible, your family members may enroll in TPRADFM during the early-eligibility period. You cannot enroll in TPR until you reach your final duty location.

Your DEERS information must be accurate and current, regardless of your status. If your DEERS information is incorrect or outdated, you may not be eligible to enroll. While on orders, you must live and work more than 50 miles (*or approximately a one-hour drive*) from the closest MTF.

To determine your eligibility for TPR, visit **www.tricare.mil/tpr/default_zip.aspx** and type in your residential and work ZIP codes. You can also contact your regional contractor.

Exceptions to Eligibility Requirements

If you live or work within 50 miles of an MTF, you will generally not be eligible for TPR. But you may submit a *TPR Determination of Eligibility Enrollment Request Form* if you believe geographic boundaries cause you to drive more than one hour to an MTF. The request must be directed through your unit commander to the TRICARE Regional Office in your area. Visit **www.tricare.mil/tpr** for the waiver request form for your region to submit your request online.

Enrolling in TRICARE Prime Remote

Complete and submit *DD Form 2876* to your regional contractor. Follow the instructions on the form or contact your regional contractor for guidance.

If you do not have *DD Form 2876*, visit **www.tricare.mil/forms** or your regional contractor's Web site to download one. You can also contact your regional contractor to get a form.

To enroll online, visit the BWE Web site at **www.dmdc.osd.mil/appj/bwe/**. For more information about BWE, see the *Getting Started* section of this handbook.

National Guard and Reserve Family Members

Eligibility for TRICARE Prime Remote for Active Duty Family Members

You are eligible for TPRADFM if your sponsor is called to active duty for a period of more than 30 consecutive days and you reside at your sponsor's TPR-qualifying residence address on the day of the sponsor's activation or the effective date of early eligibility. You are considered an ADFM when your sponsor is on active duty orders. Additionally, family members of 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 TRICARE-eligible.

Sponsors of National Guard and Reserve family members who are called to active duty for a period of more than 30 consecutive days are not required to be eligible for, or be enrolled in, TPR for their

family members to be eligible for TPRADFM. (*Some sponsors may be enrolled at a small government clinic, troop medical clinic, or other facility not capable of primary care management functions and available only to ADSMs.*)

Your DEERS information must be accurate and current. Regardless of your status, if your DEERS information is incorrect or outdated, you may not be eligible to enroll.

Once you enroll in TPRADFM, you may remain in TPRADFM as long as your National Guard and Reserve sponsor remains on active duty and you continue to reside at your sponsor's TPR-qualifying residence address, even if your sponsor receives a subsequent unaccompanied permanent change of assignment. However, if you move from the TPRADFM location where you are enrolled or if your sponsor retires, you will lose TPRADFM coverage and will be eligible for TRICARE Standard and TRICARE Extra or TRICARE Prime (*where available*).

Verify your eligibility in DEERS or contact your regional contractor to determine your eligibility for TPRADFM.

Enrolling in TRICARE Prime Remote for Active Duty Family Members

Your sponsor can include all eligible family members on his or her *DD Form 2876*. To qualify for TPR, family members must live at the sponsor's TPR-qualifying residence with a TPR-enrolled sponsor. However, this rule does not apply to family members of National Guard and Reserve sponsors called to active duty for a period of more than 30 consecutive days. As long as family members live at the sponsor's TPR-qualifying residence on the day of the sponsor's activation or the effective date of early eligibility, they are able to enroll in TPRADFM, regardless of whether or not their sponsor is enrolled in TPR. Follow the instructions on the form or contact your regional contractor for guidance.

If you do not have *DD Form 2876*, visit **www.tricare.mil/forms** or your regional contractor's Web site to download one. You can also call your regional contractor to get a form.

To enroll online, visit the BWE Web site at **www.dmdc.osd.mil/appj/bwe/**. For more information about BWE, see the *Getting Started* section of this handbook.

Supplemental Health Care Program

The Supplemental Health Care Program (SHCP) is a program for eligible uniformed service members and certain other patients who need medical care that is not available at an MTF. The SHCP allows this care to be purchased from civilian providers under TRICARE payment rules when approved by the appropriate MTF Commander or the Director, TRICARE Management Activity, as required.

US Family Health Plan

The US Family Health Plan (USFHP) is a TRICARE Prime managed care option available through networks of community-based, not-for-profit health care systems in six areas of the United States. Eligible beneficiaries must be registered in DEERS and live within one of the designated USFHP service areas to enroll.

For more information on the USFHP, visit **www.usfhp.com**.

Getting Started

TRICARE Provider Types

TRICARE defines a provider as a person, business, or institution that provides health care. For example, a doctor, hospital, or ambulance company is a provider. Providers must be authorized under TRICARE regulations and have their status certified by the regional contractors to provide services to TRICARE beneficiaries.

Military Treatment Facilities

A military treatment facility (MTF) provides medical and/or dental care to eligible individuals including members of the uniformed services and their dependents. MTFs are usually located on or near military installations. To locate an MTF near you, visit **www.tricare.mil/mtf**.

Civilian Providers

Figure 2.1 explains the different types of civilian TRICARE providers.

U.S. Department of Veterans Affairs Health Care Facilities

Most U.S. Department of Veterans Affairs (VA) health care facilities have agreed to join the TRICARE network. While VA facilities may or may not provide primary care, many provide specialty care. If you need care and a participating VA health care facility near you can provide that

TRICARE Provider Types — *Figure 2.1*

TRICARE-Authorized Providers		
• TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers (*laboratories and radiology centers*), and pharmacies that meet TRICARE requirements. If you see a provider that is not TRICARE-authorized, you are responsible for the full cost of care. • There are two types of TRICARE-authorized providers: **network** and **non-network**.		
Network Providers	**Non-Network Providers**	

• Regional contractors have established provider networks, even in areas far from military treatment facilities, and you may choose or be assigned a primary care manager (PCM) who is part of the TRICARE network.
• Using a network provider can be your best option, when coordinated by your PCM, as available.
• TRICARE network providers:
  • Have a signed agreement with your regional contractor to provide care
  • Agree to file claims for you
	• Non-network providers do not have a signed agreement with your regional contractor and are considered "out of network." In most cases, you will not receive care from non-network providers unless authorized by your regional contractor. You may seek care from a non-network provider in an emergency or if you are using the point-of-service option.
	• There are two types of non-network providers: ***participating*** and ***nonparticipating***.	

	Participating	**Nonparticipating**

	• Using a participating provider is your best option if you are seeing a non-network provider.
	• Participating providers:
	  • May choose to participate on a claim-by-claim basis
	  • Have agreed to accept payment directly from TRICARE and accept the TRICARE-allowable charge (*less any applicable patient cost-shares paid by you*) as payment in full for their services
		• If you visit a nonparticipating provider, you may have to pay the provider first and later file a claim with TRICARE for reimbursement.
		• Nonparticipating providers:
		  • Have not agreed to accept the TRICARE-allowable charge or file your claims
		  • Have the legal right to charge you up to 15 percent above the TRICARE-allowable charge for services (*You are responsible for paying this amount in addition to any applicable patient cost-shares.*)

care (*within TRICARE access standards*), you may be asked to use that VA facility. All active duty service members (ADSMs) and other TRICARE Prime enrollees who are referred to a VA medical facility for care must have an authorization. Be sure to find out the VA facility's status as a TRICARE network or non-network provider before you receive TRICARE-covered health care at a VA facility. The VA liaison at your TRICARE Regional Office can assist you.

Your Primary Care Manager

When enrolled in TRICARE Prime, your primary care manager (PCM) may be an MTF provider or a civilian TRICARE network provider within a TRICARE Prime Service Area (PSA). A PSA is a geographic area where TRICARE Prime is offered. It is typically an area around an MTF or other predetermined areas. TRICARE Prime beneficiaries who live within a one-hour drive of an MTF may be required to first seek specialty care, ancillary services, and physical therapy at the MTF. Your PCM and/or specialty care provider should coordinate any required referrals and/or prior authorizations with the regional contractor. This includes services that may need to be provided at an MTF.

When enrolled in TRICARE Prime Remote (TPR) or TRICARE Prime Remote for Active Duty Family Members (TPRADFM), your PCM will either be a civilian TRICARE network provider or, if a network provider is not available, you will not have a PCM and must use a TRICARE-authorized provider for primary care services.

Whether enrolled in TRICARE Prime, TPR, or TPRADFM, your PCM will provide all of your routine (*primary*) care and refer you for specialty care services. If you do not have an assigned network PCM, you or your primary care provider must coordinate specialty care referrals with your regional contractor. If you have any questions about your PCM, please contact your regional contractor for assistance.

You are encouraged to make initial contact with your new PCM within 30 days to establish yourself as a new patient. You should maintain an open and active relationship with your PCM so you can work together to meet your health care needs.

On-Call Providers

PCMs are required to provide services 24 hours a day, seven days a week. To cover all hours, your PCM may designate an on-call provider who will act on his or her behalf to support your health care needs. Therefore, the information, instructions, care, or care coordination you receive from the on-call provider should be treated as if it were coming from your PCM.

Changing Your Primary Care Manager

While you may change your PCM at any time, the process is different depending on whether or not you have a network PCM. If you are changing your PCM because you are moving, see "Moving" in the *Changes to Your TRICARE Coverage* section of this handbook for more information.

Network Primary Care Manager

If you have a network PCM, you may change your PCM at any time, provided the new PCM is accepting new patients and your request complies with access-to-care guidelines. Once you select a new PCM from your regional contractor's provider directory (*available on your regional contractor's Web site*), complete a *TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form* (DD Form 2876). You only need to complete the portion of the form related to the change.

If you choose a PCM that is more than 30 minutes from your home, you must sign (*in Sections V and VI of* DD Form 2876) a waiver of the TRICARE Prime access standards to acknowledge that you may have to drive more than 30 minutes to your PCM for routine care. See "Access Standards for Care" in the *Getting Care* section of this handbook for additional information. The PCM change will become effective once the application is received and processed by your regional contractor. You can find information about changing your PCM on your regional contractor's Web site. Once your PCM change is processed, you will receive a confirmation letter with your new PCM's name and telephone number.

In the United States, you can also change your PCM on the Beneficiary Web Enrollment (BWE) Web site at **www.dmdc.osd.mil/appj/bwe/**. When you select or change your PCM through BWE, the site will not factor in drive time from your home to your PCM. Therefore, you should be aware of the drive time before you choose a PCM. Enrolling through the BWE Web site confirms that you waive your access standards. See "Beneficiary Web Enrollment" later in this section for additional information.

Note: The online PCM change option is not available to ADSMs. ADSMs should submit *DD Form 2876* to their regional contractors by mail or through a TRICARE Service Center (TSC). See "Your TRICARE Regional Contractor" in the *Welcome to TRICARE Prime*, *TRICARE Prime Remote*, *and TRICARE Prime Remote for Active Duty Family Members* section at the beginning of this handbook for contact information.

Non-Network Primary Care Provider (*TPR and TPRADFM Only*)

If you are using a non-network TRICARE-authorized provider as your primary care provider, you can find a new provider by contacting your regional contractor.

Other Health Care Provider Types

Besides your PCM, there are other health care provider types to be familiar with:

- **Specialty care providers:** Specialty care providers offer treatment that your PCM cannot provide. Under TRICARE Prime program options, your PCM will provide referrals for you to receive services from specialty care providers and will coordinate the referral request with your regional contractor when necessary. Some examples of specialty care providers include obstetricians (*child birth doctors*), orthopedic surgeons (*bone doctors*), and gastroenterologists (*stomach and intestine doctors*).
- **Ancillary care providers:** Ancillary care providers are similar to specialty care providers in that your PCM (*or specialty care provider on behalf of your PCM*) will need to coordinate a referral request to see them. Some examples of ancillary care providers include laboratories, radiologists (*doctors who review X-rays*), and home health care providers.
- **Facilities:** Facilities are medical centers that offer medical and/or surgical services. Some examples of facilities are hospitals, birthing centers (*facilities with nurse-midwives that offer a more natural child birth experience*), skilled nursing facilities (*facilities such as rest homes where patients need medical support 24 hours a day*), and ambulatory surgery centers (*facilities where patients receive minor surgeries and are released to go home the same day*).
- **Behavioral health care providers:** Behavioral health care includes a broad range of MTF or civilian providers and treatments. Refer to "Behavioral Health Care Services" in the *Covered Services, Limitations, and Exclusions* section of this handbook for more information about behavioral health provider types and coverage requirements.

TRICARE Prime Annual Enrollment Fees

There are no enrollment fees for ADSMs and active duty family members (ADFMs) enrolled in TRICARE Prime, TPR, or TPRADFM. Retired service members and their eligible family members, survivors, former spouses, and others enrolled in TRICARE Prime are required to pay an annual enrollment fee, which is applied to the catastrophic cap. TRICARE Prime enrollment fees are subject to change each fiscal year (*October 1–September 30*). Surviving beneficiaries and medically retired uniformed service members and their dependents will have their TRICARE Prime enrollment fees frozen at the rate in effect at the time they become survivors or medically retired and are enrolled in a TRICARE program option. Beneficiaries in this category will not be charged a fee increase as long as at least one family member remains enrolled. Figure 2.2 details your enrollment fee payment options. Visit **www.tricare.mil/costs** for specific and current cost information.

Beneficiary Web Enrollment

The BWE Web site allows eligible sponsors and their family members in the United States to manage their enrollment without visiting a TSC or mailing a *DD Form 2876* to their regional contractors. BWE is linked to the Defense Enrollment Eligibility Reporting System (DEERS) and allows simultaneous updates to personal contact information (*e.g., home address, phone number, e-mail*) for both DEERS and TRICARE.

Log on to **www.dmdc.osd.mil/appj/bwe/** to access BWE with one of the following:

- Valid certified Common Access Card (CAC)
- Defense Financial and Accounting Services myPay PIN
- Department of Defense (DoD) Self-Service Logon

Through BWE, you can:

- Enroll or disenroll
- Transfer your enrollment to a new location
- Request a new PCM (*Refer to "Changing Your Primary Care Manager" earlier in this section for additional information on using BWE to change your PCM.*)
- Make an initial enrollment fee credit or debit card payment (*Ongoing electronic funds transfer and allotment payments can be set up separately through your regional contractor.*)
- Add other health insurance information (*when initially enrolling*)
- Request a new TRICARE Prime, TPR, or TPRADFM enrollment card
- View your enrollment information

TRICARE Prime Enrollment Fee Payment Options *Figure 2.2*

Payment Options		Payment Instructions
Monthly	**Automated Deduction from Retired Pay**	Complete an *Enrollment Fee Allotment Authorization* (*available from your regional contractor*). Once authorized, your TRICARE Prime enrollment fee is deducted automatically from your retirement pay on a monthly basis. A three-month payment is required to allow time for the allotment to be established.
	Electronic Funds Transfer (EFT)	Provide your correct banking information to your regional contractor. Once authorized, your TRICARE Prime enrollment fee is deducted automatically from your bank account on a monthly basis. A three-month payment is required to allow time for the EFT to be established.
Quarterly or Annually	**Visa® or MasterCard®**	Your initial payment will be charged to your credit card. Initial payments can be made through TRICARE's Beneficiary Web Enrollment Web site at **www.dmdc.osd.mil/appj/bwe/**, and subsequent payments can be made through your regional contractor's Web site.

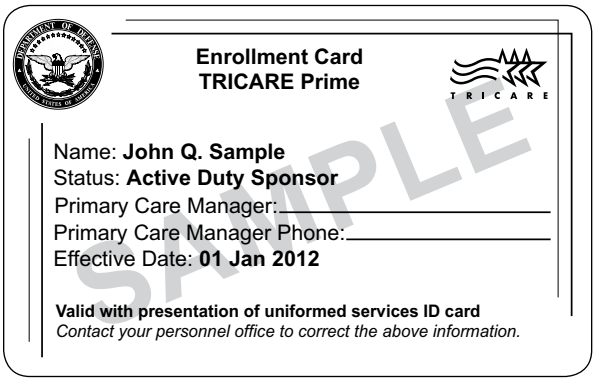
Enrollment Cards

Each enrolled family member will receive a TRICARE Prime, TPR, or TPRADFM enrollment card, which shows the effective dates of enrollment. Included with the card is a letter identifying your PCM's name and telephone number, if assigned. Write your PCM's name and telephone number on your card. If you are not assigned a PCM, write your regional contractor's contact information on your card. TRICARE network providers may require you to show the enrollment card as well as your uniformed services identification (ID) card or CAC at the time of service. You may view and download your TRICARE Prime enrollment card through milConnect at **http://milconnect.dmdc.mil**. Figures 2.3, 2.4, and 2.5 show examples of the TRICARE Prime, TPR, and TPRADFM enrollment cards.

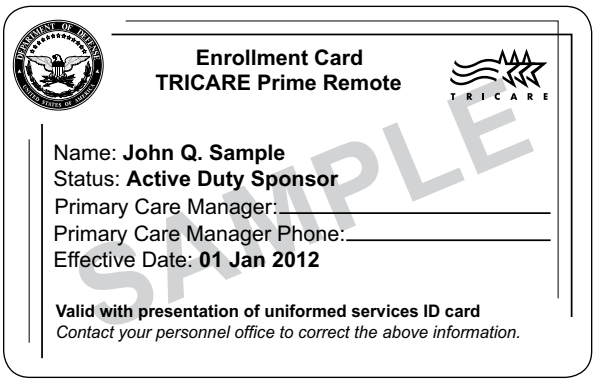
Your TRICARE Prime enrollment card does not verify your eligibility for TRICARE. Only your DEERS record can verify your eligibility.

Note: A health care provider photocopying your ID card or CAC for authorized purposes is legal.

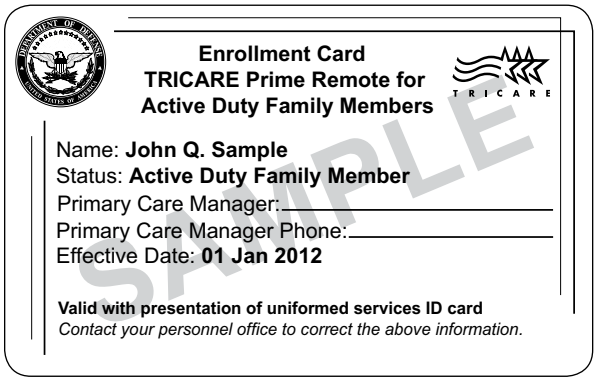
TRICARE Prime Enrollment Card *Figure 2.3*


Enrollment Card
TRICARE Prime
TRICARE
Name: **John Q. Sample**
Status: **Active Duty Sponsor**
Primary Care Manager:
Primary Care Manager Phone:
Effective Date: **01 Jan 2012**
Valid with presentation of uniformed services ID card
Contact your personnel office to correct the above information.
SAMPLE

TRICARE Prime Remote Enrollment Card *Figure 2.4*


Enrollment Card
TRICARE Prime Remote
TRICARE
Name: **John Q. Sample**
Status: **Active Duty Sponsor**
Primary Care Manager:
Primary Care Manager Phone:
Effective Date: **01 Jan 2012**
Valid with presentation of uniformed services ID card
Contact your personnel office to correct the above information.
SAMPLE

TRICARE Prime Remote for Active Duty Family Members Enrollment Card *Figure 2.5*


Enrollment Card
TRICARE Prime Remote for
Active Duty Family Members
TRICARE
Name: **John Q. Sample**
Status: **Active Duty Family Member**
Primary Care Manager:
Primary Care Manager Phone:
Effective Date: **01 Jan 2012**
Valid with presentation of uniformed services ID card
Contact your personnel office to correct the above information.
SAMPLE

Social Security Number Reduction

The DoD is removing Social Security numbers (SSNs) from uniformed services ID cards as part of the continued effort to protect the privacy and security of TRICARE's 9.7 million beneficiaries. Instead of displaying the sponsor's SSN, ID cards now show a 10-digit DoD ID number. If you have DoD benefits (*e.g., health care, commissary, exchange privileges*), a DoD Benefits Number (DBN) is also printed on the card. This is a unique number that will ensure your records are clearly aligned with your treatments. The new DBN can be found above the bar code on the back of your uniformed services ID card. The replacement process is expected to last several years, until all current uniformed services ID cards are replaced as they come up for renewal.

Note: You do not need to make a special trip to have your uniformed services ID card updated until it expires. Your health care providers and pharmacists will be able to access your benefits using either your SSN or your DBN. For more information, visit **www.tricare.mil/ssn**.

Disenrollment

Enrollment in TRICARE Prime is continuous—you do not have to reenroll every year to maintain coverage. However, certain events will cause you to be disenrolled.

Sponsor Status Change

A change in the sponsor's status (*e.g., retirement or National Guard and Reserve member deactivation*) will cause you to be disenrolled automatically from TRICARE Prime. To avoid a lapse in coverage, you should submit a new enrollment application to your regional contractor before the date of the status change if you will remain eligible for TRICARE Prime after the change. In some cases, such as during the Transitional Assistance Management Program period, you may not be able to reenroll in TPR or TPRADFM. For example, if you were enrolled in TPR and you retire from active duty, the TPR option is no longer available to you. To continue TRICARE Prime coverage, you will need to move to an area where TRICARE Prime is offered and enroll or waive access standards. Otherwise, your coverage will continue under TRICARE Standard and TRICARE Extra.

Nonpayment of Enrollment Fees

If you are required to pay enrollment fees and you do not pay them when due, you will be disenrolled from TRICARE Prime. When disenrolled for nonpayment, you are subject to a 12-month lockout during which you will not be permitted to reenroll in TRICARE Prime. To learn more about automatic payment options, visit the TRICARE Web site at **www.tricare.mil** or contact your regional contractor. If you are disenrolled from TRICARE Prime, you may be covered under TRICARE Standard if all eligibility requirements are met.

Voluntary Disenrollment

ADFMs who choose to change their enrollment status (*i.e., from enrolled to disenrolled or vice versa*) twice in an enrollment year (*October 1–September 30*) for any reason are subject to a 12-month lockout,* during which they will not be permitted to reenroll in TRICARE Prime or TPRADFM. Retirees and their family members who voluntarily disenroll from TRICARE Prime before their annual enrollment renewal date are subject to a 12-month lockout. You must contact your regional contractor to initiate a voluntary disenrollment. If you are disenrolled from TRICARE Prime, you may be covered under TRICARE Standard if all eligibility requirements are met.

Voluntary disenrollment is not an option for ADSMs; active duty personnel must enroll in either TRICARE Prime or TPR.

Note for TPRADFM beneficiaries: If your sponsor is deployed, you may remain enrolled during his or her deployment. However, if you move from your current TPR ZIP code area while your sponsor is deployed, you no longer qualify for TPRADFM. If you are moving to an area where TRICARE Prime is available, you must change from TPRADFM to TRICARE Prime. If you are moving to an area where TRICARE Prime is not available, you must disenroll from TPRADFM, and you will be covered by TRICARE Standard and TRICARE Extra.

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

Loss of Eligibility

If your DEERS record indicates loss of TRICARE eligibility, your TRICARE Prime coverage will automatically end. If you believe you are still eligible for TRICARE, you will need to update your DEERS record to reestablish your eligibility. Contact DEERS directly at **1-800-538-9552**. Once DEERS is updated, you must reenroll in TRICARE Prime or, if you are a family member, you will be covered under TRICARE Standard and TRICARE Extra.

If your DEERS record is correct and you have lost eligibility, you may qualify for transitional health care. See "Separating from the Service" in the *Changes to Your TRICARE Coverage* section of this handbook for details about transitional health care options. You will receive a certificate of creditable coverage when TRICARE eligibility is lost. See "Loss of Eligibility" in the *Changes to Your TRICARE Coverage* section of this handbook for more information about certificates of creditable coverage.

Getting Care

You receive routine (*primary*) health care from your primary care manager (PCM), and your PCM will refer you to another health care provider if necessary. You are guaranteed access to care within specific time frames. You may qualify for travel reimbursement if referred to specialty care that is more than 100 miles from your PCM's office. This section explains details about using TRICARE Prime, TRICARE Prime Remote (TPR), and TRICARE Prime Remote for Active Duty Family Members (TPRADFM).

Making an Appointment

To make a primary care appointment, contact your PCM's office. There is no need to contact your regional contractor to schedule primary care appointments.

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.

Note: Most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE. Active duty service members (ADSMs) receive dental care from military dental treatment facilities and, if necessary, from civilian providers through the TRICARE Active Duty Dental Program. Active duty family members and retirees and their family members may be eligible to enroll in either the TRICARE Dental Program or the TRICARE Retiree Dental Program, depending on their status. For more information, refer to "Dental Options" in the *Covered Services, Limitations, and Exclusions* section of this handbook.

If a medical emergency occurs, call 911 or go to the nearest emergency room. You do not need to call your PCM or regional contractor before receiving emergency medical care (*including overseas care*). However, in all emergencies, you must notify your PCM within 24 hours or on the next business day following admission to coordinate ongoing care and to ensure you receive proper authorization. Additionally, ADSMs enrolled in TPR should contact their service point of contact (SPOC) as soon as possible.

Nonemergency Care for Active Duty Service Members

If you are an ADSM traveling or between duty stations, you must receive all nonemergency care at a military treatment facility (MTF) if one is available. If an MTF is not available, prior authorization from your regional contractor and a referral from your PCM is required before receiving nonemergency civilian care. Make sure you or the requesting provider calls your regional contractor for assistance with referral coordination. You can learn more about the differences among routine, urgent, emergency, and specialty care at **www.tricare.mil**.

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.

In most cases, you can receive urgent care from your PCM by making a same-day appointment. If you do not coordinate urgent care with your PCM or regional contractor, the care will be

covered under the point-of-service (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 contact your regional contractor for assistance before receiving care.

* *The POS option does not apply to ADSMs, children for the first 60 days following their birth or adoption, emergency care, beneficiaries with other health insurance, or the first eight behavioral health outpatient visits to a network provider for a medically diagnosed and covered condition per fiscal year (*October 1–September 30*).*

TPR and TPRADFM Enrollees without an Assigned PCM

If you live in an area where a TRICARE provider network has not been established by your regional contractor, you may seek urgent care from any TRICARE-authorized provider. For cost details, visit **www.tricare.mil/costs**.

If you are not sure if a provider is TRICARE-authorized, contact your regional contractor.

Routine (*Primary*) 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. You will receive most of your routine or primary 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 will refer you to another provider. If you receive any routine care from another provider without a referral from your PCM, you will be using the POS option, resulting in higher out-of-pocket costs. For cost details, visit **www.tricare.mil/costs**.

Services That Do Not Require Referrals

Some services may be obtained without a PCM referral. These include clinical preventive services, and outpatient behavioral health care for a medically diagnosed and covered condition to a network provider authorized under TRICARE regulations to see patients independently. While a PCM referral is not required, you must obtain prior authorization from your regional contractor beginning with the ninth outpatient behavioral health care visit per fiscal year (FY). A physician referral and supervision is always required to see pastoral counselors and may be required to see mental health counselors. For more information, see the *Covered Services, Limitations, and Exclusions* section of this handbook.

If you seek care, including clinical preventive services or behavioral health care, from a non-network provider without a referral from your PCM and regional contractor, you will be using the POS option, resulting in higher out-of-pocket costs. For cost details, visit **www.tricare.mil/costs**.

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

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.

Specialty Care

There are times when you will need to see a specialist for a diagnosis or treatment that your PCM cannot provide. Your PCM will provide referrals to access services from specialty providers and will coordinate the referral request with your regional contractor, if necessary. If you do not have an assigned network PCM, you or your primary care provider must coordinate specialty care referrals with your regional contractor.

If you receive specialty care without a referral from your PCM, you will be using the POS option, resulting in higher out-of-pocket costs. For cost details, visit **www.tricare.mil/costs**.

Referrals for Specialty Care

Visit your regional contractor's Web site or call the toll-free number to learn about region-specific referral requirements and details about obtaining referrals.

If you live near an MTF and are referred for specialty care, inpatient admissions, or procedures requiring prior authorization, your regional contractor will first attempt to coordinate your care at the MTF. If the services are not available at the MTF, your regional contractor will coordinate with a TRICARE network civilian provider.

Referrals for Active Duty Service Members

ADSMs require referrals for all specialty care. Before seeing a specialist, you need a referral from your PCM or regional contractor. Network PCMs will coordinate specialty care referrals with your regional contractor for you. If you do not have an assigned network PCM, you or your primary care provider must coordinate with your regional contractor for specialty care referrals. In either case, your regional contractor will contact you or your PCM regarding all referral requests. Refer to your regional contractor's Web site or call the toll-free number to learn about region-specific referral requirements and details about obtaining referrals.

If you are an ADSM enrolled in TPR, your regional contractor refers all specialty care requests to your SPOC. The SPOC will review all requests and determine if your health care requires a fitness-for-duty determination.

- If the SPOC determines your condition may change your fitness for duty or your condition requires a medical board review, he or she will refer you to the closest MTF that has the ability to provide the care and make a fitness-for-duty determination.
- If the SPOC determines there is no impact on your fitness-for-duty, he or she will refer you to a civilian specialist for the care. The SPOC will provide an answer to your regional contractor within two working days of the referral request, or sooner, for an urgent problem.
- Your commander may also request a military medical evaluation at his or her discretion.
- If you prefer, you may obtain specialty care at an MTF at any time, as long as your commander agrees. Inform your regional contractor when coordinating your referral.
- You cannot refer yourself to a military or civilian specialist. If you seek nonemergency care from other sources without first contacting your PCM and your regional contractor, you may be held financially responsible for the entire bill for those health care services.

Specialty-to-Specialty Referrals

If your PCM refers you to a specialist who would like to refer you to another specialist, the specialist may need to contact your PCM. Your PCM or the specialist will contact your regional contractor to obtain authorization for additional specialty care, if necessary.

Specialty Care Far from Home—Travel Reimbursement

Non-active duty TRICARE Prime enrollees and those enrolled in TPRADFM who are referred by their PCMs for specialty care at a location more than 100 miles (*one way*) from the PCM's office may be eligible to have reasonable, actual-cost travel expenses reimbursed by TRICARE (*e.g., lodging, meals, gas and oil, tolls, parking, public transportation*). You are expected to use the least costly mode of transportation and must submit receipts for all expenses.

Travel reimbursement claims must be filed no later than one year after the qualifying travel date. TRICARE will use government rates to estimate the reasonable cost and will reimburse the actual costs of travel expenses up to the government rate for the area concerned. To review the rates, visit **www.defensetravel.dod.mil/site/perdiem.cfm**.

In some cases, a non-medical attendant (NMA) who travels with the patient may also be authorized for travel reimbursement. The NMA must be a parent, adult family member, legal guardian, or a companion who has been appointed medical power of attorney by the patient or legally responsible party.

To qualify, you must have a valid referral and travel orders from a TRICARE representative at your MTF (*if enrolled to an MTF PCM*) or from the TRICARE Regional Office (*if enrolled to a civilian PCM*) prior to seeking care. You should contact your local MTF or visit the TRICARE Regional Office Web site in Figure 3.1 for more information if you think you qualify for this travel reimbursement benefit.

Note: Travel for ADSMs is reimbursed through other travel regulations. ADSMs should contact their unit representatives for information about traveling long distances for medical care.

TRICARE Regional Office Information for Travel Reimbursement *Figure 3.1*

TRICARE Regional Office North	www.tricare.mil/tronorth/prime-travel.cfm
TRICARE Regional Office South	www.tricare.mil/trosouth/prime-travel.cfm
TRICARE Regional Office West	www.tricare.mil/trowest/prime-travel.cfm

Access Standards for Care

TRICARE has access standards in place to help ensure you receive timely health care. These include:

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

These access standards begin at the time of your call or contact with the provider. It is important to contact your provider as soon as possible. At times, appointments may not be available within the time frames listed due to high demand for specialty care services. If the provider does not have appointments available within the access standards, you can choose to schedule the earliest available appointment with the provider or coordinate care with a network provider of the same specialty.

You should have access to a PCM whose office is within 30 minutes of your home under normal circumstances. Specialty care should be available within one hour from your home. See "Specialty Care Far From Home—Travel Reimbursement" earlier in this section for information about travel reimbursement if you are referred for specialty care more than 100 miles from your PCM's office.

Additionally, it is important to understand your provider's specific policies regarding canceled or missed appointments. Some providers charge a missed-appointment fee, which is not covered by TRICARE. Please be sure to notify your

provider's office within the appropriate time, usually 24 to 48 hours prior, if you will not be able to make your scheduled appointment.

Waiving Access Standards

Non-active duty TRICARE Prime beneficiaries may choose to receive care at MTFs. Assignment of a PCM at an MTF is determined by provider availability and the MTF's policy for the TRICARE Prime Service Area (PSA).

If you live more than a 30-minute drive from the MTF where you want to enroll, you must waive TRICARE's access standards for both routine (*primary*) care and specialty care using one of the following options:

- Enroll through the Beneficiary Web Enrollment Web site at **www.dmdc.osd.mil/appj/bwe/** to confirm that you waive your access standards.
- Submit a *TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form* (DD Form 2876) to your regional contractor, and sign Sections V and VI.

Note: A signed waiver is also required when choosing a civilian PCM outside the access standards.

If a waiver is approved by the MTF for beneficiaries residing less than 100 miles from the MTF, it remains in effect until the beneficiary changes residency location. A waiver for beneficiaries who reside 100 miles or more from an MTF must be approved by the TRICARE Regional Office and the MTF. It will remain in effect through the beneficiary's current enrollment period, so long as he or she does not change residence.

Note: Each MTF can specify whether or not it will accept beneficiaries who live more than a 30-minute drive from the MTF and can make a determination on mileage limitations or include specific ZIP codes. Signing a waiver of access standards does not guarantee enrollment at the MTF of your choice. Waivers may not be available for some beneficiaries who reside more than 100 miles from an MTF. Contact your regional contractor for more information.

Since an MTF's provider availability can change over time, the MTF may not always renew your waiver at the end of your enrollment period. Should this occur, your regional contractor will notify you at least two months before your enrollment period ends.

If your request is initially denied or your waiver is not renewed at the end of your enrollment period, you have several other options:

- Enroll at another MTF within your area
- Enroll with a civilian PCM if you live in, or within 100 miles of, a PSA
- Enroll in the US Family Health Plan if you live in an area where it is offered
- Use TRICARE Standard and TRICARE Extra for your health care needs

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 in the case of an emergency admission, within 24 hours or on the following business day.

Your PCM or specialty care provider will request prior authorization from your regional contractor, if necessary. If the service is authorized, the regional contractor will give your PCM or specialty care provider an authorization number and specific instructions. For example, prior authorizations for medical or surgical services have a begin date and end date. Prior authorizations for behavioral health care services specify a number of visits as well as a begin date and end date. You must receive care under the authorization before it expires. If not, your PCM or specialty care provider will need to get another authorization.

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.

For all other TRICARE Prime enrollees, the following services require prior authorization:

- Adjunctive dental services
- Extended Care Health Option services
- Home health care services
- Home infusion therapy
- Hospice care
- Nonemergency inpatient admissions for substance use disorders or behavioral health care
- Outpatient behavioral health care beyond the eighth visit per FY (*October 1–September 30*)
- Transplants—all solid organ and stem cell

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

Each regional contractor has additional prior authorization requirements. Visit your regional contractor's Web site or call the toll-free number to learn about your region's requirements, as they may change periodically. See the *Welcome to TRICARE Prime, TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members* section at the beginning of this handbook for your regional contractor's Web site and toll-free number.

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 or regional contractor may also request a second medical opinion on your behalf. If you wish to seek a second opinion, contact your PCM or your regional contractor to explain your situation and ask any questions you may have about the first specialist's suggested care. Then you or your PCM can request a referral to another specialist from your regional contractor. Be sure to indicate the request is for a second opinion. ADSMs enrolled in TPR also need SPOC approval.

Point-of-Service Option

The TRICARE POS option gives you the freedom, at an additional cost, to seek and receive nonemergency health care services from any TRICARE-authorized provider without requesting a referral from your PCM. For cost details, visit **www.tricare.mil/costs**.

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

- ADSMs
- Newborns or newly adopted children in the first 60 days after birth or adoption
- Emergency care
- Clinical preventive care received from a network provider
- Beneficiaries with other health insurance

The POS cost-share is applied when:

- You receive medical care from a network or non-network TRICARE-authorized provider without a referral from your PCM
- You self-refer to a network specialty care provider after a referral has been authorized by the regional contractor to an MTF specialty care provider
- When you are enrolled at an MTF and you self-refer to a network or non-network civilian provider for a routine (*primary*) care service
- You receive behavioral health care from a non-network TRICARE-authorized provider without prior authorization from your regional contractor

Using the POS option results in higher out-of-pocket costs and higher deductibles. POS costs do not apply to your annual catastrophic cap.

Note: Prior authorization requirements still apply when using the POS option.

Covered Services, Limitations, and Exclusions

TRICARE Prime 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. 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.

For detailed coverage information on covered outpatient, inpatient, and clinical preventive services, please see *Appendix A* of this handbook. Visit **www.tricare.mil/coveredservices** for additional information.

This chapter is **not** all-inclusive.

Behavioral Health Care Services

For detailed coverage information on outpatient behavioral health care services, inpatient behavioral health care services, and substance use disorder services, please see *Appendix A* of this handbook. For additional information about covered and non-covered behavioral health care services and how to access care, contact your regional contractor.

Active Duty Service Members

Active duty service members (ADSMs) must have a referral and prior authorization before seeking behavioral health care. TRICARE does not want to discourage you from getting help but wants to make sure that your condition does not adversely affect your health and your ability to perform worldwide duty. Your primary care manager (PCM) will coordinate all of your behavioral health care referrals and authorizations.

Note: In the event of a behavioral health emergency, go immediately to the nearest emergency room or call 911.

All Others Enrolled in TRICARE Prime or TPRADFM

You may see a network provider authorized under TRICARE regulations to see patients independently for the first eight outpatient behavioral health care services per fiscal year (FY) (*October 1–September 30*) for a medically diagnosed and covered condition without a PCM referral or authorization from your regional contractor. Independent behavioral health providers generally include psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, certified mental health counselors who meet TRICARE standards for independent practice, and certified marriage and family therapists. The first eight visits only apply to an initial appointment and any follow-on visits that are related to a diagnosed medical or behavioral condition. If you need non-medical or non-behavioral health condition short-term counseling, you may also be eligible for services through a military family support center, Military OneSource at **www.militaryonesource.mil**, or counseling services in your community. Your behavioral health care provider must obtain prior authorization from your regional contractor for visits exceeding eight in an FY. If you obtain care from a non-network provider without prior authorization from your regional contractor, point-of-service (POS) fees will apply.

Authorized Behavioral Health Care Providers

You may seek outpatient behavioral health care from TRICARE-authorized network providers. The following types of behavioral health providers may be authorized providers under TRICARE:

- **Certified psychiatric nurse specialists** are licensed, master's-level psychiatric nurses with an additional American Nurses Association certification in behavioral health. Certified psychiatric nurse specialists include both psychiatric clinical nurse specialists and psychiatric nurse practitioners. Psychiatric clinical nurse specialists mainly perform psychotherapy while psychiatric nurse practitioners generally provide medication management.
- **Mental health counselors** have a master's degree in counseling. They perform counseling and psychotherapy services but cannot prescribe medication. Some mental health counselors are licensed and TRICARE-certified to practice independently, without physician referral and supervision. For mental health counselors who

do not meet these TRICARE certification requirements, a doctor of medicine (MD) or doctor of osteopathic medicine (DO) must refer a beneficiary for therapy prior to the initial visit, and a physician must provide ongoing oversight and supervision of the therapy. Contact your regional contractor to find out if a mental health counselor requires physician referral and supervision before getting services.

- **Pastoral counselors** have a master's degree in counseling. They perform counseling and psychotherapy services but cannot prescribe medication. In order to provide services to TRICARE beneficiaries, an MD or DO must refer a beneficiary for therapy prior to the initial visit, and a physician must provide ongoing oversight and supervision of the therapy.
- **Certified marriage and family therapists** have a master's degree in counseling with an emphasis on family and marriage therapy. They perform individual counseling and family and marriage therapy but cannot prescribe medication.
- **Licensed clinical social workers** have a master's-level degree in social work with additional training in psychotherapy and counseling. They perform psychotherapy and counseling services but cannot prescribe medication.
- **Clinical psychologists** have a doctoral-level degree (*doctor of philosophy or doctor of psychology*) in psychology. They perform psychotherapy, psychological testing, and counseling services, but usually cannot prescribe medication.
- **Psychiatrists** are physicians who have a general medical degree (*MD or DO*) and have completed advanced residency training in psychiatry. Most psychiatrists treat persons with more serious conditions 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.

Outpatient Behavioral Health Care Services

Referrals and authorizations may apply for certain outpatient services. ADSMs should always seek nonemergency behavioral health care at military treatment facilities (MTFs), when available. If services are not available, ADSMs must obtain referrals from their MTFs or service points of contact before receiving civilian care for each visit outside an MTF. All other TRICARE beneficiaries (*non-ADSMs*) do not need prior authorization from their regional contractors for the first eight outpatient behavioral health care visits per FY (*October 1–September 30*) to a network provider authorized under TRICARE regulations to see patients independently for a medically diagnosed and covered condition.

Telemental Health Program

The Telemental Health program uses secure audio-visual conferencing to connect eligible beneficiaries, including TRICARE Prime, TRICARE Prime Remote (TPR), and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) enrollees in the United States, with off-site TRICARE network providers. Telemental Health provides medically necessary behavioral health care services, including:

- Clinical consultation
- Individual psychotherapy
- Psychiatric, diagnostic interview examination
- Medication management

Telemental Health interaction may involve live, two-way audio-visual visits between patients and medical professionals.

TRICARE Prime, TPR, and TPRADFM enrollees will not be charged for Telemental Health services, but behavioral health care limitations and referral and authorization requirements apply. Visit **www.tricare.mil/mentalhealth** or contact your regional contractor for more information.

Inpatient Behavioral Health Care Services

Prior authorization from the regional contractor is required for all nonemergency inpatient behavioral health care services. Psychiatric emergencies do not require prior authorization for admission to an inpatient unit, 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: ADSMs who receive care at MTFs do not require prior authorization.

Substance Use Disorder Services

Substance use disorders include alcohol or drug abuse or dependence. Services are only covered by TRICARE-authorized institutional providers—an authorized hospital or an organized treatment program in an authorized freestanding or hospital-based substance use disorder rehabilitation facility. Treatment includes detoxification, rehabilitation in an inpatient or partial hospitalization program setting, and outpatient individual, group, and family therapy. TRICARE covers three substance use disorder rehabilitation treatments in a lifetime and one per benefit period. A benefit period begins with the first date of the covered treatment and ends 365 days later.

Emergency and inpatient hospital services are considered medically necessary only when the patient's condition requires hospital personnel and facilities. Generally, these services may be medically necessary in certain detoxification circumstances or for stabilization of a medical condition. All treatment for substance use disorders requires prior authorization from your regional contractor.

TRICARE Smoking Quitline

TRICARE's Smoking Quitline is a telephone support and referral triage service available 24 hours a day, seven days a week. Current smokers who want to quit or former smokers concerned about relapsing may call the Smoking Quitline to speak with a trained smoking-cessation coach who will recommend appropriate treatment and resources. Call the toll-free number for your region for assistance. Figure 4.1 provides contact information for the regional TRICARE Smoking Quitlines.

Note: The Smoking Quitline is only available to TRICARE beneficiaries in the United States who are not eligible for Medicare.

Regional TRICARE Smoking Quitline Contact Information *Figure 4.1*

TRICARE North Region Health Net Federal Services, LLC	1-866-459-8766
TRICARE South Region Humana Military	1-877-414-9949
TRICARE West Region UnitedHealthcare Military & Veterans	1-888-713-4597

The Smoking Quitline is part of the Department of Defense (DoD) and TRICARE-sponsored tobacco-cessation program, which offers a variety of online tools and resources to help beneficiaries quit. Visit **www.ucanquit2.org** for more information.

Dental Options

ADSMs receive dental care from military dental treatment facilities (DTFs) and, if necessary, from civilian providers through the TRICARE Active Duty Dental Program (ADDP). For all other beneficiaries, TRICARE offers two dental programs—the TRICARE Dental Program (TDP) and the TRICARE Retiree Dental Program (TRDP). Each benefit is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

TRICARE Active Duty Dental Program

The ADDP benefit, administered by United Concordia Companies, Inc., provides civilian dental care to ADSMs who are either referred for care by a DTF to the civilian dental community or who have a duty station and residence greater than 50 miles from a DTF. The ADDP is available in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). For more information about the ADDP, visit **www.tricare.mil/addp**.

TRICARE Dental Program

The TDP is a voluntary, premium-based DoD dental program available to eligible active duty family members (ADFMs) and eligible National Guard and Reserve members and their family members. The TDP benefit is administered by MetLife. ADSMs (*and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 180 days before their report date*) are not eligible for the TDP. They receive dental care through DTFs or the ADDP. Visit **www.tricare.mil/tdp** for information about the TDP.

TRICARE Retiree Dental Program

The TRDP is a voluntary, premium-based dental insurance benefit administered by the Federal Services division of Delta Dental of California (Delta Dental). The TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, retired National Guard and Reserve members and 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 more information about the TRDP, visit **www.tricare.mil/trdp** or call Delta Dental toll-free at **1-888-838-8737**.

Hospice Care

If you or another TRICARE-eligible family member is faced with a terminal illness, hospice care is available from TRICARE. Hospice care emphasizes supportive services, rather than cure-oriented treatment, for patients with a life expectancy of six months or less. The benefit allows for personal care and home health aide services, which are otherwise limited under TRICARE's basic program options.

Hospice Benefit Coverage

Four levels of care are covered by the hospice benefit: routine home care, continuous home care, inpatient respite care, and general hospice inpatient care.

Note: Respite care is covered when 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 determinations of the medical team managing their 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

Care is managed by the hospice care team and the PCM, always in consultation with the patient and his or her family. The hospice care team evaluates and approves changes in the levels of care.

Note: Hospice care is only covered in the United States and in U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

For more information on TRICARE's hospice coverage, visit **www.tricare.mil** or contact your regional contractor.

Maternity Care

Prenatal care is important, and we strongly recommend that those who are pregnant, or who anticipate becoming pregnant, seek appropriate medical care. TRICARE Prime, TPR, and TPRADFM cover all necessary maternity care, from your first obstetric visit through six weeks after your child is born, including:

- Obstetric visits throughout your pregnancy
- Medically necessary fetal ultrasounds

- Hospitalization for labor, delivery, and postpartum care
- Anesthesia for pain management during labor and delivery
- Medically necessary cesarean section
- Management of high-risk or complicated pregnancies

Newborns are covered separately. To ensure your newborn is covered by TRICARE, you must register your child in the Defense Enrollment Eligibility Reporting System (DEERS) at a uniformed services identification (ID) card-issuing facility. If you wish for your child to be covered under TRICARE Prime, enroll your child in TRICARE Prime or TPRADFM within 60 days after birth or adoption. For more information, see "Having a Baby or Adopting a Child" in the *Changes to Your TRICARE Coverage* section of this handbook.

The following services are **not** covered by TRICARE:

- 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 U.S. Food and Drug Administration (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, or salivary estriol test for preterm labor*)
- Umbilical cord blood collection and storage, except for patients who undergo umbilical stem cell transplantation for a covered transplant
- Private hospital rooms

Maternity Ultrasounds

TRICARE covers medically necessary maternity ultrasounds that may be needed to:

- Estimate gestational age due to unknown date of last menstrual period, irregular periods, size/date different by 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, oligohydramnios, polyhydramnios, 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 heart rate is not detectable by Doppler and/or suspected fetal demise*)
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
- Evaluate the condition of the fetus in late registrants for prenatal care

A physician is not obligated to perform 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. Refer to your regional contractor's Web site for additional details on maternity ultrasound coverage.

Getting Maternity Care

As soon as you think you may be pregnant, visit your PCM. If your PCM is not an obstetrician, he or she will refer you to one. You may see the same provider throughout your pregnancy, depending on the circumstances and provider availability, or request a change at any time. If you relocate to a new region during your pregnancy, you must transfer your enrollment to your new region and select a new PCM. You are encouraged to obtain copies of your health care records from your PCM before relocating. For more information on transferring your TRICARE Prime enrollment, see "Moving" in the *Changes to Your TRICARE Coverage* section of this handbook.

Maternity care services may require referrals and prior authorizations. Refer to your regional contractor's Web site for additional information.

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. All beneficiaries, except ADSMs, may use the POS option to self-refer to an obstetrician; however, higher out-of-pocket costs will apply. ADSMs who are pregnant at the time of release from active duty should contact their local Beneficiary Counseling and Assistance Coordinator to determine if maternity care is available through the MTF.

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

- Work through their service (*unit personnel and MTF administrative channels*) to establish ongoing eligibility for care within the MTF
- 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

Visit **www.tricare.mil/tamp** to learn more about TAMP. CHCBP is administered by Humana Military. For CHCBP details, visit **Humana-Military.com**.

To ensure your newborn is covered by TRICARE, you must register your child in DEERS at a uniformed services ID card-issuing facility and enroll your child in TRICARE Prime or TPRADFM within 60 days after birth or adoption. For more information, see "Having a Baby or Adopting a Child" in the *Changes to Your TRICARE Coverage* section of this handbook.

TRICARE Extended Care Health Option

TRICARE Extended Care Health Option (ECHO) provides services to ADFMs who qualify based on specific mental or physical disabilities. ECHO offers beneficiaries integrated services and supplies beyond those offered by the basic TRICARE health benefit programs.

Active duty sponsors with family members seeking ECHO registration must enroll in their service's Exceptional Family Member Program (EFMP) (*unless waived in specific situations*) and register for ECHO with their regional contractors in order to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Prior authorization must be obtained from the regional contractor for all ECHO services. For more information about EFMP, contact your service branch's EFMP representative or visit **www.militaryhomefront.dod.mil/tf/efmp**.

Conditions qualifying an ADFM for ECHO coverage may include, but are not limited to:

- Moderate or severe mental retardation
- Serious physical disability
- Extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
- 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

ECHO Benefits

ECHO provides coverage for the following products and services:

- Applied behavior analysis (ABA)* (*which includes the DoD Enhanced Access to Autism Services Demonstration, discussed later*) 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) (*limited to the 50 United States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands*)
- 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**.

* *ABA services are limited to only those ECHO-eligible and enrolled beneficiaries with a diagnosis of autism spectrum disorder.*

DoD Enhanced Access to Autism Services Demonstration

The DoD Enhanced Access to Autism Services Demonstration was established to test the feasibility and advisability of permitting TRICARE reimbursement for educational interventions for autism spectrum disorders delivered by paraprofessional providers known as tutors. This demonstration provides information that will enable the DoD to determine the following:

- If there is increased access to these services
- If the services are reaching those most likely to benefit from them
- If the quality of these services is meeting the appropriate standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board
- That state licensure and certification requirements, where applicable, are being met

The DoD Enhanced Access to Autism Services Demonstration allows non-certified paraprofessional providers, or tutors, to provide autism-related services (*in particular, ABA*), under the supervision of a TRICARE-authorized certified therapist, to eligible ADFMs in the United States. TRICARE beneficiaries must be registered in ECHO to receive benefits through the DoD Enhanced Access to Autism Services Demonstration.

Note: The allowed cost of services provided by the DoD Enhanced Access to Autism Services Demonstration accrues to the ECHO FY government maximum cost-share. Visit the ECHO Web site at **www.tricare.mil/echo** for details.

More information about the DoD Enhanced Access to Autism Services Demonstration is available at **www.tricare.mil** in the "Special Programs" section.

TRICARE Pharmacy Program

TRICARE offers comprehensive prescription drug coverage and several options for filling your prescriptions. To fill a prescription, you need a written prescription and a valid uniformed services ID card or Common Access Card. The TRICARE pharmacy benefit is administered by Express Scripts, Inc. (Express Scripts). More information on the TRICARE Pharmacy Program is available at **www.tricare.mil/pharmacy** or **www.express-scripts.com/TRICARE**.

Military Treatment Facility Pharmacies

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 you are enrolled at the MTF.

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

Visit **www.tricare.mil/militarypharmacy** for more information on MTF pharmacies.

TRICARE Pharmacy Home Delivery

TRICARE Pharmacy Home Delivery is your least expensive option when not using an MTF pharmacy. There is no cost for TRICARE Pharmacy 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 convenient notifications about your order status, refill reminders, 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 speak confidentially with you.

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

You may register for TRICARE Pharmacy Home Delivery using any of the options in Figure 4.2.

TRICARE Pharmacy Home Delivery Registration Methods ***Figure 4.2***

Online	• www.express-scripts.com/TRICARE
Phone	• 1-877-363-1303 • 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

For faster processing of your home delivery prescription, you can register before placing your first order. Once you are registered, your provider can fax or call in your prescriptions.

Express Scripts will send your medications directly to your home within about 14 days of receiving your prescription. 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 by your OHI or if you exceed the OHI's coverage dollar limit.

Member Choice Center

The Member Choice Center makes it easy to reduce your out-of-pocket costs by transferring your current retail pharmacy maintenance medication prescriptions to TRICARE Pharmacy Home Delivery. If you prefer the convenience of home delivery, contact the Member Choice Center for assistance with converting your current prescriptions.

Visit **www.express-scripts.com/TRICARE** or call **1-877-363-1433** to get started.

Note: To use the Member Choice Center, you must have a maintenance prescription dispensed at a retail pharmacy or MTF. The Member Choice Center will contact your provider to obtain a new written prescription for home delivery.

TRICARE Retail Network Pharmacies

Another option for filling your prescriptions is through a TRICARE retail network pharmacy. You may fill prescriptions (*one copayment for each 30-day supply*) when you present your written prescriptions and your uniformed services ID card to the pharmacist.

This option allows you to fill your prescriptions at TRICARE retail network pharmacies across the country without having to submit a claim. You have access to a network of approximately 56,000 retail pharmacies in the United States and 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.express-scripts.com/TRICARE** or call **1-877-363-1303** to find the nearest TRICARE retail network pharmacy.

Note: In the Philippines, you must use a TRICARE-certified host nation pharmacy. Visit **www.tricare.mil/pacific** for more information or to find a certified provider.

Non-Network Pharmacies

If you fill prescriptions at a non-network pharmacy, you will pay the full price of your medication up front and file a claim for partial reimbursement. Reimbursements are subject to out-of-network cost-shares after you meet the POS deductible. Log on to **www.express-scripts.com/TRICARE** or contact Express Scripts at **1-877-363-1303** to locate a TRICARE network pharmacy. For details about filing a claim, see the *Claims* section of this handbook.

Quantity Limits for Certain Medications

TRICARE has established quantity limits on certain medications, which means that the DoD will only pay for up to a specified, limited amount of medication each time you fill a prescription. Quantity limits are often applied to ensure medications are used safely and appropriately. Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity.

Prior Authorization

Some drugs require prior authorization from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics Committee, brand-name medications with a generic equivalent, infusion therapy delivered in the home, medications with age limitations, and medications prescribed for a quantity exceeding normal limits. For a general list of prescription drugs that are covered under TRICARE, and for drugs that require prior authorization or that have quantity limits, visit **www.pec.ha.osd.mil/formulary_search.php**. 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 FDA and clinically equivalent to brand-name medications. Generic drugs provide the same safe, effective treatment as brand-name drugs and help save you money. 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 that indicates use of 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 will be dispensed at the brand-name copayment. If you fill a prescription with a brand-name drug that is not considered medically necessary and a generic equivalent is available, you will be responsible for paying the entire cost of the prescription.

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

Non-Formulary Drugs

The DoD has established a uniform formulary, which is a list of covered generic and brand-name drugs. This formulary also contains a third tier of medications that are non-formulary. Prescriptions for non-formulary drugs are dispensed at a higher cost to beneficiaries.

Non-formulary medications include any drug in a therapeutic class determined to be not as clinically effective or as cost-effective as other drugs in the same class. For an additional cost, all non-formulary drugs are available through TRICARE Pharmacy Home Delivery and most are available through retail network pharmacies. 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. Forms and medical-necessity criteria are available online at **www.pec.ha.osd.mil/forms_criteria.php** or by calling Express Scripts at **1-877-363-1303**.

If medical necessity is approved, ADSMs may receive non-formulary medications through TRICARE Pharmacy Home Delivery or at retail network pharmacies at no cost. ADSMs may not fill prescriptions for non-formulary medications unless medical necessity is established. For all other eligible beneficiaries, if medical necessity is approved, beneficiaries may receive non-formulary medications at the formulary cost through TRICARE Pharmacy Home Delivery or at retail network pharmacies.

Note: Non-formulary drugs are generally not available at MTFs.

To learn more about medications and common drug interactions, check for generic equivalents, or to determine if a drug is a non-formulary medication, visit the TRICARE Formulary Search Tool at **www.pec.ha.osd.mil/formulary_search.php**.

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 management of medication use. This program provides:

- Access to proactive, clinically based services for specific diseases designed to help you get the most benefit from your medicine
- Refill reminder calls
- Scheduled deliveries to your specified location
- Specialty consultation with a pharmacist or nurse 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, you will receive additional information from Express Scripts 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 described. You may submit a specialty medication prescription by mail or your provider may submit it by fax. If you are currently using another pharmacy to fill your specialty medication prescription, you can contact the Member Choice Center at **1-877-363-1433** to switch to the Specialty Medication Care Management program. With specific mailing instructions from you or your provider, TRICARE Pharmacy Home Delivery will ship your specialty medication to your home. For your convenience and safety, the home delivery program will contact 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, the home delivery program will either forward your prescription to a pharmacy of your choice that can fill it or will provide you with instructions about where to send the prescription to have it filled. To determine if your specialty medication is available through TRICARE Pharmacy Home Delivery, visit **www.pec.ha.osd.mil/formulary_search.php**.

Limitations and 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 mental disorder*), injury, or for the diagnosis and treatment of pregnancy or well-child care. All services and supplies (*including inpatient institutional costs*) related to a non-covered condition or treatment, or provided by an unauthorized provider, 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 A* of this handbook. Visit your regional contractor's Web site for more information.

Claims

Health Care Claims

In most cases, you will not need to file claims for health care services. However, there may be times when you will need to pay for care up front and then file a claim for reimbursement. You will be reimbursed for TRICARE-covered services at the TRICARE-allowable charge, less any copayments, cost-shares, or deductibles.

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 either the date of service or the date of inpatient discharge. Overseas, claims must be filed within three years of either the date of service or the date of inpatient discharge. You must submit proof of payment with overseas claims.

To file a claim, obtain and complete a *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request for Medical Payment* (DD Form 2642). You can download forms and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from your regional contractor's Web site. You also can obtain forms and instructions at a TRICARE Service Center or a military treatment facility (MTF). Fill out the form completely and sign it. In particular, the initial claim form may be signed by the beneficiary (*if age 18 and legally competent*), the sponsor, spouse, parent, or guardian of the beneficiary. However, any forms submitted based on later requests for additional information needed to process a claim must be signed by the beneficiary (*if 18 or older, or the parent/guardian must sign if the beneficiary is under 18*).

When filing a claim, attach a readable copy of the provider's bill to the claim form, making sure it contains the following information:

- Patient's name
- Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN) (*Eligible former spouses should use their own SSN or DBN, not the sponsor's.*)
- Provider's name and address (*If more than one provider's name is on the bill, circle the name of the provider who delivered the service for which reimbursement is requested.*)
- 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, complete block 8a on the form.*)

Note: Providers submit inpatient facility claims.

Send your claims to the claims processor for the region in which you are enrolled. If you receive care while traveling in the United States, you must file your TRICARE claims in the region where you live, not the region where you received care. If you receive care while traveling overseas (*including U.S. territories*), you must file your TRICARE claims with the TRICARE Overseas Program (TOP) claims processor. Always keep a copy of the paperwork for your records. Figure 5.1 on the following page lists stateside regional claims-processing information. Figure 5.2 on the following page lists TOP claims-processing information.

Call your regional contractor, visit your regional contractor's Web site, or visit **www.tricare.mil/claims** for more information on processing claims.

Pharmacy Claims

You will not need to file pharmacy claims if you have prescriptions filled at an MTF pharmacy, through TRICARE Pharmacy Home Delivery, or at a TRICARE retail network pharmacy. However, if you fill a prescription at a non-network pharmacy in the United States and U.S. territories (*American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), you must pay the full price of your prescription up front and file a claim for reimbursement.

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

Stateside Regional Health Care Claims-Processing Information *Figure 5.1*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Send claims to: Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 Check the status of your claim at **www.myTRICARE.com** or **www.hnfs.com**.	**Send claims to:** TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 Check the status of your claim at **www.myTRICARE.com** or **Humana-Military.com**.	**Send claims to:** TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 Check the status of your claim at **www.uhcmilitarywest.com**.

TRICARE Overseas Program Claims-Processing Information *Figure 5.2*

Active Duty Service Members (ADSMs) (*all overseas areas*)	**Send claims to:** TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968
Non-ADSMs, TRICARE Eurasia-Africa (*Africa, Europe, and the Middle East*)	**Send claims to:** TRICARE Overseas Program P.O. Box 8976 Madison, WI 53707-8976
Non-ADSMs, TRICARE Latin America and Canada (*Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands*)	**Send claims to:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
Non-ADSMs, TRICARE Pacific (*Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific Remote countries*)	**Send claims to:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985

To file a pharmacy claim:

1. Download *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 66518
   St. Louis, MO 63166-6518

Prescription claims require the following information for each drug:

- Patient's name
- 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

If you have other health insurance (OHI) with pharmacy benefits, see "Pharmacy Claims and Other Health Insurance" later in this section. Call Express Scripts, Inc. (Express Scripts) at **1-877-363-1303** with questions about filing pharmacy claims.

Note: Active duty family members (ADFMs) who fill prescriptions at non-network pharmacies are using the point-of-service option. Active duty service members (ADSMs) may be required to pay the full price of prescriptions up front and will receive a full reimbursement when the claim is filed.

Proof-of-Payment Requirement Overseas

You must submit proof of payment with all claims for care received overseas. 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 OHI, if applicable. 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.

Visit **www.tricare.mil/proofofpayment** for more information on proof of payment requirements overseas.

Coordinating Benefits with Other Health Insurance

TRICARE is the primary payer for ADSMs. For ADFMs, TRICARE is the last payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs and plans as identified by the TRICARE Management Activity.

If you have OHI, you must follow the OHI's rules for filing claims and file the claim with them first. If there is an amount your OHI does not cover, you can file the claim with TRICARE for reimbursement. It is important to meet your OHI's requirements. If your OHI denies a claim for failure to follow its rules, such as obtaining care without authorization or using a non-network provider, TRICARE may also deny your claim.

Keep your regional contractor and health care providers informed about your OHI so they can better coordinate your benefits and help ensure that there is no delay (*or denial*) in the payment of your claims.

Note: Many employers, including state and local governments, offer TRICARE-eligible employees a TRICARE supplement as an incentive not to enroll in the employer's primary group health plan. Please inform your employers of the illegality of this practice and report any continued noncompliance to the TRICARE Program Integrity unit at:

TRICARE Program Integrity
16401 East Centretech Parkway
Aurora, CO 80011-9066

You may also report noncompliance to your TRICARE regional contractor's program integrity unit online at **www.tricare.mil/fraud**.

Pharmacy Claims and Other Health Insurance

When you have OHI, your OHI pays first for pharmacy coverage, and the OHI rules apply. After your OHI has paid, your TRICARE coverage may reimburse you for part or all of your out-of-pocket costs including copayments. Your best option with OHI is to use a retail pharmacy that is covered by your OHI and is also a TRICARE retail network pharmacy.

You are not eligible to use TRICARE Pharmacy Home Delivery if you have OHI with a prescription plan, including a Medicare Part D prescription program, unless you meet one of the following requirements:

- The medication you need is not covered by your OHI
- You have met your OHI's benefit cap (*i.e., you have met your benefit's maximum-coverage limit*)

Once you have met one of these requirements, you may submit your prescription to TRICARE Pharmacy Home Delivery. See "TRICARE Pharmacy Home Delivery" in the *Covered Services, Limitations, and Exclusions* section of this handbook for instructions on how to use home delivery.

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

Appealing a Claim or Authorization Denial

TRICARE has a multilevel appeals process to address claim and authorization denials. You may appeal the denial of a requested authorization of services, as well as TRICARE decisions regarding

the payment of claims. Submit appeals to your regional contractor. For more detailed information on the appeals process, see "Appealing a Decision" in the *For Information and Assistance* section of this handbook, visit **www.tricare.mil/claims**, or contact your regional contractor.

Pharmacy Claim Appeals

If you disagree with the determination on your 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 from the date of the decision and must include a copy of the claim decision.

Your signed, written request must state the specific matter with which you disagree 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 from the date of the decision, the request for reconsideration should **not** be delayed pending the acquisition of additional documentation. If additional documentation will be submitted at a later date, the letter requesting the reconsideration must state that additional documentation will be submitted and specify the expected date of the submission. Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed.

Third-Party Liability

The Federal Medical Care Recovery Act allows TRICARE to be reimbursed for treatment costs if your injury or illness was caused by someone else. The *Statement of Personal Injury—Possible Third Party Liability* (DD Form 2527) will be 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. You can download *DD Form 2527* at **www.tricare.mil/claims** or from your regional contractor's Web site.

Explanation of Benefits

A TRICARE explanation of benefits (EOB) is not a bill. It is an itemized statement that shows what 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. (*For more information about appeals, see the* For Information and Assistance *section of this handbook*.) You should keep EOBs with your health records for reference.

For a sample of the EOB in your region and for a description of the information in the EOB, see the following figures in *Appendix B* of this handbook:

- **North Region:** Figure 9.1
- **South Region:** Figure 9.2
- **West Region:** Figure 9.3

Changes to Your TRICARE Coverage

TRICARE Prime continues to provide health coverage for you and your family as you experience major life events. However, you will need to take specific actions to make sure you remain eligible for TRICARE. With every 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 TRICARE Prime, TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members* section at the beginning of this handbook for details.

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

Getting Married or Divorced

Marriage

It is extremely important for sponsors to register new spouses in DEERS to ensure they are eligible for TRICARE. To register a new spouse in DEERS, the sponsor will need to provide a copy of the marriage certificate to the nearest uniformed services identification (ID) card-issuing facility. The new spouse will also be 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 Common Access Card [CAC]*). Once the spouse is registered in DEERS, he or she will receive a uniformed services ID card and will be eligible for TRICARE. When accessing care, the spouse will be asked to show his or her ID card.

Registration in DEERS is not the same as enrolling in TRICARE Prime, TRICARE Prime Remote (TPR), or TRICARE Prime Remote for Active Duty Family Members (TPRADFM). Once your spouse is registered in DEERS, he or she will need to enroll in TRICARE Prime or TPRADFM; otherwise, he or she will be covered by TRICARE Standard and TRICARE Extra.

To enroll in TRICARE Prime or TPRADFM, complete the *TRICARE Prime Enrollment and Primary Care Manager (PCM) Change Form* (DD Form 2876) and submit the form to your regional contractor. You can download the form from **www.tricare.mil/forms** or contact your regional contractor to request an enrollment form. You may also enroll your spouse in TRICARE Prime or TPRADFM through the Beneficiary Web Enrollment (BWE) Web site at **www.dmdc.osd.mil/appj/bwe/**. For more information on the BWE Web site, see "Beneficiary Web Enrollment" in the *Getting Started* section of this handbook.

Your new spouse's TRICARE Prime or TPRADFM enrollment is effective based on the 20th-of-the-month rule. Applications received by your regional contractor by the 20th of the month become effective at the beginning of the following month (*e.g., an application received by December 20 becomes effective January 1*). If the application is received after the 20th of the month, coverage will not become effective until the first day of the month following the next month (*e.g., an application received on December 27 becomes effective February 1*). After your regional contractor processes your application, your new spouse will receive a TRICARE Prime or TPRADFM enrollment card and a letter identifying his or her primary care manager (PCM).

Note: If you are a retired service member and currently pay the individual enrollment fee, your enrollment fee will increase to the family plan rate when you enroll your new spouse in TRICARE Prime.

Divorce

Sponsors must update DEERS when there is a divorce. The sponsor will need to provide a copy of the divorce decree, dissolution, or annulment.

Children

After a divorce, any child who retains eligibility under the sponsor remains 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 prior to his or her 21st birthday. See "Keep Your DEERS Information Up To Date!" in the *Prime, TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members* section at the beginning of this handbook for contact information.

Dependent children who have aged out of TRICARE coverage, but have not yet reached age 26, may be eligible to purchase TRICARE Young Adult (TYA). It is available for purchase by unmarried adult children who do not have access to an employer-sponsored health plan. For more information on TYA, see "TRICARE Young Adult" later in this section.

Although a child normally does not get his or her own uniformed services ID card until reaching 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. In this case, a uniformed services ID card-issuing facility will issue an ID card for the child. Patient privacy may be a factor for divorced parents attempting to obtain information about received health care services. Contact your regional contractor for assistance.

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

If children are living with a sponsor's former spouse in a different TRICARE region than the one in which the sponsor resides, they may continue TRICARE Prime coverage using split enrollment. See "Split Enrollment" later in this section for more information.

Former Spouses

Certain former spouses are TRICARE-eligible, 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 an employer-sponsored health plan
- Are not also a former spouse of a North Atlantic Treaty Organization or Partners for Peace nation member
- Meet the requirements of one of the two situations in Figure 6.1

Former spouses who are TRICARE eligible must change their personal information in DEERS so their name and Social Security number (SSN) or Department of Defense Benefits Number (DBN) are listed as the primary contact information. The former spouse's TRICARE eligibility will be shown in DEERS under his or her own SSN or DBN. Completing a new *DD Form 2876* is required to enroll in TRICARE Prime under the former spouse's SSN or DBN. Otherwise, the former spouse will be covered under TRICARE Standard and TRICARE Extra.

Note: TPRADFM is not available to former spouses.

Eligibility Situations for Former Spouses ***Figure 6.1***

A	• The former spouse must have been married to the same service 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. • If this requirement is met, 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.
B	• The former spouse must have been married to the same service 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. • If this requirement is met, 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 for verification of eligibility.

Having a Baby or Adopting a Child

If you are a new parent, please remember there are two important steps you must take within 60 days from the date of birth or adoption to have continuous TRICARE Prime or TPRADFM coverage for your newborn or newly adopted child:

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 will show "loss of eligibility," and he or she will no longer be able to receive TRICARE benefits until registered in DEERS. See "Keep Your DEERS Information Up To Date!" in the *Welcome to TRICARE Prime, TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members* section at the beginning of this handbook for DEERS contact information.
2. Enroll your child in TRICARE Prime or TPRADFM within 60 days after birth or adoption by submitting a *DD Form 2876* to your regional contractor. On day 61, if you have not enrolled your child in a TRICARE Prime option, he or she will be covered under TRICARE Standard and TRICARE Extra.

Maternity care for TYA beneficiaries is covered; however, a TYA beneficiary's child will not be covered by TRICARE unless the newborn's father is a sponsor or the newborn is adopted by a sponsor.

Note: You must complete DEERS registration before you enroll your child in TRICARE Prime or TPRADFM. Contact your regional contractor for enrollment assistance.

Going to College or Other Approved Institution of Higher Learning

Eligibility

Children of a TRICARE-eligible 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 their DEERS information is current. Your dependent child's TRICARE Prime or TPRADFM coverage ends if his or her DEERS record is not updated before age 21. To extend benefits for a dependent student beyond age 21, contact DEERS to verify what documentation is needed before his or her 21st birthday. See "Keep Your DEERS Information Up To Date!" in the *Welcome to TRICARE Prime, TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members* section at the beginning of this handbook for DEERS contact information.

Dependent students who are enrolled in TPRADFM may keep their TPRADFM enrollment only if they continue to reside with the TPR-enrolled sponsor. If your dependent student's school is in an area where TRICARE Prime is offered, he or she may enroll in TRICARE Prime in that new location.

To reenroll a dependent student in TRICARE Prime or TPRADFM, you must update DEERS and document that the dependent student is continuing his or her college education until reaching age 23. Then you must submit *DD Form 2876* to reenroll in TRICARE Prime or TPRADFM after the DEERS record is updated. Both steps must be taken to reenroll in TRICARE Prime or TPRADFM, as updating DEERS does not update enrollment.

Note: In most cases, dependent students going overseas to attend college or another approved institution of higher learning on their own are eligible only for TRICARE Overseas Program (TOP) Standard in the overseas area, and are not eligible for TOP Prime.

TRICARE benefits end when a dependent student reaches age 23 or when full-time student status ends, whichever comes first. For example, if a dependent student turns 23 on January 3, but does not graduate until May, coverage ends at midnight on January 2. However, if a dependent student graduates with a bachelor's degree while age 22 and enrolls in a full-time graduate program, he or she remains TRICARE eligible until reaching age 23.

Dependent children who have aged out of TRICARE coverage at age 21 and dependent students who have aged out of TRICARE coverage at age 23 may be eligible to purchase TYA until reaching age 26. TYA is available for purchase by unmarried adult children who do not have access to their own employer-sponsored health plan. For more information on TYA, see "TRICARE Young Adult" later in this section.

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

Health Care Options for College and Other Students

If TRICARE Prime is available where your child attends school and the school is in your TRICARE region, a dependent student may request a change to a new PCM in that same region by submitting a *DD Form 2876* or calling your regional contractor. All nonemergency care and non-behavioral health care must be coordinated by a dependent student's PCM; otherwise, higher point-of-service (POS) costs may apply. If urgent or specialty care is required, TRICARE Prime referral and authorization rules apply. If an emergency occurs, your child should call 911 or go to the nearest emergency room. His or her PCM must be notified within 24 hours or the next business day to ensure proper claims payment.

If the school is in a different TRICARE region, a dependent student may transfer his or her TRICARE Prime enrollment to the new region (*if TRICARE Prime is available in that area*) using split enrollment. You will need to submit a new *DD Form 2876* and select a PCM for your child at the new location.

Some colleges and universities offer student health plans for purchase from commercial insurers in addition to providing access to basic student health services (*usually covered as part of student fees*). Depending on the nature of a school-sponsored commercial insurance plan, such purchased health plans may be considered other health insurance (OHI). Access to basic student health services, such as a campus infirmary provided as part of a student fee, is generally not considered OHI. When a dependent student has purchased OHI, TRICARE pays second to the OHI coverage.

Split Enrollment

Split enrollment allows families living in different TRICARE regions to enroll in TRICARE Prime together. To use split enrollment, you must notify each family member's regional contractor of the split enrollment status and establish one family enrollment fee (*where applicable*). Dependent student enrollment in TRICARE Prime is automatically renewed after one year, unless the renewal offer is declined.

Note: If a dependent student enrolls separately in TRICARE Prime after arriving at school and no other family members are enrolled in TRICARE Prime, it is considered a single enrollment. However, if the dependent student enrolls and there are two or more family members enrolled elsewhere, your TRICARE Prime family enrollment fee remains the same. The regional contractors will coordinate enrollment fees and send the statements to the designated payer. An enrollment fee left unpaid will cause the entire family to be disenrolled.

The following are key points to remember with split enrollment:

- Families with dependent students, children living with former spouses, or families otherwise separated can enroll together in different regions.
- Active duty family members (ADFMs) are not required to pay enrollment fees, but individual eligible family members may still enroll in different regions.
- Retiree families have only one enrollment fee and one enrollment anniversary date.
- There is no limit on the number of family members who can enroll.

- In most cases, only family members who accompany their active duty sponsor on his or her orders overseas and are command sponsored may be enrolled in TOP Prime options.
- Dependent students who are enrolled in TPRADFM may keep their TPRADFM enrollment only if they continue to reside with the TPR-enrolled sponsor. If your dependent student's school is in an area where TRICARE Prime is offered, he or she may enroll in TRICARE Prime in that new location.

If a dependent student does not continue enrollment in TRICARE Prime or TPRADFM, he or she will be automatically covered by TRICARE Standard and TRICARE Extra, as long as his or her DEERS information is current. Visit your regional contractor's Web site or call the toll-free number if you have questions about using TRICARE Standard and TRICARE Extra.

TRICARE Young Adult

TYA is a premium-based health care plan available for purchase by qualified dependents. TYA offers TRICARE Prime and TRICARE Standard coverage worldwide. TYA includes medical and pharmacy benefits, but excludes dental coverage.

Who Is Eligible?

If you are an adult-age dependent, your sponsor's status determines whether you are eligible for TYA Prime and/or TYA Standard.

Note: Special eligibility conditions may exist. See Figure 6.2 for eligibility information based on your sponsor's status.

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 provides 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

Eligibility to Purchase TRICARE Young Adult Coverage Based on Sponsor Status — *Figure 6.2*

Sponsor Status	TRICARE Prime[1]	TRICARE Prime Remote[1]	TRICARE Standard	Uniformed Services Family Health Plan[1]	TRICARE Overseas Program (TOP) Prime[1]	TOP Prime Remote[1]	TOP Standard
Active Duty	✔	✔	✔	✔	✔	✔	✔
Retired	✔	✘	✔	✔	✘	✘	✔
Selected Reserve of the Ready Reserve[2]	✘	✘	✔	✘	✘	✘	✔
Retired Reserve[2]	✘	✘	✔	✘	✘	✘	✔

1. *To enroll in this program, it must be offered in your geographic area, and you must meet all other eligibility criteria (*such as command sponsorship overseas*).*
2. *If you are an adult child of a non-activated member of the Selected Reserve of the Ready Reserve or of the Retired Reserve, your sponsor must be enrolled in TRICARE Reserve Select or TRICARE Retired Reserve for you to be eligible to purchase TYA coverage.*

Purchasing TRICARE Young Adult

TYA offers open enrollment, so, if you qualify, you may purchase coverage at any time. The *TRICARE Young Adult Application* is available at **www.tricare.mil/tya**. When applying, you must verify that you are not married and not eligible to enroll in an employer-sponsored health plan.

Note: If you are not already in DEERS, your sponsor must add you to the system before starting the application process. For information on adding family members to DEERS, visit **www.tricare.mil/deers**.

Once you complete and sign the application, take it, along with your initial premium payment, to a TRICARE Service Center (TSC), or mail or fax it to your regional contractor.

Your completed application must include the initial premium payment, paid by personal check, cashier's check, money order, or credit/debit card. After the initial payment, premiums must be paid in advance by monthly automated electronic payment.

Enrollment in TRICARE Young Adult

After enrolling in TYA, you and your sponsor may visit a uniformed services ID card-issuing facility to obtain an ID card for you. You must bring two forms of ID—one must be an unexpired government-issued ID card with a picture. If you enroll in TYA Standard, your coverage will begin the first day of the following month after your enrollment application is processed and payment is received. If you enroll in TYA Prime following a break in TRICARE coverage, your coverage will follow the 20th-of-the-month rule: As long as your enrollment application is received by the 20th of the month, coverage can begin on the first day of the next month. If it is received after the 20th of the month, it will start the first day of the following month. If you wish for TYA coverage to start immediately following the termination of coverage under another TRICARE program, your TYA application must be postmarked or received no later than 30 days following the termination of coverage.

Note: You may be eligible for the Continued Health Care Benefit Program (CHCBP) after TYA coverage ends, unless you have been locked out of TYA coverage. Visit **www.tricare.mil/chcbp** for more information.

Covered Services

The TYA benefit includes TRICARE Prime and TRICARE Standard. TYA includes medical and pharmacy benefits, but excludes dental coverage. TYA Prime enrollees have TRICARE Prime access to care through their assigned military or civilian PCMs. All TYA enrollees are eligible for care at military treatment facilities (MTFs), but TYA Standard enrollees have access only on a space-available basis. TYA is only available for individuals and is not offered as a family plan. For more information on covered services, visit **www.tricare.mil/coveredservices**.

Note: Expectant mothers enrolled in a TYA program option receive maternity care for the duration of their pregnancy. However, the child will not be covered by TRICARE, unless the newborn's father is a sponsor, or the newborn is adopted by a sponsor.

TRICARE Young Adult Costs and Fees

TYA premiums are adjusted annually, effective January 1. Ongoing premiums must be paid in advance by automated electronic payment. Premiums are not credited to deductibles or catastrophic caps.

TYA Prime has the same copayments as TRICARE Prime and TOP Prime. TYA Standard has the same cost-shares as TRICARE Standard and TRICARE Extra in the United States and TOP Standard overseas. Copayments and cost-shares are credited to the family's catastrophic cap. For TYA Standard, TYA cost-shares contribute to individual and family deductibles, which vary based on the sponsor's category.

For more information on costs, visit **www.tricare.mil/costs**.

Ending TRICARE Young Adult Coverage

Choosing to End Coverage

You may choose to end TYA coverage at any time by completing the fields related to terminating coverage on the *TRICARE Young Adult Application* and submitting it to your regional contractor. If you decide to end TYA coverage, you will be locked out from purchasing TYA coverage for one year from the date of termination. There will be no lockout if the coverage is terminated because you gain access to employer-sponsored coverage.

Nonpayment

Your premium payment is due no later than the last day of the month for the next month's coverage. Failure to pay total premium amounts due and any insufficient fund fees owed will result in a termination of coverage. A 12-month TYA purchase lockout will go into effect.

Change in Status

Your sponsor must always report all family and status changes to DEERS. A change in your sponsor's status may affect your TYA enrollment and you may be required to submit a new enrollment application.

Your TYA coverage ends when any of the following occurs:

- You reach age 26
- You get married
- You become eligible for an employer-sponsored health plan under your own employment as defined in TYA regulations
- You gain other TRICARE coverage
- You lose eligibility because your sponsor ends TRICARE coverage

Traveling

Active Duty Service Members

If an emergency occurs, call 911 or go to the nearest emergency room and notify your PCM or the local TOP Regional Call Center (*if overseas*) within 24 hours or on the next business day. Prior authorization is not required for emergency care (*including overseas care*) before receiving treatment. If you are hospitalized, contact your regional contractor or service point of contact. If possible, active duty service members (ADSMs)* traveling overseas should contact the local TOP Regional Call Center before seeking care or before making a payment. Figure 6.3 on the following page lists contact information for each overseas area.

If traveling or between duty stations, you **must** receive all nonemergency care, including urgent care, at an MTF if one is available. If an MTF is not available, prior authorization from your PCM is required before receiving nonemergency care. Routine care, which includes routine dental care and general office visits for treatment and ongoing care, should be handled before you travel or postponed until you return. For urgent care overseas, ADSMs should contact the TOP Regional Call Center.

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

All Other TRICARE Prime Enrollees

If you need emergency care while traveling in the United States, visit the nearest emergency room or call 911. If you are admitted, your PCM or regional contractor must be notified within 24 hours or on the next business day so that ongoing care can be coordinated and to ensure you receive proper authorization for care.

If urgent treatment cannot wait until you return home to see your PCM, you must contact your PCM for a referral. If you are unable to reach your PCM, you may contact your regional contractor for assistance before receiving care. Failure to obtain a referral may cause your care to be covered under the POS option,† and you will incur higher out-of-pocket costs.

† *The POS option does not apply to ADSMs, children for the first 60 days following their birth or adoption, emergency care, beneficiaries with OHI, or the first eight behavioral health outpatient visits per FY to a network provider for a medically diagnosed and covered condition.*

When traveling overseas, plan for possible health care needs in advance of the trip. If you need emergency care, go to the nearest emergency care facility or call the TOP Medical Assistance number for the overseas area where you are traveling. If you are admitted, you must call your PCM and the TOP Regional Call Center before leaving the facility, preferably within 24 hours or the next business day to coordinate authorization, continued care, and payment, if applicable. Contact your PCM and the TOP Regional Call Center for urgent care. See Figure 6.3 for overseas contact information.

Note: When seeking care from a host nation (*overseas*) provider, you should be prepared to pay up front for services and then file a claim with the TOP contractor. To process your claims reimbursements quickly and efficiently, you must submit proof of payment with all claims. For more information on proof of payment requirements overseas, visit **www.tricare.mil/proofofpayment**. In the Philippines, you must use a TRICARE-certified provider. Visit **www.tricare.mil/pacific** for more information or to find a certified provider.

Filling Prescriptions on the Road

You may use any TRICARE pharmacy option when traveling, but be sure your DEERS information is current. To fill a prescription, you need a valid uniformed services ID card. At overseas host nation pharmacies, you will pay up front for medications and then file a claim for reimbursement of covered charges with the TOP contractor.

Note: In the Philippines you must use a TRICARE-certified host nation pharmacy. Visit **www.tricare.mil/pacific** for more information.

Military Treatment Facility Pharmacy

If you are traveling, you can fill a new prescription at any MTF pharmacy free of charge if the medication is on the MTF formulary and in stock. All you will need is the written prescription and your uniformed services ID card or CAC. An MTF pharmacy will determine if you can obtain a refill of a prescription that was originally filled at another MTF.

TRICARE Retail Network Pharmacies

You can fill prescriptions at any TRICARE retail network pharmacy in the United States and 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.

TRICARE Overseas Program Contact Information *Figure 6.3*

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
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

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

Visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303** to find the nearest TRICARE retail network pharmacy.

TRICARE Pharmacy Home Delivery

If you will be staying away from home for a longer period of time, you can plan ahead to receive prescriptions using TRICARE Pharmacy Home Delivery. 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 your least expensive option for filling prescriptions when not using an MTF pharmacy. Home delivery allows you to receive up to a 90-day supply of generic medications at no cost to you. Copayments apply for brand-name and non-formulary medications. If you have a prescription and are a TRICARE-eligible beneficiary, you may order by mail, phone, fax, or online, and prescriptions are delivered with free standard shipping. Not all persons with uniformed services ID cards or CACs are eligible. If you would like to convert a current maintenance prescription to home delivery, call the Member Choice Center at **1-877-363-1433**, or use the online tool on the TRICARE Pharmacy Program Web site at **www.express-scripts.com/TRICARE**.

Non-Network Pharmacies

If there is no other option, you can fill prescriptions at a non-network pharmacy. If you fill a prescription at a non-network pharmacy, you will be using the POS option. You may be required to pay for prescriptions up front and then file a claim with Express Scripts for reimbursement. See the *Claims* section of this handbook for details about filing pharmacy claims.

Filling Prescriptions Overseas

Your pharmacy coverage is limited overseas. TRICARE recommends that you fill all your prescriptions before you travel overseas. TRICARE retail network pharmacies are only located in the United States and 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 have an APO/FPO address to use TRICARE Pharmacy Home Delivery overseas, and the prescription must be from a U.S.-licensed provider. Be prepared to pay up front for medications and file a claim with the TOP contractor for reimbursement for host nation pharmacy services when traveling overseas.

Note: In the Philippines you must use a TRICARE-certified pharmacy. Visit **www.tricare.mil/pacific** for more information or to find a certified provider.

Moving

TRICARE Prime coverage is portable—you can easily transfer your TRICARE Prime enrollment when you move within your TRICARE region or to a new TRICARE region. ADSMs and their families may transfer their enrollment as often as needed. Retired service members and their families, survivors, eligible former spouses, and others are currently limited to two enrollment transfers each enrollment year.

Note: Beneficiaries must meet eligibility requirements to enroll in TPR and TPRADFM. For more information, see the *Eligibility and Enrollment* section of this handbook.

Active Duty Service Members and Active Duty Family Members

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 regional contractor to begin the process. If you are moving to a new region, your information will be sent to your new regional contractor, who will follow up with you to complete the enrollment transfer after you arrive at your new location. Your new regional contractor will also work with you to assign or choose a PCM best suited to your needs and the location of your work or home. If you are moving within your current region, your regional contractor will help you transfer to a new PCM.

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

Note: This enrollment transfer option is only available to ADSMs and ADFMs enrolled in TRICARE Prime, TPR, TPRADFM, TOP Prime, or TOP Prime Remote. Retirees and their dependents who are enrolled in TRICARE Prime should transfer their enrollment when they reach their new location using the options described below.

All Other TRICARE Prime Enrollees

If you move to another TRICARE Prime Service Area (PSA) in the same TRICARE region, you will only need to change your PCM once you arrive at your new location. If you move to another contractor's region or service area, you will need to transfer your TRICARE Prime enrollment. Do not disenroll from TRICARE Prime before you move to your new location.

If you move to an area where TRICARE Prime is not available (*same or new region*), you must disenroll from TRICARE Prime. You will be covered automatically by TRICARE Standard and TRICARE Extra as long as your DEERS information is current. If you do not disenroll, you will be using the POS option resulting in higher out-of-pocket costs.

You may transfer your TRICARE Prime enrollment or change your PCM online or by mail.

Online

If you are a stateside TRICARE Prime beneficiary, you may transfer your enrollment online using the BWE Web site. For more information or to access BWE, visit **www.tricare.mil/bwe** and use one of the following to log on:

- Valid CAC
- Defense Finance and Accounting Service myPay login ID and password
- Department of Defense (DoD) Self-Service Logon

Mail

You may transfer your TRICARE Prime enrollment by completing *DD Form 2876* and mailing it to your new regional contractor at the address listed. You may also drop it off at a TSC. To download *DD Form 2876*, visit **www.tricare.mil/forms**.

TRICARE North Region
Health Net Federal Services, LLC
P.O. Box 105146
Atlanta, GA 30348-5146

TRICARE South Region
Humana Military
ATTN: PNC Bank
P.O. Box 105838
Atlanta, GA 30348-5838

TRICARE West Region
UnitedHealthcare Military & Veterans
P.O. Box 105492
Atlanta, GA 30348-5492

Moving Overseas

If you are moving overseas, contact the appropriate TOP Regional Call Center before you move to determine TOP Prime eligibility requirements. Retirees and their family members are not eligible for TOP Prime options, but may be eligible for TOP Standard. See Figure 6.3 earlier in this section for TOP Regional Call Center contact information.

Separating from the Service

If you are separating from the uniformed services, TRICARE coverage may or may not continue, depending on the circumstances of your separation. TRICARE offers transitional health care options—the Transitional Assistance Management Program (TAMP) and the Continued Health Care Benefit Program (CHCBP)—that provide temporary coverage until you have a new health plan.

Transitional Assistance Management Program

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

You are not eligible for TAMP while on terminal leave, permissive temporary duty (PTDY), or authorized excess leave. During leave and PTDY, you continue to receive ADSM coverage from your last duty station, even if you relocate. If you stay in the same location during leave and PTDY, your family members remain covered under TRICARE Prime or TPRADFM. Please note that an ADSM is not eligible to change his or her PCM while on terminal leave. If you have an injury, illness, or disease that was incurred while on active duty, contact your unit or service branch for eligibility determination or authorizations for follow-up medical or dental care.

If you qualify, the 180-day TAMP period begins the day after your date of separation from active duty. When you become eligible for TAMP, you and your family members are covered under TRICARE Standard and TRICARE Extra. If you live in a PSA, you and your family members may choose to enroll in TRICARE Prime. TPR and TPRADFM are not available during TAMP. If you were enrolled in one of these programs, you will be disenrolled and covered by TRICARE Standard and TRICARE Extra.

You may also enroll or reenroll in TRICARE Prime under the following conditions:

- If you or your family members were enrolled in TRICARE Prime immediately prior to your change in status, you may continue your enrollment with no break in coverage as long as you complete a new *DD Form 2876* and submit it to your regional contractor before the TAMP period ends. The effective date will be the date the sponsor separated from active duty.
- If your family members were not enrolled in TRICARE Prime when you separated from active duty and would like to enroll, you must complete a *DD Form 2876* and submit it to your regional contractor. Such enrollment is subject to the 20th-of-the-month rule. Applications received by your regional contractor by the 20th of the month will become effective at the beginning of the following month (*e.g., an enrollment received by December 20 would become effective January 1*). If your application is received after the 20th of the month, your coverage will become effective on the first day of the month following the next month (*e.g., an enrollment received on December 27 would become effective on February 1*).

Contact your regional contractor or a Beneficiary Counseling and Assistance Coordinator (BCAC) to discuss your family's eligibility for this program. You also can visit **www.tricare.mil/tamp** for more information.

Transitional Care for Service-Related Conditions

If you are eligible under TAMP and have a newly diagnosed medical condition that is related to your active duty service, you may qualify for the Transitional Care for Service-Related Conditions (TCSRC) program, which provides 180 days of care for your condition with no out-of-pocket costs. If you believe you have a service-related condition that may qualify you for TCSRC, visit **www.tricare.mil/tcsrc** for instructions on how to apply.

Continued Health Care Benefit Program

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

CHCBP acts as a bridge between military health care benefits and your new civilian health care plan. CHCBP benefits are comparable to TRICARE Standard, with the same benefits, providers, and program rules. The main difference is that you pay premiums to participate. CHCBP enrollees are not

legally entitled to space-available care at MTFs. For more information about CHCBP, visit Humana Military's Web site at **Humana-Military.com** or call **1-800-444-5445**.

Contact your regional contractor or a BCAC to discuss your family's eligibility for this program. You also can visit **www.tricare.mil/chcbp** for more information.

TRICARE Reserve Select®

TRICARE Reserve Select (TRS) is a premium-based health care plan that qualifying members of the Selected Reserve of the Ready Reserve may purchase. TRS provides comprehensive health care coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra. However, unlike TRICARE Standard beneficiaries, TRS enrollees must pay monthly premiums. Visit **www.tricare.mil/trs** for more information about TRS coverage.

TRICARE Retired Reserve®

TRICARE Retired Reserve (TRR) is a premium-based health plan that members of the Retired Reserve may qualify to purchase. TRR provides comprehensive health care coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra. However, unlike TRICARE Standard beneficiaries, TRR enrollees must pay monthly premiums. Visit **www.tricare.mil/trr** for more information about TRR coverage.

Retiring from Active Duty

When you retire from active duty, you and your eligible family members experience a "change in status," and, after you update your DEERS record, you will receive a new uniformed services ID card that reflects your status as a retiree.

You will have new TRICARE coverage options after you retire. Understanding these options will help you and your family make the best health care decisions. After you retire, it is still essential to keep your DEERS information current.

Note: TPR and TPRADFM are not available to retirees and their families. If you are enrolled in TPR or TPRADFM and stay at your current residence, you may be able to enroll in TRICARE Prime if you waive your access standards. Contact your regional contractor for details.

After you retire, the following changes to your TRICARE coverage will apply:

- If you enroll in TRICARE Prime, you will:
  - Pay an annual enrollment fee (*Network copayments apply.*)
  - Be responsible for copayments for certain medical services
  - See an increase in your catastrophic cap
  - Experience minor differences in covered services (*e.g., eye examinations are now only covered every two years and hearing aids are no longer covered*)
- Your dental coverage will change (*See "Dental Options" in the* Covered Services, Limitations, and Exclusions *section of this handbook.*)
- Your family members who use TRICARE Standard and TRICARE Extra will see a cost-share increase of 5 percent

You and your family members should look at your health care options together and determine which option best meets your needs after you retire. If you decide to reenroll in TRICARE Prime, you must submit your *DD Form 2876* to your regional contractor prior to your retirement date; otherwise, the 20th-of-the-month rule may apply (*see "Transitional Assistance Management Program" earlier in this section for details*). Visit **www.tricare.mil/costs** for additional information regarding program 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** the sponsor retires. 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 anytime the sponsor is on active duty or within the first eight months

following the month that (a) the sponsor retires, or (b) TRICARE coverage ends, whichever is first.

Retired Status

Once active duty status ends, if you or a family member is entitled to premium-free Medicare Part A, enrollment in Medicare Part B is required to remain TRICARE-eligible. TRICARE benefits will be terminated for any period of time during which you have only Medicare Part A. Retirees under age 65 with Medicare Part A and Part B have the option to continue enrollment in TRICARE Prime if it is available.

Note: Retirees and their family members are not eligible for TPR or TPRADFM.

Survivor Coverage

If 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 current and you are:

- A surviving spouse who has not remarried (*Eligibility cannot be regained later, even if you divorce or your new spouse dies.*)
- A surviving 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*) **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, including TRICARE Prime and TPRADFM eligibility. After three years, you remain eligible as a "survivor," and are eligible for benefits as a retiree family member. You pay retiree rates* under TRICARE Prime (*if available*) or TRICARE Standard and TRICARE Extra. As a "survivor," you are not eligible for TPRADFM, but you may enroll in TRICARE Prime, if it is available where you live and you meet enrollment criteria. If you do not enroll in TRICARE Prime, coverage automatically continues under TRICARE Standard and TRICARE Extra.

Surviving children: Surviving children whose sponsor died on or after October 7, 2001, remain eligible for TRICARE benefits as ADFMs. Unlike spouses, eligibility will not change after three years, and children remain covered as ADFMs until eligibility ends due to the age limits previously noted or for another reason (*e.g., marriage*).

Transitional survivors enrolled in TRICARE Prime at the time of their sponsor's death will not be disenrolled. Coverage continues as long as DEERS information is up to date or until eligibility ends.

If you are not enrolled in TRICARE Prime or TPRADFM and are eligible, you may enroll at any time after your sponsor's death. Normal enrollment rules apply; there is no retroactive enrollment. Transitional survivors not enrolled in TRICARE Prime or TPRADFM will be covered as ADFMs under TRICARE Standard and TRICARE Extra.

Upon the death of a sponsor, you will receive a letter from Defense Manpower Data Center telling you about your program options and how your benefits will eventually change. Contact your regional contractor if you have any questions.

** You will need to reenroll at that time and pay retiree enrollment fees.*

Dependent Parent Coverage

As a TRICARE Prime beneficiary, if your parents or parents-in-law reside with you and are dependent on you for over 50 percent of their support, your local MTF may be able to help with the cost of their health care. Although dependent parents are not eligible for most TRICARE benefits, they may be eligible to receive health care at certain MTFs on a space-available basis. Dependent parents can also fill prescriptions at MTF pharmacies, and through the other TRICARE Pharmacy Program options once they become entitled to Medicare Part A and purchase Medicare Part B.

Your branch of service will determine MTF care eligibility for your parents or parents-in-law, register them as dependents in DEERS, and issue their ID cards.

Access to MTF care is subject to change based on the MTF's capacity and capabilities. Also, space-available access at one MTF does not guarantee space-available access at another MTF. When moving, you should check with the MTF at your new location to determine whether care is available.

Dependent parents or parents-in-law may also enroll in TRICARE Plus if your MTF offers it and space permits. TRICARE Plus allows them to make primary care appointments at the MTF within the same access standards as beneficiaries enrolled in TRICARE Prime.

Note: Dependent parents or parents-in-law are not eligible for any TRICARE civilian health care services, including emergency care, through TRICARE Prime, TRICARE Standard and TRICARE Extra, and TRICARE For Life. TRICARE will not pay for services received outside an MTF. You should consider a private commercial health insurance plan and/or other federal and state programs for your parents and/or parents-in-law if they need services that the MTF cannot provide.

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

Loss of Eligibility

Upon loss of TRICARE eligibility, each family member will automatically receive 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 care plan for preexisting conditions. Certificates may be issued in the following circumstances:

- Upon the sponsor's separation from active duty, a certificate will be issued to the sponsor listing all eligible family members.
- Upon the loss of eligibility for a dependent child (*age 21, or 23 if enrolled in a full-time course of study at an 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 will be issued to the former spouse as soon as the information is updated in DEERS.

Certificates automatically reflect the most recent period of continuous coverage under TRICARE. Certificates issued upon request of a beneficiary will reflect each period of continuous coverage under TRICARE 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 for whom it is issued, the dates TRICARE coverage began and ended, and the certificate issue date.

Requests for certificates may be made in writing, via fax, or by phone. Written (*mailed or faxed*) requests for a certificate must include:

- Sponsor's name and Social Security number or DoD Benefits Number
- Name of person for whom the certificate is requested
- Reason for the request
- Name and address to whom and where the certificate should be sent
- Signature of the requester

Mail written requests to:

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

Fax requests to **1-831-655-8317**.

Call DMDC directly at **1-800-538-9552** to request or check the status of your certificate. DMDC will review each request. Certificates can take up to three weeks to process. However, if your request is urgent, you can request that processing be expedited and your certificate can be faxed directly 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 the TRICARE Regional Offices. To locate a BCAC, visit **www.tricare.mil/bcacdcao** and use the online directory.

Debt Collection Assistance Officers

Debt Collection Assistance Officers (DCAOs) are located at MTFs and TRICARE Regional Offices to help you resolve health care collection-related issues. A DCAO is also located at the Military Medical Support Office (MMSO) for active duty service members and National Guard and Reserve members with service-documented line-of-duty injuries. Contact a DCAO if you have received a negative credit rating or have been contacted by a collection agency due to an issue related to TRICARE services.

When you visit a DCAO for assistance, you must bring or submit paperwork associated with a collection action or adverse credit rating, including debt collection letters, explanation of benefits (EOB) statements, and medical and/or dental bills from providers. The more information you can provide, the faster the cause of the problem can be determined. The DCAO will research your claim, provide you with a written resolution of your collection problem, and inform 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 you through the debt collection process 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 DCAO directory online at **www.tricare.mil/bcacdcao**.

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 denial 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 was submitted.

There are some things you may not appeal. For example, you may not appeal the denial of a service provided by a health care provider not eligible for TRICARE certification.

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

Appeal Requirements

Your appeal must meet the requirements listed in Figure 7.1 on the following page.

TRICARE 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 a representative, in writing, by you.
2	The appeal must be submitted in writing. See Figure 7.2 below 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 in a timely manner. An appeal must be filed within 90 days after 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.

Regional Appeals Filing Information *Figure 7.2*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Claims Appeals: Health Net Federal Services, LLC TRICARE Claim Appeals P.O. Box 105266 Atlanta, GA 30348-5266 **Claims Appeals Fax:** 1-888-458-2554 **Prior Authorization Appeals:** Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 105087 Atlanta, GA 30348-5087 **Prior Authorization Appeals Fax:** 1-888-881-3622 **Appeals Online:** www.hnfs.com	**Claims Appeals:** TRICARE South Region Appeals P.O. Box 202002 Florence, SC 29502-2002 **Prior Authorization Appeals:** Humana Military ATTN: Utilization Management P.O. Box 740044 Louisville, KY 40201-7444 **Behavioral Health Appeals:** ValueOptions Behavioral Health ATTN: Appeals and Reconsideration Department P.O. Box 551138 Jacksonville, FL 32255-1138	**Claims Appeals:** TRICARE West Region Appeals Department P.O. Box 105493 Atlanta, GA 30348-5493 **Claims Appeals Fax:** 1-877-584-6628 **Prior Authorization Appeals:** TRICARE West Region Appeals Department P.O. Box 105493 Atlanta, GA 30348-5493 **Prior Authorization Appeals Fax:** 1-877-584-6628

Filing an Appeal

Appeals must be filed with your regional contractor within 90 days from the date that appears on the 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 regional contractor.

Prior authorization denial appeals may be either expedited or non-expedited, depending on the type of denial and the urgency of the situation. You or an appointed representative must file an expedited review of a prior authorization denial based on medical necessity within three calendar days after receipt of the initial denial. A non-expedited review of a denial 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
- Appealing party's or representative's signature

A description of the issue or concern must include:

- The specific issue in dispute
- A copy of the previous denial determination notice

You may submit supporting documentation, but the timely filing of the appeal should not be delayed while gathering the documentation. If you intend to obtain supporting documentation that is not readily available, file your appeal and state in the appeal letter your intention to submit additional documentation and the estimated date of submission. Remember, you must meet the 90-day filing deadline or your request for reconsideration will generally not be accepted.

Send your appeal to your regional contractor. See Figure 7.2 on the previous page for appeals filing information.

Filing a Grievance

A grievance is a written complaint or concern about a non-appealable issue regarding a perceived failure by any member of the health care delivery team—including TRICARE-authorized providers, military providers, regional contractors, 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 the opportunity 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. Your regional contractor is responsible for the investigation and resolution of all grievances. Grievances are generally resolved within 60 days from receipt. Following resolution, the party who submitted the grievance will be notified of the review completion.

Grievances may include such issues as:

- The quality of health care or services (*i.e., 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

File grievances with your regional contractor. See Figure 7.3 on the following page for grievance filing information.

Reporting Suspected Fraud and Abuse

Fraud happens when a person or organization deliberately deceives 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.

You are an important partner in the ongoing fight against fraud and abuse. Your EOB is a statement of services and/or supplies received, making it one of the first lines of defense against health care fraud. Each EOB provides a toll-free number to call if you have concerns about services you believe are billed fraudulently. You can also visit the TRICARE fraud and abuse Web site at **www.tricare.mil/fraud** for direct links to your regional contractor's fraud and abuse reporting office. Through your regional contractor's Web site, you can use claims tools to view your EOBs and claims history and track the costs TRICARE pays. **TRICARE strongly encourages you to read your EOBs carefully.**

To report fraud or abuse regarding the pharmacy program, contact Express Scripts, Inc. by phone at **1-866-216-7096**, or by e-mail at **fraudtip@express-scripts.com**.

Report suspected fraud and abuse to your regional contractor. See Figure 7.4 for details. You also can report fraud or abuse issues directly to TRICARE at **fraudline@tma.osd.mil**.

Regional Grievance Filing Information *Figure 7.3*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Mail: Health Net Federal Services, LLC TRICARE Grievances P.O. Box 105338 Atlanta, GA 30348-5338 **Fax:** 1-888-317-6155 **Online:** www.hnfs.com	**Mail:** Regional Grievance Coordinator Humana Military 8123 Data Point Drive Suite 400 San Antonio, TX 78229 **Behavioral Health Care Concerns:** Grievance Specialist ValueOptions P.O. Box 551188 Jacksonville, FL 32255-1188	**Mail:** TRICARE West Region Grievances P.O. Box 105493 Atlanta, GA 30348-5493 **Fax:** 1-877-584-6628

Regional Fraud and Abuse Reporting Information *Figure 7.4*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Phone: 1-800-977-6761 **Fax:** 1-888-881-3644 **Online:** www.hnfs.com **E-mail:** program.integrity@healthnet.com **Mail:** HNFS Program Integrity P.O. Box 105310 Atlanta, GA 30348-5310	**Phone:** 1-800-333-1620 **Online:** Humana-Military.com **Mail:** Humana Military ATTN: Program Integrity 500 W. Main Street, 19th Floor Louisville, KY 40202	**Phone:** 1-888-899-5071 **Online:** www.uhcmilitarywest.com **Mail:** TRICARE West Region Program Integrity P.O. Box 740826 Atlanta, GA 30348-0826

Appendix A

TRICARE Prime, TRICARE Prime Remote, and TRICARE Prime Remote for Active Duty Family Members cover 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 8.1 provides coverage details for outpatient services. **Note:** This figure is **not** all-inclusive.

Outpatient Services: Coverage Details *Figure 8.1*

Service	Description
Ambulance Services	The following ambulance services are covered: • Emergency transfers between a beneficiary's home, accident scene, or other location and 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.

Outpatient Services: Coverage Details (continued)

Service	Description
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.
Home Health Care	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[1] 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. More than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.

Inpatient Services

Figure 8.2 provides coverage details for inpatient services. **Note:** This figure is **not** all-inclusive.

Inpatient Services: Coverage Details *Figure 8.2*

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 (*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. Skilled nursing care is only covered in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

Clinical Preventive Services

Figure 8.3 provides coverage details for clinical preventive services. **Note:** This figure is **not** all-inclusive.

Clinical Preventive Services: Coverage Details *Figure 8.3*

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:** Testing covered 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

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 • 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 • **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 • First-degree relative (*parent, child, sibling*) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves • 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 • **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 a 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:** A digital rectal examination and prostate-specific antigen screening is covered annually for certain high-risk men ages 40–49 and all men over age 50. • **Routine Pap smears:** Covered 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 reaching age 6 (*children and adults*).
Eye Examinations	• **Well-child care coverage (*infants and children until reaching age 6*):** • Infants (*until reaching age 3*): One eye and vision screening is covered at birth and at 6 months. • Children (*from age 3 until reaching age 6*): One routine eye examination is covered every two years. Active duty family member (ADFM) children are covered for one routine eye examination annually.

Clinical Preventive Services: Coverage Details (continued)

Service	Description
Eye Examinations (*continued*)	• **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. **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 before reaching 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.
Infectious Disease Screening	TRICARE covers screening for the following infectious diseases: 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 until reaching 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 8.4 provides coverage details for outpatient behavioral health care services. **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Outpatient Coverage Details *Figure 8.4*

Service	Description

Outpatient Psychotherapy (*physician referral and supervision may be required when seeing mental health counselors and is always required when seeing 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 8.5 provides coverage details for inpatient behavioral health care services. **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Inpatient Coverage Details ***Figure 8.5***

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 continuing 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 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 8.6 provides coverage details for 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 8.6*

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 FY[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.
2. October 1–September 30.

Services or Procedures with Significant Limitations

Figure 8.7 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 8.7*

Service	Description
Bariatric Surgery	These procedures are covered for the treatment of morbid obesity under certain limited circumstances. For more information, contact your regional contractor or visit **www.tricare.mil/coveredservices**.
Botulinum Toxin (Botox®) Injections	Botulinum toxin injections for cosmetic procedures, myofascial pain, and fibromyalgia are not covered. Cost-sharing may apply for injections to treat certain other defined conditions.
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 neoplastic surgery, or reconstruct the breast after cancer surgery.
Cranial Orthotic Device or Molding Helmet	Cranial orthotic devices are covered for adjunctive use for infants from 3–18 months of age whose synostosis has been surgically corrected, but who still have moderate to severe cranial deformities. Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery.
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 military treatment facilities 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.
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 (ADFMs) who meet specific hearing-loss requirements. • Hearing aids are excluded under any circumstance for retirees, retiree family members, TRICARE Reserve Select (TRS) members, and TRICARE Retired Reserve (TRR) members. • TRICARE Young Adult coverage for hearing aids is derived from the young adult's sponsor status. If the sponsor is an active duty service member, hearing aids are covered the same as for an ADFM. If the sponsor is a retiree, TRS member, or TRR member, hearing aids are excluded under any circumstance.
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**. **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 from civilian providers*)
- Alterations to living spaces
- Artificial insemination 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 bariatric surgery, 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 last 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

Appendix B

Sample Explanation of Benefits Statements

The following pages list figures and reference details for each regional contractor's explanation of benefits (EOB) statement.

- **North Region:** Figure 9.1
- **South Region:** Figure 9.2
- **West Region:** Figure 9.3

How to Read Your TRICARE Summary EOB (SEOB) for the North Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the North Region.
2. **Regional Contractor:** The Health Net Federal Services, LLC logo appears here.
3. **Mail-to Name and Address:** The TRICARE SEOB is mailed directly to the patient (*or patient's parent or guardian for minors*) at the address on file. **Note:** Be sure your doctor has updated your records with your current address.
4. **Date of Notice:** PGBA prepared your TRICARE SEOB on this date.
5. **Insured ID:** Your claim is processed using the insured ID of the service member (*active duty, retired, or deceased*) who is your TRICARE sponsor. For security reasons, only the last four digits of your insured's ID appear on the SEOB.
6. **Patient Name:** The name of the patient who received care and for whom the claim(s) were submitted.
7. **Claims Processed From:** The reporting period of claims activity contained in the SEOB.
8. **Provider of Service:** This section lists who provided your medical care.
9. **Total Paid This Reporting Period:** The total amount paid to your provider(s).
10. **Total Patient Responsibility:** The total amount your provider(s) may bill you.
11. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. Your annual deductible and maximum out-of-pocket expense is calculated by fiscal year (*October 1–September 30*).
12. **Sponsor Name:** The name of the service member who is your TRICARE sponsor.
13. **Patient Name:** The name of the patient who received care and for whom this claim was filed.
14. **Insured ID:** The last four digits of the insured's ID.
15. **Provider:** The provider of your services.
16. **Amount Other Insurance Paid:** The amount your primary health insurance paid (*if TRICARE is your secondary insurance*).

    Amount You Paid: The amount (*if any*) you paid the provider of medical services, as indicated on the claim.
17. **Amount Your Provider May Bill You:** The amount you are responsible for after TRICARE benefits were applied.

    Amount Paid To Your Provider: Benefits paid to the provider of services.

    Amount Paid To You: Benefits paid to you.
18. **Claim Number:** A unique number assigned by TRICARE for tracking purposes.
19. **Date(s) of Service:** The date(s) you received care.
20. **Service Provided:** This section describes the services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and laboratories use to identify the services you received.
21. **APC #:** Ambulatory Payment Classification (APC) program. A number assigned by Medicare or TRICARE that consists of one or more grouped medical procedure codes.
22. **Remarks:** If you see a code or a number here, refer to the "Remarks" section at the bottom of the SEOB for more information about your claim.
23. **Claim Summary:** Explains the action taken on your claim. You will find the following totals: amount your provider charged, amount allowed by TRICARE, and the non-covered amount.
24. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor billed. If so, that amount will be itemized here. It will include any charges applied to your annual deductible and any copayment or cost-share you must pay to the provider of services.

(1) PGBA, LLC
TRICARE NORTH REGION CLAIMS
P.O BOX 870140
SURFSIDE BEACH, SC 29587-9740

TRICARE SUMMARY EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claims.
Keep this notice for your records.

(2) TRICARE is a registered trademark of the TRICARE Management Activity. All rights reserved.

(3) PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

This is not a bill. Any amount you may owe your provider should not be sent directly to us.

(4) June 10, 2011

SUMMARY EXPLANATION OF BENEFITS (5)

This summary information is for claims processed for PATIENT, covered under sponsor ID *****6789. You will receive this summary if you had claims activity the previous reporting period.

This document outlines your share of the charges for services. You should use this to determine how much you need to pay. If there is a discrepancy, use this summary to discuss the charges with your provider.

(6) **Patient Name: PATIENT**

(7) **Claims Processed from 05/12/11 to 06/10/11**

(8) **Provider of Service:**	**Amount We Paid Your Provider:**	**Amount Your Provider May Bill You:**
PROVIDER OF MEDICAL CARE 1	$ 4. 10	$ 1. 37
PROVIDER OF MEDICAL CARE 2	$ 79. 30	$ 19. 82
(9) Total Paid This Reporting Period:	$ 83. 40	
(10) Total Patient Responsibility:		$ 21. 19

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2010.

As of June 7, 2011, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

We're honored to serve you through the TRICARE program for your commitment to the U. S. Uniformed Services.

CN: 100524N0000002

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

The following important information shows how much we covered and how much you may owe your provider for services PATIENT received.

(12) **Sponsor Name:** SPONSOR (13) **Patient Name:** PATIENT (14) **Sponsor SSN:** ***-**-6789

(15) Provider: **PROVIDER OF MEDICAL CARE 1**
(18) Claim #: **0118LLG00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: (16) **0. 00**

Amount Your Provider May Bill You: **1. 37**
Amount Paid To Your Provider: (17) **4. 10**
Amount Paid To You: **0. 00**

(19)

Date(s) of Service Begin	Date(s) of Service End	(20) Service Provided	(21) APC #	Remarks (22)	Your Provider Charged	Allowed Amount (23)	Amount Not Covered	Deductible	Copayment (24)	Cost Share
05/22/11	05/22/11	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

Provider: **PROVIDER OF MEDICAL CARE 2**
Claim #: **0118XXH00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: **0. 00**

Amount Your Provider May Bill You: **19. 82**
Amount Paid To Your Provider: **79. 30**
Amount Paid To You: **0. 00**

Date(s) of Service Begin	Date(s) of Service End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/11	05/23/11	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

1. THE AMOUNT ALLOWED WAS THE LESSER OF BILLED CHARGES, CONTRACTED RATE, STATE PREVAILING, OR THE TRICARE MAXIMUM ALLOWABLE CHARGE.
2. HAVE YOU CONSIDERED USING THE TRICARE MAIL ORDER PHARMACY SERVICE? IT CAN SAVE YOU UP TO 66% ON THE COST OF YOUR MEDICATIONS. CALL 1-877-363-1433 OR CHECK ONLINE AT WWW.EXPRESS-SCRIPTS.COM/TRICARE FOR MORE INFORMATION.
3. CHOOSING NETWORK PROVIDERS CAN SAVE YOU MONEY AND TIME. USE THE PROVIDER LOCATOR AT WWW.HNFS.COM TO FIND THE NETWORK PROVIDERS YOU NEED CLOSE TO YOU.
4. CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

CN: 100524N0000002

How to Read Your TRICARE Summary EOB (SEOB) for the South Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the South Region.
2. **Regional Contractor:** The Humana Military logo appears here.
3. **Mail-to Name and Address:** We mail the TRICARE SEOB directly to the patient (*or patient's parent or guardian for minors*) at the address on file. **Note:** Be sure your doctor has updated your records with your current address.
4. **Date of Notice:** PGBA prepared your TRICARE SEOB on this date.
5. **Insured ID:** Your claim is processed using the insured ID of the service member (*active duty, retired, or deceased*) who is your TRICARE sponsor. For security reasons, only the last four digits of your insured's ID appear on the SEOB.
6. **Patient Name:** The name of the patient who received medical care and for whom the claim(s) were submitted.
7. **Claims Processed From:** The reporting period of claims activity contained in the SEOB.
8. **Provider of Service:** This section lists who provided your medical care.
9. **Total Paid This Reporting Period:** The total amount we paid to your provider(s).
10. **Total Patient Responsibility:** The total amount your provider(s) may bill you.
11. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. Your annual deductible and maximum out-of-pocket expense is calculated by fiscal year (*October 1–September 30*).
12. **Sponsor Name:** The name of the service member who is your TRICARE sponsor.
13. **Patient Name:** The name of the patient who received care and for whom this claim was filed.
14. **Insured ID:** The last four digits of the insured's ID.
15. **Provider:** The provider of your services.
16. **Amount Other Insurance Paid:** The amount your primary health insurance paid (*if TRICARE is your secondary insurance*).

    Amount You Paid: The amount (*if any*) you paid the provider of medical services, as indicated on the claim.
17. **Amount Your Provider May Bill You:** The amount you are responsible for paying after TRICARE benefits were applied.

    Amount Paid To Your Provider: Benefits we paid to the provider of services.

    Amount Paid To You: Benefits paid to the beneficiary.
18. **Claim Number:** A unique number assigned to each claim for tracking purposes.
19. **Date(s) of Service:** The date(s) you received care.
20. **Service Provided:** This section describes the services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and laboratories use to identify the services you received.
21. **APC #:** Ambulatory Payment Classification (APC) program. A number assigned by Medicare or TRICARE that consists of one or more grouped medical procedure codes.
22. **Remarks:** If you see a code or a number here, refer to the "Remarks" section at the bottom of the SEOB for more information about your claim.
23. **Claim Summary:** Explains the action taken on your claim. You will find the following totals: amount your provider charged, amount allowed by TRICARE, and the non-covered amount.
24. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges we applied to your annual deductible and any copayment or cost-share you must pay to the provider of services.

South Region Explanation of Benefits Statement Sample *Figure 9.2*

(1) PGBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

TRICARE SUMMARY EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claims.
Keep this notice for your records.

(2) Humana. Military

This is not a bill. Any amount you may owe your provider should not be sent directly to us.

(3) PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

(4) June 10, 2011

SUMMARY EXPLANATION OF BENEFITS (5)

This summary information is for claims processed for PATIENT, covered under sponsor ID *****6789. You will receive this summary if you had claim activity this reporting period. A reporting period represents approximately 28 days of claim activity. If you have questions about these claims, please visit our user-friendly Web site at www.myTRICARE.com any time to check on the status of your claims. You can also call our customer service center at 1-800-403-3950 Monday thru Friday from 8 am to 6 pm.

This EOB outlines the amount you need to pay your provider. If there is a difference, use this summary to discuss the charges with your provider.

(6) **Patient Name: PATIENT**

(7) **Claims Processed from 05/12/11 to 06/10/11**

(8) **Provider of Service:**	**Amount We Paid Your Provider:**	**Amount Your Provider May Bill You:**
PROVIDER OF MEDICAL CARE 1	$ 4. 10	$ 1. 37
PROVIDER OF MEDICAL CARE 2	$ 79. 30	$ 19. 82
(9) Total Paid This Reporting Period:	$ 83. 40	
(10) Total Patient Responsibility:		$ 21. 19

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2010.

As of June 7, 2011, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

The TRICARE program is honored to serve you. Thank you for your commitment to the United States Uniformed Services.

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

The following important information shows how much we covered and how much you may owe your provider for services PATIENT received.

(12) **Sponsor Name:** SPONSOR (13) **Patient Name:** PATIENT (14) **Sponsor SSN:** ***-**-6789

(15) Provider: **PROVIDER OF MEDICAL CARE 1**
(18) Claim #: **0118LLG00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: (16) **0. 00**

Amount Your Provider May Bill You: **1. 37**
Amount Paid To Your Provider: (17) **4. 10**
Amount Paid To You: **0. 00**

(19)

Date(s) of Service Begin	Date(s) of Service End	(20) Service Provided	(21) APC #	Remarks (22)	Your Provider Charged (23)	Allowed Amount	Amount Not Covered	Deductible	Copayment (24)	Cost Share
05/22/11	05/22/11	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

Provider: **PROVIDER OF MEDICAL CARE 2**
Claim #: **0118XXH00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: **0. 00**

Amount Your Provider May Bill You: **19. 82**
Amount Paid To Your Provider: **79. 30**
Amount Paid To You: **0. 00**

Date(s) of Service Begin	Date(s) of Service End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/11	05/23/11	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

1. THE AMOUNT ALLOWED WAS THE LESSER OF BILLED CHARGES, CONTRACTED RATE, STATE PREVAILING, OR THE TRICARE MAXIMUM ALLOWABLE CHARGE.
2. HAVE YOU CONSIDERED USING THE TRICARE MAIL ORDER PHARMACY SERVICE? IT CAN SAVE YOU UP TO 66% ON THE COST OF YOUR MEDICATIONS. CALL 1-877-363-1433 OR CHECK ONLINE AT WWW.EXPRESS-SCRIPTS.COM/TRICARE FOR MORE INFORMATION.
3. CHOOSING NETWORK PROVIDERS CAN SAVE YOU MONEY AND TIME. USE THE PROVIDER LOCATOR AT WWW.HUMANA-MILITARY.COM TO FIND THE NETWORK PROVIDERS YOU NEED CLOSE TO YOU.
4. CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

CN: 100524S0000002

How to Read Your TRICARE Summary EOB (SEOB) for the West Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the West Region.
2. **Regional Contractor:** The Humana Military logo appears here.
3. **Mail-to Name and Address:** The TRICARE SEOB is mailed directly to the patient (***or patient/s parent or guardian for minors***) at the address on file. **Note:** Be sure your doctor has updated your records with your current address.
4. **Date of Notice:** PGBA prepared your TRICARE SEOB on this date.
5. **Insured ID:** Your claim is processed using the insured ID of the military service member (*active duty, retired, or deceased*) who is your TRICARE sponsor. For security reasons, only the last four digits of your insured's ID appear on the SEOB.
6. **Patient Name:** The name of the patient who received care and for whom the claim(s) were submitted.
7. **Claims Processed From:** The reporting period of claims activity contained in the SEOB.
8. **Provider of Service:** This section lists who provided your medical care.
9. **Total Paid This Reporting Period:** The total amount paid to your provider(s).
10. **Total Patient Responsibility:** The total amount your provider(s) may bill you.
11. **Benefit Period Summary:** This section reflects how much of the individual and family annual deductible and maximum out-of-pocket expense met to date. Your annual deductible and maximum out-of-pocket expense is calculated by fiscal year (*October 1 – September 30*).
12. **Sponsor Name:** The name of the service member who is your TRICARE sponsor.
13. **Patient Name:** The name of the patient who received care and for whom this claim was filed.
14. **Insured ID:** The last four digits of the insured's ID.
15. **Provider:** The provider of your services.
16. **Amount Other Insurance Paid:** The amount your primary health insurance paid (*if TRICARE is your secondary insurance*).

    Amount You Paid: The amount (*if any*) you paid the provider of medical services, and indicated on the claim.
17. **Amount Your Provider May Bill You:** The amount you are responsible for after TRICARE benefits were applied.

    Amount Paid To Your Provider: Benefits paid to the provider of services.

    Amount Paid To You: Benefits paid to you.
18. **Claim Number:** A unique number assigned by TRICARE for tracking purposes.
19. **Date(s) of Service:** The date(s) you received care.
20. **Services Provided:** This section describes the services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and laboratories use to identify the services you received.
21. **APC #:** Ambulatory Payment Classification (APC) program. A number assigned by Medicare or TRICARE which consists of one or more grouped medical procedure codes.
22. **Remarks:** If you see a code or a number here, refer to the "Remarks" section at the bottom of the SEOB for more information about your claim.
23. **Claim Summary:** Explains the action taken on your claim. You will find the following totals: amount your provider charged, amount approved by TRICARE, and the non-covered amount.
24. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor billed. If so, that amount will be itemized here. It will include any charges applied to your annual deductible and any copayment or cost- share you must pay to the provider of services.

(1) PGBA, LLC
TRICARE WEST REGION
P.O. BOX 7065
CAMDEN, SC 29020-7065

TRICARE SUMMARY EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claims.
Keep this notice for your records.

(2) UnitedHealthcare | TRICARE®

(3) PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

This is not a bill. Any amount you may owe your provider should not be sent directly to us.

(4) June 10, 2011

SUMMARY EXPLANATION OF BENEFITS (5)

This summary information is for claims processed for PATIENT, covered under sponsor ID *****6789. You will receive this summary if you had claim activity this reporting period.

This document outlines your share of the charges for services. You should use this to determine how much you need to pay. If there is a discrepancy, use this summary to discuss the charges with your provider.

(6) **Patient Name: PATIENT** (7) **Claims Processed from 05/12/11 to 06/10/11**

(8) **Provider of Service:**	**Amount We Paid Your Provider:**	**Amount Your Provider May Bill You:**
PROVIDER OF MEDICAL CARE 1	$ 4. 10	$ 1. 37
PROVIDER OF MEDICAL CARE 2	$ 79. 30	$ 19. 82
(9) Total Paid This Reporting Period:	$ 83. 40	
(10) Total Patient Responsibility:		$ 21. 19

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2010.

As of June 7, 2011, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

We're honored to serve you through the TRICARE program for your commitment to the U.S. Uniformed Services.

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

The following important information shows how much we covered and how much you may owe your provider for services PATIENT received.

(12) **Sponsor Name:** SPONSOR (13) **Patient Name:** PATIENT (14) **Sponsor SSN:** ***-**-6789

(15) Provider: **PROVIDER OF MEDICAL CARE 1**
(18) Claim #: **0118LLG00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: (16) **0. 00**

Amount Your Provider May Bill You: **1. 37**
Amount Paid To Your Provider: (17) **4. 10**
Amount Paid To You: **0. 00**

(19) Date(s) of Service Begin	End	(20) Service Provided	(21) APC #	(22) Remarks	Your Provider Charged	(23) Allowed Amount	Amount Not Covered	Deductible	(24) Copayment	Cost Share
05/22/11	05/22/11	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

Provider: **PROVIDER OF MEDICAL CARE 2**
Claim #: **0118XXH00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: **0. 00**

Amount Your Provider May Bill You: **19. 82**
Amount Paid To Your Provider: **79. 30**
Amount Paid To You: **0. 00**

Date(s) of Service Begin	End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/11	05/23/11	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

1. THE AMOUNT ALLOWED WAS THE LESSER OF BILLED CHARGES, CONTRACTED RATE, STATE PREVAILING, OR THE TRICARE MAXIMUM ALLOWABLE CHARGE.
2. HAVE YOU CONSIDERED USING THE TRICARE MAIL ORDER PHARMACY SERVICE? IT CAN SAVE YOU UP TO 66% ON THE COST OF YOUR MEDICATIONS. CALL 1-877-363-1433 OR CHECK ONLINE AT WWW.EXPRESS-SCRIPTS.COM/TRICARE FOR MORE INFORMATION.
3. CHOOSING NETWORK PROVIDERS CAN SAVE YOU MONEY AND TIME. USE THE PROVIDER LOCATOR AT WWW.UHCMILITARYWEST.COM TO FIND THE NETWORK PROVIDERS YOU NEED CLOSE TO YOU.
4. CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

CN: 100524S0000002

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
APC	Ambulatory payment classification
BCAC	Beneficiary Counseling and Assistance Coordinator
BWE	Beneficiary Web Enrollment
CAC	Common Access Card
CDC	Centers for Disease Control and Prevention
CHCBP	Continued Health Care Benefit Program
DBN	Department of Defense Benefits Number
DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DO	Doctor of osteopathic medicine
DoD	Department of Defense
DRG	Diagnosis-related group
DTF	Dental treatment facility
ECHO	TRICARE Extended Care Health Option
EFMP	Exceptional Family Member Program
EFT	Electronic funds transfer
EHHC	ECHO Home Health Care
EOB	Explanation of benefits
FDA	U.S. Food and Drug Administration
FY	Fiscal year
HNPCC	Hereditary non-polyposis colorectal cancer
HPV	Human papillomavirus
ID	Identification
MD	Doctor of medicine
MMSO	Military Medical Support Office
MRI	Magnetic resonance imaging
MTF	Military treatment facility
NMA	Non-medical attendant
OHI	Other health insurance
PCM	Primary care manager
PHP	Partial hospitalization program
POS	Point-of-service
PSA	Prime Service Area
PTDY	Permissive temporary duty
RTC	Residential treatment center
SEOB	Summary explanation of benefits
SHCP	Supplemental Health Care Program
SNF	Skilled nursing facility
SPOC	Service point of contact
SSN	Social Security number
SUDRF	Substance use disorder rehabilitation facility
TAMP	Transitional Assistance Management Program
TCSRC	Transitional Care for Service-Related Conditions
TDP	TRICARE Dental Program
TOP	TRICARE Overseas Program
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRDP	TRICARE Retiree Dental Program
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TYA	TRICARE Young Adult
USFHP	US Family Health Plan
VA	U.S. Department of Veterans Affairs

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Important Contact Information

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

TRICARE® Web site: **www.tricare.mil**

TRICARE Regional Contractors		
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
TRICARE Overseas Program		
International SOS Assistance, Inc. TRICARE Eurasia-Africa:[1] 1-877-678-1207 TRICARE Latin America and Canada:[1] 1-877-451-8659 TRICARE Pacific:[1] 1-877-678-1208 (*Singapore*) 1-877-678-1209 (*Sydney*) TRICARE Overseas Program Web site: www.tricare-overseas.com		

*1. For overseas contact information, visit **www.tricare-overseas.com***

Service Points of Contact

U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, and U.S. Coast Guard	1-888-MHS-MMSO (1-888-647-6676)
U.S. Public Health Service	1-800-368-2777
National Oceanic and Atmospheric Administration	Commissioned Personnel Center 1-800-224-6622

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
Visit a local uniformed services 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 1-866-363-2883 (*TDD/TTY*)
Online	**Fax**
Visit the milConnect Web site at **http://milconnect.dmdc.mil** to update DEERS information. Visit **www.tricare.mil/bwe** to access the Beneficiary Web Enrollment (BWE) Web site.	1-831-655-8317
	Mail
	Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771

Health Care Claims

You can download forms and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from your regional contractor's Web site. Submit claims to the addresses provided. You can also check the status of your claims at the Web sites provided.

TRICARE North Region	TRICARE South Region	TRICARE West Region
Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 www.myTRICARE.com www.hnfs.com	TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 www.myTRICARE.com Humana-Military.com	TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 www.uhcmilitarywest.com

TRICARE Pharmacy Program

Find a TRICARE retail network pharmacy, register for TRICARE Pharmacy Home Delivery, or find information on how to save money and make the most of your pharmacy benefit. Visit **www.tricare.mil/pharmacy** for more information. TRICARE has partnered with Express Scripts, Inc. to provide your pharmacy benefit.

Express Scripts, Inc.		
www.express-scripts.com/TRICARE 1-877-363-1303 1-877-540-6261 (*TDD/TTY*) Member Choice Center (*convert retail prescriptions to home delivery*): 1-877-363-1433	**TRICARE Pharmacy Home Delivery**	**TRICARE Retail Network Pharmacy**
	To register for TRICARE Pharmacy Home Delivery, download the *Express Scripts New Patient Home Delivery Form* from **www.express-scripts.com/TRICARE**, complete it, and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954	Send pharmacy claims to: Express Scripts, Inc. TRICARE Claims P.O. Box 66518 St. Louis, MO 63166-6518
Prescription Drug Formulary Search		
www.pec.ha.osd.mil/formulary_search.php		

TRICARE Dental Options

Visit **www.tricare.mil/dental** for information on all of TRICARE's dental program options.

Active Duty Dental Program	TRICARE Dental Program	TRICARE Retiree Dental Program
www.addp-ucci.com	https://mybenefits.metlife.com/tricare	www.trdp.org

Other Resources

TRICARE Forms	www.tricare.mil/forms
Beneficiary Web Enrollment	www.tricare.mil/bwe
US Family Health Plan	www.tricare.mil/usfhp
TRICARE Behavioral Health	www.tricare.mil/mentalhealth
Continued Health Care Benefit Program	www.tricare.mil/chcbp

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

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Humana-Military.com
1-800-444-5445

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UnitedHealthcare Military & Veterans
www.uhcmilitarywest.com
1-877-988-WEST (1-877-988-9378)

www.tricare.mil

HA5181BEC11123