# TRICARE Prime Handbook

*Your guide to program benefits*

TRICARE

DEPARTMENT OF DEFENSE · UNITED STATES OF AMERICA

## *Important Information*

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|---|---|
| TRICARE National Web site: | www.tricare.mil |
| TRICARE Mail Order Pharmacy *(Express Scripts, Inc.)*: | 1-866-DoD-TMOP (1-866-363-8667) |
| TRICARE Retail Pharmacy *(Express Scripts, Inc.)*: | 1-866-DoD-TRRx (1-866-363-8779) |

*TRICARE North Region Contractor*

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

*TRICARE South Region Contractor*

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

*TRICARE West Region Contractor*

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

*TRICARE Overseas (TRICARE Europe, TRICARE Latin America and Canada, and TRICARE Pacific)*

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

### *An Important Note About TRICARE Program Changes*

At the time of printing, the information in this handbook is current. It is important to remember that TRICARE policies and benefits are governed by public law. Changes to TRICARE programs are continually made as public law is 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*

Dear TRICARE Prime Member:

Your decision to enroll in TRICARE Prime was an important one. To make the best use of your benefits, read this *TRICARE Prime Handbook*. If you have questions about your benefit after reading this handbook, there are many resources available to help you.

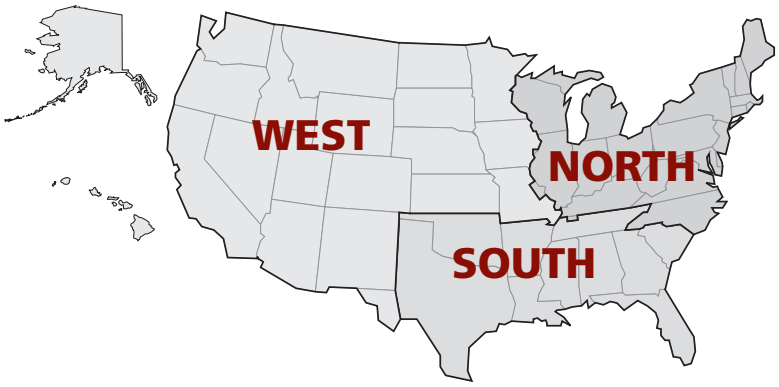
## Health Care Services

With TRICARE Prime, you will receive most of your care from an assigned primary care manager (PCM). Your PCM can be either a military treatment facility (MTF) provider or a civilian TRICARE network provider. We will discuss your PCM and other provider types later in this handbook.

A TRICARE Prime enrollment card and letter have been, or will be, mailed 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

The regional contractors administer TRICARE Prime in each region. We will refer regularly to your regional contractor throughout this handbook, and describe differences in each region. In cases where there are differences, refer to the information specific to your region. We encourage you to visit your regional contractor's Web site, which includes information about how to change PCMs, how to enroll a newborn or adopted child, covered and non-covered services, referral and authorization requirements, and other helpful information. You can also call your regional contractor toll-free for assistance at the numbers listed below. Regional contractors also have TRICARE Service Centers (TSCs) located throughout the region, typically at MTFs, that have customer service representative to assist you.




### TRICARE North Region

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

| | |
|---|---|
| **Regional contractor** | Health Net Federal Services, Inc. (Health Net) |
| **Phone** | **1-877-TRICARE (1-877-874-2273)** |
| **Web site** | **www.healthnetfederalservices.com** |

### TRICARE South Region

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

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|---|---|
| **Regional contractor** | Humana Military Healthcare Services, Inc. (Humana Military) |
| **Phone** | **1-800-444-5445** |
| **Web site** | **www.humana-military.com** |

### TRICARE West Region

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

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| **Regional contractor** | TriWest Healthcare Alliance (TriWest) |
| **Phone** | **1-888-TRIWEST (1-888-874-9378)** |
| **Web site** | **www.triwest.com** |

TRICARE Prime offers enhanced benefits and personalized care. Look in the mail 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.

## Keep Your DEERS Information Current!

It is essential that you keep information in the Defense Enrollment Eligibility Reporting System (DEERS) current for you and your family. DEERS is a worldwide computerized database of uniformed service members (active duty and retired), their family members, and others who are eligible for military benefits, including TRICARE. The key to receiving timely, effective TRICARE benefits—including doctor appointments, prescriptions, payment of health care expenses, etc.—is proper and current registration in DEERS.

To update DEERS:

- Visit a uniformed services personnel office. Find one near you at **www.dmdc.osd.mil/rsl**.
- Call **1-800-538-9552**.
- Fax address changes to DEERS at **1-831-655-8317**.
- Mail address changes to:

  Defense Manpower Data
  Center Support Office
  Attn: COA
  400 Gigling Road
  Seaside, CA 93955-6771

- Update addresses online at **www.tricare.mil/DEERS**.

## Important Note for National Guard and Reserve Members and their Families

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

Throughout this *TRICARE Prime Handbook*, we will refer to active duty service members and active duty family members. Be aware that we also are referring to activated National Guard and Reserve members and their families enrolled in TRICARE Prime. If you have any questions about TRICARE Prime, contact your regional contractor.

# Table of Contents

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

# 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) is a medical facility (hospital, clinic, etc.) owned and operated by the uniformed services—usually located on or near a military base. To locate an MTF near you, visit **www.tricare.mil/mtf**.

### Civilian Providers

Figure 1.1 explains the different types of civilian TRICARE providers.

***TRICARE Provider Types***

*Figure 1.1*

**TRICARE-authorized Providers**

- A provider who meets TRICARE's licensing and certification requirements and has been certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (laboratories and radiology centers), and pharmacies. If you see a provider who 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 | |
|---|---|---|
| • Network providers have a signed agreement with your regional contractor to provide care at a negotiated rate. Network providers file claims for you.<br>• You will receive most of your care from TRICARE network providers. | • Non-network providers do not have a signed agreement with your regional contractor and are therefore "out of network." In most cases, you will not receive care from non-network providers unless approved 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 (POS) option.<br>• There are two types of non-network providers: ***Participating*** and ***Nonparticipating***. | |
| | **Participating** | **Nonparticipating** |
| | • Participating* providers have agreed to file claims for you, to accept payment directly from TRICARE and to accept the TRICARE allowable charge less any applicable cost-shares paid by you as payment in full for their services.<br>• Using a participating provider is your best option if you must visit a non-network provider. | • Nonparticipating providers have not agreed to accept the TRICARE allowable charge or file your claims. If you use the POS option and seek care from a nonparticipating provider, the provider may charge you up to 15% above the TRICARE allowable charge for services (in addition to POS fees). This amount is your responsibility and will not be shared by TRICARE.<br>• If you visit a nonparticipating provider, you may have to pay the provider first and file a claim with TRICARE for reimbursement. |

**Providers may decide to participate on a claim-by-claim basis.*

### Department of Veterans Affairs Health Care Facilities

Many Department of Veterans Affairs (VA) health care facilities participate in TRICARE as network providers. While VA facilities may or may not provide primary care, many do provide specialty care. 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.

**Note**: Active duty service members who are referred to a VA medical facility for a service-connected condition must receive health care benefits under the VA program. When an active duty service member with a service-connected condition is referred to/being treated by the VA, the Department of Defense (DoD) is still responsible for payment for the care rendered.

Some retired service members may be eligible for both TRICARE and VA benefits (the VA offers health care programs separate from TRICARE—refer to the VA Web site at **www.va.gov** for details), so you will have to choose which program you want to use. When choosing between TRICARE and VA benefits, carefully compare the costs and the financial demands of each option to make the best decision.

## Your Primary Care Manager

When you enrolled in TRICARE Prime, you selected or were assigned a primary care manager (PCM). Your PCM provides your routine health care and coordinates referrals for specialty care that he or she cannot provide. Your PCM may be an MTF provider or a civilian TRICARE network provider within a Prime service area (PSA).

A PSA is a geographic area where TRICARE Prime benefits are offered. It's typically a geographic area around an MTF and specific areas with a significant concentration of uniformed service personnel and retirees and their families.

A PSA must also have a substantial medical community to support most or all TRICARE Prime enrolled beneficiary medical needs.

### On-Call Providers

PCMs are required to provide access to care 24 hours a day, seven days a week. To cover all hours, your PCM may designate an on-call provider who will act on their 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 was coming from your PCM.

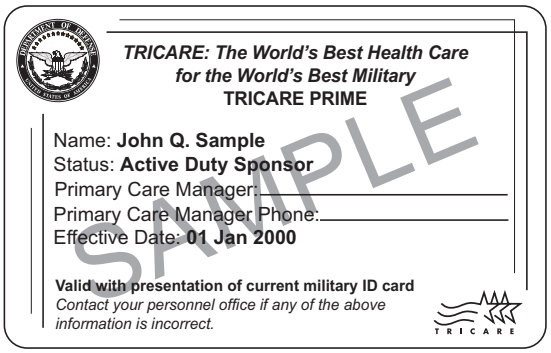
### Changing Your Primary Care Manager

You may change your PCM at any time provided the new PCM is accepting new patients and your request complies with local MTF guidelines. Once you have selected a new PCM from your regional contractor's provider directory (viewable online at each contractor's Web site), complete a *TRICARE Prime Enrollment and PCM Change Form* with the new PCM's name and address.

You only need to complete the portion of the form related to the PCM change. The change will become effective once the application is received and processed by your regional contractor. You may also call your regional contractor to change your PCM. Once your PCM change is processed, you will be mailed a confirmation letter with the new PCM name and telephone number.

## Enrollment Card

You and each enrolled family member will receive his or her own TRICARE Prime enrollment card. Included with the card is a letter identifying your PCM's name and telephone number. Write your PCM's name and telephone number on your card. TRICARE network providers may require you to show the enrollment card as well as your uniformed services identification (ID) or Common Access Card (CAC) at the time of service. Your TRICARE Prime enrollment effective date is printed on this card.




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

## Disenrollment

Enrollment in TRICARE Prime is continuous—you do not have to re-enroll every year to maintain coverage. Certain events will, however, cause you to be disenrolled from TRICARE Prime.

### Sponsor Status Change

Any 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. If you will remain eligible for TRICARE Prime (after the status change), you should submit a new enrollment application to your regional contractor before the status change occurs to avoid a lapse in coverage.

### Non-Payment 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 non-payment, you are subject to a 12-month lockout during which you will not be permitted to re-enroll in TRICARE Prime. To avoid missing an appointment, learn about automatic payment options in the *TRICARE: Summary of Beneficiary Costs* flyer or contact your regional contractor.

### Becoming Medicare-Eligible at Age 65

When you become entitled to premium-free Medicare Part A at age 65, you automatically lose eligibility for TRICARE Prime and become eligible for TRICARE For Life (TFL) if you have Medicare Part B coverage. Visit **www.tricare.mil/tfl** for more information about TFL.

**Note**: If you are not entitled to premium-free Medicare Part A when you become age 65, you remain eligible for TRICARE Prime, Standard, and Extra, and you are not required to have Medicare Part B coverage. You must present a Social Security Administration Letter of Disallowance to an ID card-issuing facility to retain TRICARE coverage.

### Voluntary Disenrollment

If you choose to disenroll from TRICARE Prime before the annual enrollment renewal date, you are subject to a 12-month lockout,* during which you will not be permitted to re-enroll in TRICARE Prime. You must contact your regional contractor to initiate a voluntary disenrollment.

Active duty service members must enroll in either TRICARE Prime or TRICARE Prime Remote. Voluntary disenrollment is not an option.

** The 12-month lockout provision does not apply to active duty family members of sponsors grade E-1 through E-4.*

## Loss of Eligibility

If you lose your TRICARE eligibility as shown in DEERS, your TRICARE Prime coverage will end automatically. If you believe you are still eligible for TRICARE, you will need to update your DEERS record to re-establish your eligibility. Once DEERS is updated, you must re-enroll in TRICARE Prime, or 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 the *Life Events*, "Separating from the Service" section for details about transitional health care options. You will receive a certificate of creditable coverage when TRICARE eligibility is lost. See the *Life Events*, "Loss of Eligibility" section for more information about the certificate of creditable coverage.

# Getting Care

You receive routine or primary health care from your primary care manager (PCM), and your PCM will refer you to a specialist for necessary specialty care. You are guaranteed access to care within specific time frames, and you may qualify for a travel reimbursement if referred to specialty care that is more than 100 miles from your PCM's office. This section explains these and other details about using TRICARE Prime.

## Making an Appointment

Contact your PCM's office directly to make an appointment. There is no need to contact your regional contractor to schedule appointments.

## Access Standards for Care

There are certain access standards for care.

- 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 to 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 above 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 contact your regional contractor for assistance in locating another provider.

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 the section titled, *Specialty Care far From Home* 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 cancelled 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.

## 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, or the absence of immediate medical attention would result in a threat to life, limb, or eyesight, or when the person has painful symptoms requiring immediate attention to relieve suffering. If you need emergency care, go to the nearest emergency room or call 911. It is important that you know the emergency telephone numbers in your area. Take a minute to look these numbers up and write them here or on the inside front cover of this book.

Emergency Assistance:

_____

Ambulance:

_____

Poison Control: 1-800-222-1222

You do not need to call your PCM or regional contractor before receiving emergency medical care. However, in **all** emergency situations, you must notify your PCM within 24 hours, or the next business day, so that ongoing care can be coordinated, and to ensure you receive proper authorization for care.

## Urgent Care

Urgent care is 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 would require urgent care for conditions such as a sprain, sore throat, or rising temperature that have 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 are away from home, contact your regional contractor for assistance in obtaining urgent care. 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. See the *TRICARE: Summary of Beneficiary Costs* flyer to learn about POS fees.

## 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 without a referral from your PCM, you will be utilizing the POS option, resulting in higher out-of-pocket costs. See the *TRICARE: Summary of Beneficiary Costs* flyer to learn about POS fees.

### Services That Do Not Require Referrals

Some services may be obtained without a PCM referral. These include clinical preventive services and the first eight outpatient behavioral health care visits per fiscal year (October 1-September 30). When seeking clinical preventive services or behavioral health care, you must use a **network** provider. If you seek care from a non-network provider without a referral from your PCM, you will be utilizing the POS option, resulting in higher out-of-pocket costs. See the *TRICARE: Summary of Beneficiary Costs* flyer to learn about POS fees.

For more information about these services, see the *Covered Benefits*, *Limitations*, *and Exclusions* section. Remember, you will **never** need a referral for emergency care. **Note**: Active duty service members require a referral for any clinical preventive services, behavioral health care, or specialty 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, when necessary. If you receive specialty care without a referral from your PCM, you will be utilizing the POS option, resulting in higher out-of-pocket costs. See the *TRICARE: Summary of Beneficiary Costs* flyer to learn about POS fees.

### 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 for details about obtaining referrals.

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

### Specialty to Specialty Referrals

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

## Specialty Care Far From Home—Travel Reimbursement

Non-active duty TRICARE Prime enrollees who are referred by their PCM for specialty care at a location more than 100 miles (one way) from the PCM's office may be eligible to have "reasonable travel expenses" reimbursed by TRICARE. Reasonable travel expenses are the actual costs incurred while traveling, including meals, gas/oil, tolls, parking, and tickets for public transportation (i.e., airplane, train, bus, etc.). You must submit receipts for expenses above $75.

TRICARE will use government rates to estimate the reasonable cost. You are expected to use the least costly mode of transportation. TRICARE will reimburse the actual costs of lodging (including taxes and tips) and the actual cost of meals (including taxes and tips, but excluding alcoholic beverages) up to the government rate for the area concerned.

In some cases, a non-medical attendant may also be authorized for travel reimbursement. The non-medical attendant must be a parent, guardian, or another adult family member 21 years of age or older.

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 (TRO) (if enrolled to a civilian PCM). You should obtain the travel orders before traveling. Contact your local MTF or TRO travel representative if you think you may qualify for this travel reimbursement.

*TRO Contact Information for Travel Reimbursement* *Figure 2.1*

| | |
|---|---|
| **TRO-North** | Visit www.tricare.mil/tronorth or call 1-866-307-9749 |
| **TRO-South** | Call 1-800-554-2397 or 1-210-292-3256 |
| **TRO-West** | Call 1-619-236-5324 |

You may also visit the TRICARE Web site at **www.tricare.mil/primetravel** for more information.

**Note**: Travel for active duty service members is reimbursed through other travel regulations. Active duty service members should contact their unit representatives for information about traveling long distances for medical care.

## Prior Authorizations 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 authorization is required for certain types of care and must be obtained before services are rendered.

Your PCM will request prior authorization from your regional contractor when required. If the service is authorized, the regional contractor will give your PCM an authorization number along with specific instructions. For example, prior authorizations for medical or surgical services will have a begin date and end date. Prior authorizations for behavioral health services will 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, you will need to get another referral and authorization from your PCM.

### Services Requiring Prior Authorization

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

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

- Adjunctive dental services
- Home health services
- Hospice care
- Nonemergency inpatient admissions for substance-use disorders or behavioral health
- Outpatient behavioral health care beyond the eighth visit
- Transplants—all solid organ and stem cell
- TRICARE Extended Care Health Option services

Each regional contractor has additional prior authorization requirements. Visit your regional contractor's Web site or call their toll-free number to learn about each region's requirements, as they may change periodically. See page 2 for a list of regional toll-free numbers.

## Getting a Second Opinion

You have every right to request a consultation with another provider for a second medical opinion when the initial provider is uncertain about a contemplated course of action. You, your PCM, or your regional contractor may request a second medical opinion. If you wish to seek a second opinion, go to your PCM and explain your situation and any questions you may have about the first specialist's suggested care. Then, ask your PCM to coordinate a referral to another specialist and request a referral from your regional contractor if necessary.

## Point of Service Option

The TRICARE Prime point of service (POS) option gives you the freedom to seek and receive nonemergency health care services from any TRICARE-authorized provider without requesting a referral from your PCM for additional costs. See the *TRICARE: Summary of Beneficiary Costs* flyer for details about POS fees.

The POS option does not apply to the following:

- Active duty service members
- Newborns or adopted children in their first 60 days
- Emergency care
- Preventive care services from a network provider
- First eight behavioral health outpatient visits from a network provider
- If you have other health insurance

# Covered Services, Limitations, and Exclusions

TRICARE Prime covers most care that is medically necessary and considered proven. However, there are special rules or limits on certain types of care, while other types of care are not covered at all. **This chapter is not intended to be all-inclusive**. Visit your regional contractor's Web site for additional information about covered services and benefits.

## Outpatient Services

Figure 3.1 provides coverage details for covered outpatient services. **Note:** This chart is not intended to be all-inclusive.

***Outpatient Services: Coverage Details*** *Figure 3.1*

| Service | Description |
|---|---|
| **Ambulance Services** | Covers emergency transfers to or from a beneficiary's home, accident scene, or other location to a hospital and transfers between hospitals; ambulance transfers from a hospital-based emergency room to a hospital more capable of providing the required care; and transfers between a hospital or skilled nursing facility and another hospital-based or freestanding outpatient therapeutic or diagnostic department/facility.<br>Excludes ambulance service used 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; and Medicabs or ambicabs that function primarily as public passenger conveyances transporting patients to and from their medical appointments. |
| **Ancillary Services** | Certain diagnostic radiology and ultrasound, diagnostic nuclear medicine, pathology and laboratory services, and cardiovascular studies. |
| **Durable Medical Equipment (DME)** | Generally covered if medically necessary and appropriate, and if prescribed by a physician for the specific use of the beneficiary. Duplicate items of DME which are essential to provide a fail-safe, in-home, life-support system are covered. In this case, "duplicate" means an item that meets the definition of DME and serves the same purpose but may not be an exact duplicate of the original DME item. For example, a portable **oxygen concentrator** may be covered as a backup for a stationary **oxygen generator**. |
| **Emergency Services** | Emergency services are covered for medical, maternity, or psychiatric conditions 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 medical attention would result in a threat to the patient's life, limb, or eyesight; that the patient may be a danger to self or others and requires immediate medical treatment; or that the patient manifests painful symptoms requiring immediate palliative effort to relieve suffering. |
| **Eye Examinations** | • Infants (regardless of beneficiary category): Covered for one eye and vision screening by the PCM during a routine exam at birth and 6 months of age<br>• Active duty service members and family members: Covered for one eye exam per year<br>• All other TRICARE Prime enrollees: Covered for one eye exam every two years<br>• Diabetic patients (regardless of beneficiary category): Covered for one eye exam per year |
| **Home Health Care** | Part-time or intermittent skilled nursing services and home health services; physical, speech, and occupational therapy; medical social services; and routine and non-routine medical services. All care must be provided by a participating home health care agency and be authorized in advance by the regional contractor. |
| **Individual Provider Services** | 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 therapy, speech pathology services, and occupational therapy); and medical supplies used within the office. |

*Outpatient Services: Coverage Details (continued)*

| Service | Description |
|---|---|
| **Laboratory and X-ray Services** | Generally covered if prescribed by a physician (some exceptions apply, e.g., chemo-sensitivity assays and bone density X-ray studies for routine osteoporosis screening). |
| **Papanicolaou (Pap) Smear** | Covered as either a diagnostic or routine preventive procedure. **Note**: The HPV Pap test is not covered as a routine screening Pap smear. |
| **Prosthetic Devices and Medical Supplies** | Generally covered if prescribed by a physician and is directly related to a medical condition. Prosthetic devices must be FDA-approved. |

## Inpatient Services

Figure 3.2 provides coverage details for covered inpatient services. **Note**: This chart is not intended to be all-inclusive.

*Inpatient Services: Coverage Details* *Figure 3.2*

| Service | Description |
|---|---|
| **Hospitalization** | Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physical and surgical services; meals (including special diets); drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products. |
| **Skilled Nursing Facility Care** | Semiprivate room; regular nursing services; meals, including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Unlike Medicare, unlimited number of days as medically necessary. |

## Clinical Preventive Services

Figure 3.3 provides coverage details for clinical preventive services. **Note**: This chart is not intended to be all-inclusive.

*Clinical Preventive Services: Coverage Details* *Figure 3.3*

| Service | Description |
|---|---|
| **Health Promotion and Disease Prevention Examinations** | Office visits may be covered for the following services (subject to age and other criteria):<br>• Cancer screening examinations and services (breast cancer, cancer of female reproductive organs, colorectal cancer, and prostate cancer)<br>• Infectious diseases (Hepatitis B screening, human immunodeficiency virus [HIV] testing) and preventive therapy when at-risk (tetanus, animal bite, Rh immune globulin, and exposure to certain infectious diseases, including tuberculosis)<br>• Genetic testing and counseling for certain clinical indications during pregnancy<br>• Other: Routine chest X-rays and electrocardiograms required for admission when a patient is scheduled to receive general anesthesia on an inpatient or outpatient basis |
| **Immunizations** | Covered for age-appropriate dose of vaccines as recommended by the Centers for Disease Control and Prevention. Immunizations for active duty family members whose sponsors have permanent change of station orders to overseas locations also are covered. |

*Clinical Preventive Services: Coverage Details (continued)*

| Service | Description |
|---|---|
| **Other Health Promotion and Disease Prevention Services** | The following services may be covered if provided in connection with a visit for immunizations, Pap smears, mammograms, or examinations for colon and prostate cancer:<br>• Cancer screening (testicular, skin, oral cavity, pharyngeal, and thyroid)<br>• Infectious disease (tuberculosis screening, Rubella antibodies)<br>• Cardiovascular disease (cholesterol screening, blood pressure screening)<br>• Body measurements (height and weight)<br>• Vision screening<br>• Audiology screening (only allowed under well-child services)<br>• Counseling services expected of good clinical practice that are included with the appropriate office visit at no additional charge (dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; promoting dental health; accident and injury prevention; and stress, bereavement, and suicide risk assessment) |
| **School Physicals** | Covered for children ages 5-11 if required in connection with school enrollment.<br>**Note:** Annual sports physicals are not a covered benefit. |
| **Well-child Services** | Covered for beneficiaries from birth to age 6; includes visits, immunizations, and vision screening. |

## Behavioral Health Care Services

### Active Duty Service Members

Active duty service members must have prior authorization before seeking behavioral health care. We do not want to discourage you from seeing a behavioral health specialist, but we want to make sure that your condition does not adversely affect your health and your ability to perform worldwide duty. Contact your regional contractor before obtaining behavioral health care services.

### All Others Enrolled in TRICARE Prime

You may receive the first eight behavioral health outpatient visits per fiscal year (October 1-September 30) from a network provider without a referral or prior authorization from your PCM. If you obtain these visits from a non-network provider without referral from your PCM and your regional contractor, POS fees will apply. After the first eight visits (beginning on the 9th visit), you must obtain a referral from your PCM and receive prior authorization from your regional contractor.

### Authorized Behavioral Health Providers

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

- Psychiatrists
- Clinical psychologists
- Certified psychiatric nurse specialists
- Clinical social workers
- Certified marriage and family therapists with a TRICARE participation agreement
- Pastoral counselors—with physician referral and supervision
- Mental health counselors—with physician referral and supervision
- Licensed professional counselors—with physician referral and supervision

If you are unsure which type of provider would best meet your needs, contact your regional contractor for assistance.

Figure 3.4 provides coverage details for covered behavioral health care services. **Note**: This chart is not intended to be all-inclusive.

### *Behavioral Health Care Services: Coverage Details*

*Figure 3.4*

| Service | Description |
|---|---|
| **Acute Inpatient Psychiatric Care** | 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.<br>**Limitations**<br>• Patients age 19 and older are limited to 30 days per fiscal year.*<br>• Patients age 18 and under are limited to 45 days per fiscal year.*<br>• Inpatient admissions for substance use disorder detoxification and rehabilitation count toward the 30- or 45-day limit.<br>**Note**: Day limits may be waived if determined to be medically or psychologically necessary (See 10 USC 1079 (i)). |
| **Medication Management** | If you are taking prescription medications for a behavioral health care 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. |
| **Partial Hospitalization** | Psychiatric partial hospitalization provides interdisciplinary therapeutic services at least three hours per day, five days a week, in any combination of day, evening, night, and weekend treatment programs.<br>• Prior authorization from your regional contractor is required.<br>• Facility must be TRICARE-authorized.<br>• Partial hospitalization programs must agree to participate in TRICARE.<br>**Limitations**<br>• Limited to 60 treatment days (whether a full- or partial-day treatment) in a fiscal year.* These 60 days are not offset or counted toward the 30- or 45-day inpatient limit. |
| **Psychological Testing and Assessment** | 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 against the limit of two psychotherapy visits per week.<br>**Limitations**<br>Testing and assessment is generally limited to six hours in a fiscal year.<br>**Exclusions**<br>Psychological testing is not covered for the following circumstances:<br>• Academic placement<br>• Job placement<br>• Child custody disputes<br>• General screening in the absence of specific symptoms<br>• Teacher or parental referrals<br>• Diagnosed specific learning disorders or learning disabilities |

** Fiscal year is October 1-September 30.*

*Behavioral Health Care Services: Coverage Details (continued)*

| Service | Description |
|---|---|
| **Psychotherapy** | Prior authorization is required after the first eight behavioral health outpatient visits per beneficiary per fiscal year.* Covered psychotherapy includes:<br>• Individual, conjoint, family, or group sessions<br>• Collateral visits<br>• Play therapy (This is a form of individual therapy used with children.)<br>• Psychoanalysis (Prior authorization from your regional contractor is required.)<br>**Limitations**<br>• Outpatient psychotherapy is limited to a maximum of two sessions per week in any combination of individual, family, collateral, or group sessions and is not covered when the patient is an inpatient in an institution.<br>• Inpatient psychotherapy is limited to five sessions per week in any combination of individual, family, collateral, or group sessions. The duration and frequency of care is dependent upon medical necessity. |
| **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.<br>• Unless therapeutically contraindicated, the family and/or guardian should actively participate in the continuing care of the patient either through direct involvement at the facility or geographically distant family therapy.<br>• Facility must be TRICARE-authorized.<br>• Prior authorization from your regional contractor is required.<br>• RTC care is considered elective and will not be covered for emergencies.<br>• Admission primarily for substance-use rehabilitation is not authorized.<br>• Care must be recommended and directed by a psychiatrist or clinical psychologist.<br>**Limitations**<br>• Limited to 150 days per fiscal year* (limitation may be waived if determined to be medically or psychologically necessary).<br>**Note:** No qualified RTCs were available in overseas locations at time of printing. |

** Fiscal year is October 1-September 30.*

*Behavioral Health Care Services: Coverage Details (continued)*

| Service | Description |
|---|---|
| **Treatment for Substance Use Disorders** | A substance use disorder includes alcohol or drug abuse or dependence. TRICARE may cover services for the treatment of substance use disorders, including detoxification, rehabilitation, and outpatient group and family therapy. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required.<br><br>**Note:** All treatment for substance use disorders requires prior authorization from your regional contractor.<br><br>**Coverage and Limitations**<br><br>• **Benefit Period**—Only three substance use disorder treatment benefit periods in a lifetime (waiver possible in accordance with policy criteria) are covered. A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit period. Emergency and inpatient hospital services for detoxification, stabilization, and for treatment of medical complications of substance use disorders do not count for purposes of establishing the beginning of a benefit period.<br><br>• **Detoxification**—If chemical detoxification is needed, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to rehabilitative care. In a diagnosis-related group (DRG)-exempt facility, detoxification services are limited to seven days per year, unless the limit is waived.<br><br>• **Rehabilitation**—Rehabilitation (residential or partial) is limited to 21 days per year or one inpatient stay in a facility subject to the DRG-based reimbursement system, per benefit period; you are limited to three benefit periods in your lifetime. All inpatient stays count toward the 30- or 45-day inpatient limit.<br><br>• **Outpatient Care**—Must be provided by an approved substance use disorder facility in a group setting. Coverage is limited up to 60 visits per fiscal year.* Individual outpatient care for substance use disorder is not covered.<br><br>• **Family Therapy**—Outpatient family therapy is covered beginning with the completion of rehabilitative care. You are covered for up to 15 visits in a benefit period. |

** Fiscal year is October 1-September 30.*

For additional information about covered and non-covered behavioral health care services and how to access care, contact your regional contractor.

## Pharmacy Services

TRICARE offers comprehensive prescription drug coverage and several options for filling your prescriptions. To have a prescription filled, you'll need a written prescription and a valid uniformed services identification (ID) or Common Access Card (CAC). Refer to the *TRICARE: Summary of Beneficiary Costs* flyer or **www.tricare.mil/pharmacy** for pharmacy cost information.

### Military Treatment Facility Pharmacy

Prescriptions may be filled (up to a 90-day supply for most medications) at an MTF pharmacy at no cost as long as the medication is on the MTF formulary. You should contact the MTF to find out what is on the formulary and for specific details about filling prescriptions at the MTF pharmacy.

### TRICARE Mail Order Pharmacy

The mail-order pharmacy is your least expensive option when not using the MTF. You may receive up to a 90-day supply for most medications delivered to your home for a small copayment. Refills may be requested by mail, phone, or online. Express Scripts, Inc. (ESI) administers the mail-order pharmacy, and registering is easy.

1. Register **online**. Complete the registration form and follow the instructions available at **www.express-scripts.com/TRICARE**.
2. Register by **phone**. Call **1-866-363-8667**.

3. Register by **mail**. Download the form at **www.express-scripts.com/TRICARE** and mail it to: P.O. Box 52150, Phoenix, AZ 85072-9954. Include the written prescription and the appropriate copayment when you mail your registration.

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

ESI will send your medications directly to your home within about 14 days after receiving your prescription. If you have prescription drug coverage from another health insurance plan, you can use the mail-order pharmacy if the medication is not covered under the other plan or if you exceed the dollar limit of coverage under the other plan.

## TRICARE Retail Pharmacy Network

You may have prescriptions filled (up to a 30-day supply) at any pharmacy in the TRICARE retail pharmacy network for a small copayment. ESI also administers the retail pharmacy network. For more information or to locate a TRICARE network pharmacy, call **1-866-DoD-TRRX (1-866-363-8779)** or visit **www.express-scripts.com/TRICARE**.
**Note**: Network pharmacies are available in the United States, Guam, Puerto Rico, and the U.S. Virgin Islands.

## Non-network Pharmacies

Filling prescriptions at a non-network pharmacy is the most expensive option. You may have to pay for the total amount first and then file a claim with ESI to receive a partial reimbursement after your deductible is met. (For more information about pharmacy claims, see the *Claims* section.)
**Note**: Non-active duty beneficiaries are using the POS option at non-network pharmacies.

## Quantity Limits and Prior Authorization

TRICARE has established quantity limits on certain medications, which means that the DoD will only pay for up to a specified quantity per 30-, 60-, or 90-day supply. Quantity limits are applied to ensure the medications are safely and appropriately used. Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity.

Some drugs require prior authorization from ESI. For a general list of prescription drugs that are covered under TRICARE and for drugs requiring prior authorization or having quantity limits, visit **www.tricare.mil/pharmacy** or call toll-free **1-866-DoD-TRRX (1-866-363-8779)** or **1-866-DoD-TMOP (1-866-363-8667)**.

## Generic Drug Use Policy

It is DoD policy to use generic medications, instead of brand-name medications, whenever possible. Brand-name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to justify medical necessity for use of the brand-name drug in place of the generic equivalent. If a generic equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name copayment. If you insist on having a prescription filled with a brand-name drug that is not considered medically necessary, and when a generic equivalent is available, you will be responsible for paying the entire cost of the prescription out of pocket.

## Non-formulary Drugs

Any drug in a therapeutic class determined to be not as relatively clinically effective or not as cost-effective as other drugs in the class may be recommended for placement in the third, "non-formulary" tier. Any drug placed into the third tier is available to beneficiaries from the mail-order or retail pharmacies, but at a higher cost. You may be able to have non-formulary prescriptions filled at formulary costs if your provider can establish medical necessity.

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

For information on how to save money and make the most of your pharmacy benefit, visit **www.tricare.mil/pharmacy**, or call **1-877-DoD-MEDS (1-877-363-6337)**.

## Maternity Services

Prenatal care is important, and we strongly recommend that those who are pregnant, or who anticipate becoming pregnant, seek appropriate medical care. TRICARE Prime covers maternity care, including prenatal care, delivery, and postpartum care. Newborns are covered separately.

### Maternity Ultrasounds

TRICARE covers maternity ultrasounds when medically necessary. Such situations include:

- Estimating gestational age
- Evaluating fetal growth
- Conducting a biophysical evaluation for fetal well-being
- Evaluating a suspected ectopic pregnancy
- Defining the cause of vaginal bleeding
- Diagnosing or evaluating multiple gestations
- Confirming cardiac activity
- Evaluating maternal pelvic masses or uterine abnormalities
- Evaluating suspected hydatidiform mole
- Evaluating the fetus's condition in late registrants for prenatal care

A physician is not obligated to perform ultrasonography on a patient who is a 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 ultrasound with a valid medical indication that constitutes medical necessity is covered by TRICARE. Refer to your regional contractor's Web site for additional details on maternity ultrasound coverage.

If TRICARE coverage ends during pregnancy, TRICARE will not cover any remaining maternity costs unless your family qualifies for other TRICARE health coverage or has purchased the Continued Health Care Benefit Program (CHCBP).

To ensure your newborn is covered by TRICARE, see "Having a Baby or Adopting a Child" in the *Life Events* section.

## Dental Options

Active duty service members receive dental care from military dental treatment facilities. For all other beneficiaries, TRICARE offers two dental programs—the TRICARE Dental Program (TDP) and the TRICARE Retiree Dental Program (TRDP). Each program is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

### TRICARE Dental Program

The TDP is a voluntary dental insurance program available to eligible active duty family members and to members of the National Guard and Reserve and/or their families. United Concordia Companies, Inc., (United Concordia) currently administers the program. For information about the TDP, visit the TDP Web site at **www.TRICAREdentalprogram.com** or call United Concordia toll-free at **1-800-866-8499**.

### TRICARE Retiree Dental Program

The TRDP is a voluntary dental insurance program available to retired service members and their eligible family members. Delta Dental Plan of California (Delta Dental) currently administers the program. For information about the TRDP, visit the TRDP Web site at **www.trdp.org** or call Delta Dental toll-free at **1-888-838-8737**.

## Services or Procedures with Significant Limitations

Below is a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist. **This list is not intended to be all-inclusive**. Check with your regional contractor's Web site for additional information.

***Services or Procedures with Significant Limitations*** *Figure 3.5*

| Service | Description |
|---|---|
| **Abortions** | Abortions are covered only when the life of the mother would be endangered if the pregnancy were carried to term. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided. |
| **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** | 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, or after a medically necessary mastectomy. |
| **Cranial Orthotic Device or Molding Helmet** | Cranial orthotic devices are excluded for treatment of nonsynostic positional plagiocephaly. |
| **Dental Care and Dental X-rays** | Both are covered only for adjunctive dental care (i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition). |
| **Education and Training** | Outpatient diabetic self-management and training programs are covered when the services are provided by a TRICARE-authorized individual provider who also meets national standards for diabetes self-management education programs recognized by the American Diabetes Association (ADA). The provider's "Certificate of Recognition" from the ADA must accompany the claim for reimbursement. |
| **Eyeglasses or Contact Lenses** | Active duty service members may receive eyeglasses at MTFs at no cost. For all other beneficiaries, contact lenses and/or eyeglasses are only covered for treatment of:<br>• Infantile glaucoma<br>• Corneal or scleral lenses for treatment of keratoconus<br>• Scleral lenses to retain moisture when normal tearing is not present or is inadequate<br>• Corneal or scleral lenses to reduce corneal irregularities other than astigmatism<br>• Intraocular lenses, contact lenses, or eyeglasses for loss of human lens function resulting from intraocular surgery, ocular injury, or congenital absence<br>**Note:** Adjustments, cleaning, and repairs for eyeglasses are not covered. |
| **Facility Charges for Non-Adjunctive Dental Services** | Covered only to safeguard a patient's life. |
| **Food, Food Substitutes or Supplements, or Vitamins** | 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. |

*Services or Procedures with Significant Limitations (continued)*

| Service | Description |
|---|---|
| **Gastric Bypass** | Gastric bypass, gastric stapling, or gastroplasty—to include vertical banded gastroplasty—is covered when one of the following conditions is met:<br>1. The patient is 100 pounds over the ideal weight for height and bone structure and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.<br>2. The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.<br>3. The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown). |
| **Genetic Testing** | Covered only under certain conditions. |
| **Hearing Aids** | Covered only for active duty family members who meet specific hearing loss requirements. |
| **Intelligence Testing** | Covered only when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders. |
| **Laser/LASIK/Refractive Corneal Surgery** | Covered only to relieve astigmatism following a corneal transplant. |
| **Marital Therapy and/or Couples Counseling** | Covered only for beneficiaries with behavioral health disorder as a primary diagnosis, and the marital or couples therapy must be medically necessary. |
| **Private Hospital Rooms** | Not covered unless ordered for medical reasons or 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. |
| **Weight Reduction** | Services and supplies related to obesity or weight reduction, whether surgical or non-surgical, are excluded except for gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity. |

## 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) or injury or for the diagnosis and treatment of pregnancy or well-baby 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. The following specific services are excluded under any circumstance. **This list is not intended to be all-inclusive**. Check your regional contractor's Web site for additional information.

- Acupuncture
- Air conditioners, humidifiers, dehumidifiers, and purifiers
- Artificial insemination, including in-vitro fertilization, gamete intrafallopian transfer, and all other such reproductive technologies
- Autopsy services or post-mortem examinations
- Bariatric surgery, except as outlined under Gastric Bypass and Weight Reduction in Figure 3.5, "Services or Procedures with Significant Limitations"
- Birth control/contraceptives (non-prescription)
- Camps (e.g., weight loss)
- Charges that providers may apply due to a missed or rescheduled appointment

- Chiropractic care (Visit **www.tricare.mil/chiropractic** for details about the Chiropractic Health Care Program for active duty service members.)
- Clothing or shoes, even if required by virtue of an allergy
- Counseling services that are not medically necessary in the treatment of a diagnosed medical condition. For example, educational counseling, vocational counseling, and counseling for socioeconomic purposes, stress management, life-style modification, etc.
- Custodial care
- Diagnostic admissions
- Diagnostic tests to establish paternity of a child or tests to determine the sex of a fetus
- 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
- Foot care (routine), except those 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
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopaths
- Orthopedic shoes (except if an integral part of a brace), arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up
- Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone
- Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breastfeeding 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 examinations; routine screening procedures; immunizations; except such preventive care, immunizations, and cancer screenings provided in the Clinical Preventive Services list (see “Clinical Preventive Services” 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 eligible under TRICARE
  - Furnished without charge (e.g., cannot file claims for services provided free-of-charge)
  - For the treatment of obesity, except as outlined in “Services or Procedures with Significant Limitations.” Diets, weight loss counseling, weight loss medications, wiring of the jaw, or any similar procedure is excluded.
  - Including 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 such 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 (TRICARE will be secondary for any remaining charges.)
- Sex changes or sexual inadequacy treatment (However, treatment of ambiguous genitalia which has been documented to be present at birth is covered.)
- Sterilization reversal surgery
- "Stop smoking" regimens
- Surgery performed primarily for psychological reasons (such as psychogenic)
- Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE
- Transportation, except by ambulance
- X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer screening mammography, cancer screening, Pap tests, and other tests allowed under the Clinical Preventive Services benefit

# Claims

## Health Care Claims

In most cases, you will not need to file claims for health care services. There may be times, however, when you will need to pay for care and then file the claims yourself to receive payment. You will be reimbursed for TRICARE-covered services at the TRICARE allowable amount, less any copayments, cost-shares, or deductibles.

Claims must be filed within one year of the date of service or within one year of the date of an inpatient discharge. To file a claim, obtain and fill out a DD Form 2642 *Patient's Request for Medical Payment*. You can download forms and instructions from your regional contractor's Web site or from the TRICARE Web site at **www.tricare.mil/claims.**

You can also visit a local TRICARE Service Center (TSC) or military treatment facility (MTF) to pick up a copy. If you have questions about a claim, call your regional contractor.

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

- Sponsor's Social Security number (SSN) (eligible former spouses should use their SSN)
- Provider's name and address (If more than one provider's name is on the bill, circle the name of the person who treated you.)
- Date and place of each service
- Description of each service or supply furnished
- Charge for each service
- Diagnosis (If the diagnosis is not on the bill, be sure to complete block 8a on the form.)

Be sure to complete all 12 blocks of the form correctly and sign it. **Note**: Your provider will submit inpatient facility claims.

Send your claims to the claims processor for the region in which you live. If you receive care while traveling, you must file your TRICARE claims in the region in which you live, not the region in which you received care. Always keep a copy of the paperwork for your records. Figure 4.1 lists regional claims processing information.

Call your regional contractor, visit your regional contractor's Web site, or visit the TRICARE Web site at **www.tricare.mil/claims** for additional claims processing information.

***Regional Claims Processing Information***

*Figure 4.1*

| TRICARE North Region | TRICARE South Region | TRICARE West Region |
|---|---|---|
| Send claims to:<br>Health Net Federal Services, Inc.<br>c/o PGBA, LLC/TRICARE<br>P.O. Box 870140<br>Surfside Beach, SC 29587-9740<br>Check the status of your claim at **www.myTRICARE.com** or **www.healthnetfederalservices.com**. | Send claims to:<br>TRICARE South Region<br>Claims Department<br>P.O. Box 7031<br>Camden, SC 29020-7031<br>Check the status of your claim at **www.myTRICARE.com** or at **www.humana-military.com**. | Send claims to:<br>West Region Claims<br>P.O. Box 77028<br>Madison, WI 53797-7028<br>Check the status of your claim at **www.triwest.com**. |

## Pharmacy Claims

If you have other health insurance (OHI), you will need to submit pharmacy claims to Express Scripts, Inc. (ESI) for payment. Pharmacy claims must be filed within one year of the date of service. To file a pharmacy claim, obtain and fill out a DD Form 2642 *Patient's Request for Medical Payment*. Prescription claims require the following information for each drug:

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

You can download forms and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from **www.tricare.mil/pharmacy/claims.cfm**.

Mail the claim to:

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

See "Coordinating Benefits with Other Health Insurance" later in this section or call **1-866-DoD-TRRX (1-866-363-8779)** with questions about filing a pharmacy claim.

**Note**: Non-active duty beneficiaries who have prescriptions filled at a non-network pharmacy are using the point of service option. Active duty service members may be required to pay for the prescriptions in full and will receive a full reimbursement when the claim is filed.

## Coordinating Benefits with Other Health Insurance

TRICARE is the primary payer for active duty service members. For all other beneficiaries, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs/plans as identified by the TRICARE Management Activity (TMA).

If you have OHI, you need to 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 follow the requirements of your OHI. If your OHI denies a claim for failure to follow their rules, such as obtaining care without authorization or use of 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.

### Pharmacy Claims and OHI (Processed by ESI)

When you have OHI, your OHI is the first payer for pharmacy coverage, and the rules of that insurer 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 in the TRICARE retail network to avoid using the POS option.

You **may not** use TRICARE's mail-order option if you have prescription drug coverage from OHI, unless the medication is not covered under your OHI, or you exceed the dollar limit of coverage under your OHI.

Contact ESI at **1-866-DoD-TRRX (1-866-363-8779)** with questions about filing pharmacy claims with OHI.

## Third-Party Liability

The Federal Medical Care Recovery Act allows TRICARE to be reimbursed for its costs of treatment if you are injured in an accident that was caused by someone else. The DD Form 2527 *Statement of Personal Injury Third Party Liability* form will be sent to you if a claim is received that appears to have third-party involvement. Within 35 calendar days, you must complete and sign this form and follow the directions for returning the form to the appropriate claims processor. You can download the DD Form 2527 from the TRICARE Web site 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. You can file an appeal in writing within 90 days of the date of the EOB notice. (For more information about appeals, see the *Information and Assistance* section.) You should keep EOBs with your health insurance records for reference.

For a sample of the EOB in your region, along with instructions for reading the EOB, see the following figure numbers in the *Appendix* section:

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

## Debt Collection Assistance Officers

Debt Collection Assistance Officers (DCAOs) are located at military treatment facilities (MTFs) and the TRICARE Regional Offices (TROs) to assist you in resolving health care collection-related issues. Contact a DCAO if you have received a negative credit rating or have been sent to a collection agency due to an issue related to TRICARE services.

When you visit a DCAO for assistance, you must bring or submit documentation associated with a collection action or adverse credit rating, including debt collection letters, EOB statements, and medical/dental bills from providers. The more information you can provide, the faster the cause of the problem will 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**.

# Life Events

TRICARE Prime continues to provide health coverage for you and your family as you experience major life events. You will, however, 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).

To update DEERS:

- Visit a uniformed services personnel office. Find one near you at **www.dmdc.osd.mil/rsl**.
- Call **1-800-538-9552**.
- Fax address changes to DEERS at **1-831-655-8317**.
- Mail the address change to:

  The Defense Manpower
  Data Center Support Office
  Attn: COA
  400 Gigling Road
  Seaside, CA 93955-6771

- Update addresses electronically at **www.tricare.mil/DEERS**.

Read the following sections to learn what to do when you get married, have a child, move, retire, and more.

## Getting Married or Divorced

### Marriage

It's extremely important for sponsors to register their 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 your marriage certificate to the nearest uniformed services identification (ID) card-issuing facility. Once your spouse is registered in DEERS, he or she will receive a uniformed services ID card and will be eligible for TRICARE. When accessing care, your spouse will be asked to show his or her ID card.

Registration in DEERS is not the same as enrolling in TRICARE Prime. Once your spouse is registered in DEERS, he or she will need to enroll in TRICARE Prime, or he or she will be covered by TRICARE Standard and TRICARE Extra. For TRICARE Prime enrollment, download an enrollment application from your regional contractor's Web site, visit a local TRICARE Service Center (TSC), or call your regional contractor to request an enrollment application.

Your new spouse's TRICARE Prime enrollment is effective based on the 20th-of-the-month rule. With the 20th-of-the-month rule, as long as your regional contractor **receives** the completed enrollment application by the 20th of the month, coverage will begin on the first day of the next month. The application must be received by the 20th of the month, not postmarked by the 20th of the month. If the form is received after the 20th of the month, then coverage begins on the first day of the following month. See the Figure 5.1 to determine when TRICARE Prime coverage begins.

*Figure 5.1*

| Application Received | Enrollment Start |
|---|---|
| January 1-20 | February 1 |
| January 21-31 | March 1 |
| February 1-20 | March 1 |
| February 21-28 | April 1 |
| March 1-20 | April 1 |
| March 21-31 | May 1 |
| April 1-20 | May 1 |
| April 21-30 | June 1 |
| May 1-20 | June 1 |
| May 21-31 | July 1 |
| June 1-20 | July 1 |
| June 21-30 | August 1 |
| July 1-20 | August 1 |
| July 21-31 | September 1 |
| August 1-20 | September 1 |
| August 21-31 | October 1 |
| September 1-20 | October 1 |
| September 21-30 | November 1 |
| October 1-20 | November 1 |
| October 21-31 | December 1 |
| November 1-20 | December 1 |
| November 21-30 | January 1 |
| December 1-20 | January 1 |
| December 21-31 | February 1 |

After your regional contractor processes your application, your new spouse will receive a letter identifying his or her primary care manager (PCM) along with an enrollment card.

**Note**: If you are a retired service member and currently paying 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. You, the sponsor, will need to provide a copy of the divorce decree.

#### *Children*

After a divorce, children (biological and adopted) remain eligible for TRICARE up to age 21 (or age 23 if enrolled in college full time and the sponsor provides at least 50 percent of the financial support) as long as their information is kept up to date in DEERS. Please contact DEERS to verify what documentation is needed to extend coverage.

While a child normally does not get his or her own uniformed services ID card until age 10, a child under age 10 should have an ID card when in custody of a parent or guardian who is not eligible for TRICARE benefits or who is not the custodial parent. Patient privacy may be a factor for divorced parents attempting to obtain information about received health care services. Contact your regional contractor for assistance. **Note**: Children with a disability may remain eligible for TRICARE beyond the normal age limits. Please check with DEERS for eligibility criteria.

If children are living in a separate region with a former spouse, they may continue TRICARE Prime coverage using the split-enrollment feature. See page 32 for a description of TRICARE Prime's split-enrollment feature.

#### *Former Spouses*

Certain former spouses are eligible for TRICARE coverage if the following requirements are met:

1. Must not remarry (If a former spouse remarries, the loss of benefits remains applicable even if the remarriage ends in death or divorce.)
2. Must not be covered by an employer-sponsored health plan
3. Must not be the former spouse of a North Atlantic Treaty Organization (NATO) or "Partners for Peace" nation member
4. Must meet the requirements of one of the three situations in Figure 5.2 on page 31.

When a former spouse is eligible for TRICARE coverage, he or she must change their personal information in DEERS so that their name and Social Security number (SSN) is listed as the primary contact. The former spouse's TRICARE eligibility will be shown in DEERS under his or her SSN.

## Having a Baby or Adopting a Child

You should register your newborn or adopted child in DEERS as soon as possible. To register your child in DEERS, you need only a certificate of live birth or adoption. The document does not need to be a certified copy of the official birth certificate. It can be a certificate of live birth authenticated by either the attending physician or other responsible party from the hospital. **Note**: Registration in DEERS is a separate step from enrolling in Prime.

Children are covered as TRICARE Prime beneficiaries for 60 days after birth as long as one other family member is enrolled in TRICARE Prime. If you wish to keep your child enrolled in TRICARE Prime, you must submit an enrollment application to your regional contractor within 60 days of birth or adoption for continuous Prime coverage.

On day 61, if you have not enrolled the child in TRICARE Prime, he or she will be covered automatically under TRICARE Standard and TRICARE Extra until 365 days after the child's birth or adoption. On day 366, if the child is not registered in DEERS, DEERS will show "loss of eligibility," and he or she will no longer be able

*Eligibility Requirements for Former Spouses* *Figure 5.2*

| | |
|---|---|
| 1 | • Must have been married to the **same** 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.<br>• If the date of the final decree of divorce or annulment was on or after February 1, 1983, the former spouse is eligible for TRICARE coverage of health care that is received after the date of the divorce or annulment.<br>• If the date of the final decree is before February 1, 1983, the former spouse is eligible for TRICARE coverage of health care received on or after January 1, 1985.<br>• Eligibility continues as long as the preceding requirements continue to be met. |
| 2 | • Must have been married to the **same** military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay.<br>• If the date of the final decree of divorce or annulment is before April 1, 1985, the former spouse is eligible only for care received on or after January 1, 1985, or the date of the decree, whichever is later.<br>• Eligibility continues as long as the preceding requirements continue to be met. However, if the date of the final divorce decree or annulment is on or after April 1, 1985, but before September 29, 1988, the former spouse is eligible for care received from the date of the decree until December 31, 1988, or two years from the date of the decree, whichever is later. |
| 3 | • Must have been married to the **same** military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay.<br>• If the date of the final decree of divorce or annulment is on or after September 29, 1988, the former spouse is eligible only for care received for one year from the date of the decree. |

to receive TRICARE benefits until they are registered in DEERS.

## Going to College

### Eligibility

Your children remain eligible for TRICARE up to age 21 (or age 23 if enrolled in college full-time and the sponsor provides at least 50 percent of the financial support) as long as their information is kept up to date in DEERS. To extend benefits for your college student beyond his or her 21st birthday, please contact DEERS to verify what documentation is needed to extend coverage. Representatives there will be able to advise you about the documentation you need to update DEERS and extend coverage. **Note**: In most cases, children going overseas to attend college on their own are eligible only for TRICARE Standard in the overseas area.

If your child loses DEERS eligibility, his or her TRICARE Prime coverage will end automatically. If you believe your child is still eligible for TRICARE, you will need to contact DEERS to update his or her record. Once DEERS is updated, you must contact your regional contractor for information if you want to re-enroll your child in TRICARE Prime. Otherwise, your child will be covered under TRICARE Standard and TRICARE Extra.

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

**Note**: Children with a disability may remain eligible for TRICARE beyond the normal age limits. Please check with DEERS for eligibility criteria.

### Health Care Options

If TRICARE Prime is available where your child is attending school and the school is in your TRICARE region, your child only needs to select a new primary care manager (PCM). If the school is in a different TRICARE region, your child may remain enrolled in TRICARE Prime using the split-enrollment feature if TRICARE Prime is available in that area.

### *Split Enrollment*

Split enrollment allows families living in separate 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 payer for enrollment fees (where applicable). The regional contractors will coordinate enrollment fees and send the statements to the designated payer. An enrollment fee left unpaid causes the entire family to be disenrolled. Key points to remember with split enrollment:

- Families with college students, children living with former spouses, or families otherwise separated can enroll together in separate regions.
- Active duty families are not required to pay enrollment fees, but they can still enroll in separate regions.
- Retiree families have only one enrollment fee and one enrollment anniversary date.
- There is no limit on the number of family members enrolling.
- In most cases, only those family members who accompany their active duty sponsor on his or her orders overseas will be enrolled in TRICARE Overseas Program Prime options.

If your child does not enroll in TRICARE Prime, he or she will be covered automatically by TRICARE Standard and TRICARE Extra as long as his or her information is kept up to date in DEERS. Visit your regional contractor's Web site or call the toll-free number if you have questions about using TRICARE Standard and TRICARE Extra.

## Traveling

### Active Duty Service Members

If you need emergency medical or dental care while traveling in the Continental United States, visit the nearest emergency room or call 911. If near an MTF when traveling, you should go to the MTF or military dental treatment facility for services.

If you require urgent care while traveling, coordinate with your PCM and/or regional contractor before receiving care.

Routine medical and dental care is **not authorized** when you are traveling. You should obtain all routine care before you travel or after you return. If you are traveling between duty locations, you should delay the care until you get to your new duty location.

If traveling overseas, contact the TRICARE Global Remote Overseas (TGRO) Call Center in the overseas area where you are traveling for assistance in obtaining care.

### *TGRO Call Center Information*

*Figure 5.3*

| TRICARE Europe | TRICARE Latin America and Canada (TLAC) | TRICARE Pacific |
|---|---|---|
| Europe, Africa, and the Middle East | Central and South America, the Caribbean Basin, Canada, Puerto Rico, and the U.S. Virgin Islands | Guam, Japan, Korea, Asia, New Zealand, India, and Western Pacific remote countries |
| Collect: 011-44-20-8762-8133<br>Fax: 011-44-20-8762-8125<br>tricarelon@internationalsos.com | Collect: 1-215-701-2800<br>Fax: 1-215-244-9617<br>tricarephl@internationalsos.com | Singapore:<br>Collect: 011-65-6338-9277<br>sin.tricare@internationalsos.com<br><br>Sydney:<br>Collect: 011-61-2-9273-2760<br>sydtricare@internationalsos.com |

*TRICARE Area Office Contact Information* *Figure 5.4*

| | TRICARE Europe | TLAC | TRICARE Pacific |
|---|---|---|---|
| **Includes** | Europe, Africa, and the Middle East | Central and South America, the Caribbean Basin, Canada, Puerto Rico, and the U.S. Virgin Islands | Guam, Japan, Korea, Asia, New Zealand, India, and Western Pacific remote countries |
| **Phone** | Comm.: 011-49-6302-67-7432<br>DSN: 496-7432<br>Toll-free: 1-888-777-8343 | Comm.: 1-706-787-2424<br>DSN: 773-2424<br>Toll-free: 1-888-777-8343 | Comm.: 011-81-6117-43-2036<br>DSN: 643-2036<br>Remote Sites: 011-65-6-338-9277<br>Toll-free: 1-888-777-8343 |
| **Fax** | Comm.: 011-49-6302-67-6374<br>DSN: 496-6374 | 1-706-787-3024 | Comm.: 011-81-611-743-2037<br>DSN: 643-2037 |
| **E-mail** | teurope@europe.tricare.osd.mil | tricare15@se.amedd.army.mil | TPAO.CSC@oki10.med.navy.mil |
| **Online** | www.tricare.mil/europe | www.tricare.mil/tlac | www.tricare.mil/pacific |

## All Other TRICARE Prime Enrollees

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

If you require urgent, routine, or specialty care while traveling, you must coordinate with your PCM and/or regional contractor before receiving care to avoid using the point of service (POS) option.

When traveling overseas, plan for health care contingencies in advance of the trip. If you need emergency or urgent care, contact the TRICARE Area Office (TAO) for the overseas area where you are traveling or the nearest American Embassy Health Unit for assistance finding a host nation provider. Visit **http://travel.state.gov** for a list of every American Embassy or Consular Office worldwide. Figure 5.4 lists contact information for the TAO in each overseas area. **Note**: When overseas, be prepared to pay for any care received from host nation providers at the time of service, and file a claim for reimbursement.

## Filling Prescriptions on the Road

TRICARE recommends that you have all your prescriptions filled before you travel, but there are several options for filling prescriptions on the road.

### *TRICARE Network Pharmacy*

You can have prescriptions filled at any TRICARE network pharmacy in the United States, Guam, Puerto Rico, and the U.S. Virgin Islands. To locate a network pharmacy, call toll-free **1-866-363-8779** or visit **www.express-scripts.com/TRICARE**.

### *Military Treatment Facility Pharmacy*

If you're near an MTF while traveling, you can have a new prescription filled at any MTF pharmacy free of charge if the medication is on the MTF formulary and the pharmacy stocks the medication you need. All you'll need is the written prescription and your uniformed services ID or Common Access Card. Refilling a prescription originally filled at another MTF is at the discretion of the MTF you are visiting.

### *TRICARE Mail Order Pharmacy*

If you will be staying away from home for a longer period of time, you can plan ahead to receive prescriptions through the mail. Provide ESI with your temporary address so prescriptions can be mailed to you at your travel destination. **Note**: The mail-order option is not available

overseas unless you have an APO or FPO address. Call toll-free **1-866-363-8667** or visit **www.express-scripts.com/TRICARE** for assistance.

### *Non-Network Pharmacy*

If there is no other option, you can have prescriptions filled at a non-network pharmacy. If you have prescriptions filled at a non-network pharmacy you will be using the POS option. You may be required to pay for prescriptions up front and file a claim with ESI for reimbursement. See the *Claims* section for details about filing a pharmacy claim.

### *Filling Prescriptions Overseas*

Your pharmacy coverage is limited overseas. TRICARE recommends that you have all your prescriptions filled before you travel overseas.

- TRICARE network pharmacies are only located in the United States, Puerto Rico, Guam, and the U.S. Virgin Islands.
- You must have an APO or FPO address to use the mail-order pharmacy overseas.
- The prescription must be from a U.S.-licensed provider.
- Be prepared to pay up front and file a claim for reimbursement for non-MTF and non-network pharmacy services when traveling overseas.

## 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. Follow these simple steps to ensure you have no break in coverage when you move.

1. Do not disenroll from TRICARE Prime before you move to your new location.
2. Once you arrive at your new location, update DEERS immediately.
3. Select a new PCM or transfer your TRICARE Prime enrollment within 30 days of arriving at your new location.

If you move to another TRICARE Prime service area (PSA) in the same TRICARE region, contact your current regional contractor—you will only need to change your PCM.
If you move to a TRICARE PSA in another TRICARE region, contact the new regional contractor to transfer your enrollment. The enrollment transfer is effective when your new enrollment application is received by your new regional contractor.

If you move to an area where TRICARE Prime is not available (same or new region):

- **Active duty service members**: Transfer your enrollment to TRICARE Prime Remote (TPR) by submitting a new enrollment form. The enrollment transfer is effective when your regional contractor receives your form.
- **Active duty family members:** If you live with your TPR-enrolled sponsor, your enrollment will transfer to TRICARE Prime Remote for Active Duty Family Members (TPRADFM). Your sponsor can include you on his or her enrollment form. Or, you can disenroll from TRICARE Prime and you are automatically covered by TRICARE Standard and TRICARE Extra as long as your DEERS information stays current.
- **Retired service members, their families, and all other TRICARE Prime enrollees**: You must disenroll from TRICARE Prime and you are covered automatically by TRICARE Standard and TRICARE Extra as long as your DEERS information is current. If you do not disenroll, you will be utilizing the POS option.

Active duty service members and their families may transfer TRICARE Prime enrollment as often as needed. Retired service members, their family members, survivors, eligible former spouses, and others are limited to two enrollment transfers each enrollment year, as long as the second transfer is back to the original region of enrollment.

If you are moving overseas, contact the appropriate overseas TAO in advance of the move to determine TRICARE Overseas Program (TOP) Prime eligibility requirements. Retirees and their family members are not eligible for any TOP Prime options. See Figure 5.4 on the previous page for TAO 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 certain uniformed services members and their families, if the active duty sponsor is:

1. Involuntarily separating from active duty under honorable conditions
2. A member of the National Guard or Reserves separating from active duty for a period of more than 30 consecutive days in support of a contingency operation
3. Separating from active duty following involuntary retention (stop-loss) in support of a contingency operation
4. Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation

If you qualify for coverage under TAMP, you and your family will have 180 days of transitional health benefits after you separate. During this 180-day period, you may enroll in TRICARE Prime if you reside in a TRICARE PSA, or you will be covered under TRICARE Standard and TRICARE Extra. You and your family members will be covered as active duty family members, and copayments, cost-shares, deductibles, rules, and processes for these programs will apply.

### Continued Health Care Benefit Program

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

CHCBP acts as a bridge between military health benefits and your new civilian health 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. For more information about CHCBP visit **www.humana-military.com** or call **1-800-444-5445**.

Contact your regional contractor or a beneficiary counseling and assistance coordinator (BCAC) to discuss your family's eligibility for these programs. You also can visit **www.tricare.mil** for more information.

### TRICARE Reserve Select

Some members of the National Guard and Reserve may be eligible for TRICARE Reserve Select—a voluntary, premium-based health plan available for members who qualify when they separate from active duty. Visit **www.tricare.mil/reserve/reserveselect** for information about how to qualify for this program.

## Retiring from Active Duty

When you retire from active duty, you and your eligible family members experience a "change in status," and you will all receive new "retired" uniformed services ID card when DEERS is updated.

As a "retired service member" you will have new health care options. When on active duty, you were enrolled in either TRICARE Prime or TPR. After you retire, you can choose to re-enroll in TRICARE Prime, or you can use TRICARE Standard and TRICARE Extra. TPR is not available to retirees.

Here's a quick glance at some of the changes in TRICARE when you retire:

- If you re-enroll in TRICARE Prime:

- You begin paying annual enrollment fees.
- Network copayments/cost-shares will apply.
- Your catastrophic cap increases.
- Minor differences in covered services
- Annual eye exams are no longer covered, but if you stay in TRICARE Prime, they are covered every two years.
- Hearing aids are no longer covered.
- If family members were using TRICARE Standard and TRICARE Extra before you retired, the cost-shares will now increase by five percent.

- You must have Medicare Part B coverage for all Medicare-eligible family members to remain eligible for TRICARE.

Review the costs, including applicable TRICARE Prime enrollment fees, in the *TRICARE: Summary of Beneficiary Costs* flyer. 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 re-enroll in TRICARE Prime, the 20th-of-the-month rule will apply for you and your family members. See Figure 5.1 on page 29 for enrollment deadlines.

## Becoming Entitled to Medicare

When you or another family member become entitled to premium-free Medicare A—at age 65 or due to a disability or end-stage renal disease—TRICARE becomes the second payer after Medicare, if you have Medicare Part B coverage.

Medicare-eligible beneficiaries under age 65 have the option to continue enrollment in TRICARE Prime or use TRICARE For Life. If they remain enrolled in TRICARE Prime, annual enrollment fees are waived, if applicable.

**Note**: Active duty family members are not required to have Medicare Part B coverage to remain eligible for TRICARE. When the active duty sponsor retires, Medicare-eligible family members must have Medicare Part B or they lose eligibility for TRICARE.

## Deceased Sponsor

When a sponsor dies, TRICARE coverage continues for eligible family members. Surviving spouses remain eligible for TRICARE as long as they do not remarry. If a surviving spouse remarries, he or she loses eligibility for TRICARE and cannot regain eligibility in the case of divorce or the death of the new spouse. Surviving children remain eligible for TRICARE until they turn age 21 (or 23 if enrolled in college full time and you, the parent, provide more than 50 percent of your child's financial support). **Note**: Children with a disability may remain eligible for TRICARE beyond the normal age limits.

After the death of an active duty service member, all surviving family members continue to be treated as active duty dependents for three years. During this three-year "transitional survivor" period, all family members receive the same benefits at the same costs as active duty family members.

After three years, surviving spouses remain eligible for TRICARE Prime, Standard, and Extra at retired family member rates. TRICARE Prime enrollment fees will apply for surviving spouses who choose to enroll in TRICARE Prime after the three-year transitional survivor period. Surviving children remain eligible for TRICARE (TRICARE Prime, TPRADFM, TRICARE Standard, and TRICARE Extra) for three years after the date of the member's death or up to age 21, whichever is longer. This age limit extends to age 23 if the surviving children were, at the time of the member's death, dependent upon the former member for more than 50 percent of their financial support or if they were pursuing a full-time course of education in a secondary school or an institution of higher education. **Note**: The effective date of this benefit is retroactive to October 7, 2001.

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

## 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 plan for pre-existing conditions. Examples of when certificates may be issued include:

- 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 a full-time student), a certificate will be issued to the dependent child.
- 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.

Send written requests for a certificate of creditable coverage to the Defense Manpower Data Center Support Office (DSO) at:

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

The request must include:

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

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

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

# 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 (TROs). To locate a BCAC, visit **www.tricare.mil/bcacdcao** for an online directory.

## Appealing a Decision

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

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

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

### Appeal Requirements

Your appeal must meet the requirements listed in Figure 6.1.

***TRICARE Appeal Requirements***

*Figure 6.1*

| | |
|---|---|
| 1 | An appropriate appealing party must submit the appeal. Proper appealing parties include:<br>• You, the beneficiary<br>• Your custodial parent (if you are a minor) or your guardian<br>• A person appointed in writing by you to represent you for the purpose of the appeal<br>• An attorney filing on your behalf<br>• Non-network participating providers<br>If a physician or other party is going to submit the appeal, you must complete and sign the *Appointment of Representative and Authorization to Disclose Information* form, which is available on your regional contractor's Web site. If the appeal is submitted without this form, it will not be processed.<br>**Note:** Network providers are not appropriate appealing parties (unless appointed by you in writing). |
| 2 | The appeal must be in writing. See Figure 6.2 on the next page for addresses to submit different appeals. |
| 3 | The issue in dispute must be an appealable issue. The following are non-appealable issues:<br>• Allowable charges<br>• Eligibility<br>• Denial of services from an unauthorized provider<br>• Denial of treatment plan when an alternative treatment plan is selected<br>• Refusal by a PCM to provide services or refer a beneficiary to a specialist<br>• Point of service issues, except for whether the 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 EOB or denial notification letter. |
| 5 | There must be an amount in dispute to file an appeal. In the case 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 in dispute necessary to request a reconsideration. |

## Filing an Appeal

Appeals must be filed with your regional contractor within particular deadlines. If you are not satisfied with a decision rendered on an appeal, there are further levels of appeal. 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 urgency of the situation. You or an appointed representative must file an expedited review of a prior authorization denial 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
- Sponsor's Social Security number (SSN)
- Beneficiary's date of birth
- Beneficiary's or appealing party's signature

A description of the issue or concern must include:

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

Send your appeal to your regional contractor. See Figure 6.2 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 full opportunity to report in writing any concern or complaint regarding health care quality or service. Any



***Regional Appeals Filing Information***

*Figure 6.2*

| TRICARE North Region | TRICARE South Region | TRICARE West Region |
|---|---|---|
| **Claims Appeals:**<br>Health Net Federal Services, Inc.<br>c/o PGBA LLC/TRICARE<br>Claims Appeals<br>P.O. Box 870148<br>Surfside Beach, SC 29587-9748<br>**Claims Appeals Fax:**<br>1-888-458-2554<br>**Prior Authorization Appeals:**<br>Health Net Federal Services, Inc.<br>c/o PGBA, LLC/TRICARE<br>Authorization Appeals<br>P.O. Box 870142<br>Surfside Beach, SC 29587-9742<br>**Prior Authorization Appeals Fax:**<br>1-888-881-3622 | **Claims Appeals:**<br>TRICARE South Region Appeals<br>P.O. Box 202002<br>Florence, SC 29502-2002<br>**Prior Authorization Appeals:**<br>Humana Military Healthcare Services<br>Attn: Clinical Appeals<br>P.O. Box 740044<br>Louisville, KY 40201-9973<br>**Behavioral Health Appeals:**<br>ValueOptions Behavioral Health<br>Attn: Appeals and Reconsideration Department<br>P.O. Box 551138<br>Jacksonville, FL 32255-1138 | **Claims Appeals:**<br>TriWest Healthcare Alliance<br>Claims Appeals<br>P.O. Box 86508<br>Phoenix, AZ 85080<br>**Prior Authorization Appeals:**<br>TriWest Healthcare Alliance<br>Claims Appeals<br>P.O. Box 86508<br>Phoenix, AZ 85080 |

TRICARE civilian or military provider, TRICARE beneficiary, sponsor, parent or 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 resolved no later than 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 aspects like accessibility, appropriateness, level, continuity, or timeliness of care
- The demeanor or behavior of providers and their staff
- The performance of any part of the health care delivery system
- Practices related to patient safety

When filing a grievance, include the following:

- The beneficiary's name, address, and telephone number
- Sponsor's SSN
- Beneficiary's date of birth
- Beneficiary's signature
- A description of the issue or concern must include:
  - Date and time of the event
  - Name 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 your grievance with your regional contractor. See Figure 6.3 for grievance filing information.

### *Regional Grievance Filing Information*

*Figure 6.3*

| TRICARE North Region | TRICARE South Region | TRICARE West Region |
|---|---|---|
| **All grievances should be addressed to:**<br>Health Net Federal Services, Inc.<br>c/o PGBA, LLC/TRICARE Grievance<br>P.O. Box 870150<br>Surfside Beach, SC 29587-9750<br>**Submit online at:**<br>www.healthnetfederalservices.com<br>**Submit by fax:**<br>1-888-317-6155 | **Submit your grievance in writing to the nearest location:**<br>Regional Grievance Coordinator<br>Humana Military Healthcare Services<br>8123 Datapoint Drive<br>Suite 400<br>San Antonio, TX 78229<br>**For behavioral health care concerns, send your information to:**<br>Grievance Specialist<br>ValueOptions<br>P.O. Box 551188<br>Jacksonville, FL 32255-1188 | **All grievances should be addressed to:**<br>TriWest Healthcare Alliance<br>Attn: Customer Relations Dept.<br>P.O. Box 86036<br>Phoenix, AZ 85080 |

## Reporting Suspected Fraud and Abuse

Fraud happens when a person or organization deliberately deceives others to gain some sort of unauthorized benefit. Health care abuse occurs when providers supply services or products that are medically unnecessary or that do not meet professional standards.

Beneficiaries are important partners in the ongoing fight against fraud and abuse. Because an explanation of benefits (EOB) is a tangible statement of services/supplies received, it is one of the first lines of defense against health care fraud. Each EOB provides a toll-free number to call if you have questions about services you believe are billed fraudulently, or you can access the TRICARE Program Integrity Web site at **www.tricare.mil/fraud** for direct links to each contractor's fraud and abuse reporting office. Through your regional contractor's Web site, you can use claims tools to view your EOBs, claims history, and track TRICARE costs paid. **We strongly encourage you to read your EOBs carefully**.

Report suspected fraud and abuse to your regional contractor. See Figure 6.4 for details.

To report fraud or abuse regarding the pharmacy program, contact ESI:

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

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



### *Regional Fraud and Abuse Reporting Information*

*Figure 6.4*

| TRICARE North Region | TRICARE South Region | TRICARE West Region |
|---|---|---|
| • Call 1-800-977-6761<br>• Fax 1-888-881-3644<br>• Report online at www.healthnetfederalservices.com.<br>• Send an e-mail message to: program_integrity@healthnet.com<br>• Mail information to:<br>Health Net Federal Services, Inc.<br>Attn: Program Integrity<br>P.O. Box 870147<br>Surfside Beach, SC 29587-9747 | • Call 1-800-333-1620<br>• Report online at www.humana-military.com.<br>• Mail information to:<br>Humana Military Healthcare Services, Inc.<br>Attn: Program Integrity<br>500 W. Main Street, 19th floor<br>Louisville, KY 40202 | • Call 1-888-584-9378<br>• Fax 1-602-564-2458<br>• Report online at www.triwest.com. |

# Acronyms

| | |
|---|---|
| ADA | American Diabetes Association |
| BCAC | Beneficiary Counseling and Assistance Coordinator |
| CAC | Common Access Card |
| CHCBP | Continued Health Care Benefit Program |
| DCAO | Debt Collection Assistance Officer |
| DEERS | Defense Enrollment Eligibility Reporting System |
| DME | Durable Medical Equipment |
| DoD | Department of Defense |
| DRG | Diagnosis-related Group |
| DSO | Defense Manpower Data Center Support Office |
| EOB | Explanation of Benefits |
| ESI | Express Scripts, Inc. |
| MTF | Military Treatment Facility |
| OHI | Other Health Insurance |
| PCM | Primary Care Manager |
| POS | Point of Service |
| PSA | Prime Service Area |
| RTC | Residential Treatment Center |
| SNF | Skilled Nursing Facility |
| SSN | Social Security Number |
| TAMP | Transitional Assistance Management Program |
| TAO | TRICARE Area Office |
| TDP | TRICARE Dental Program |
| TFL | TRICARE For Life |
| TLAC | TRICARE Latin America and Canada |
| TMA | TRICARE Management Activity |
| TMOP | TRICARE Mail Order Pharmacy |
| TRDP | TRICARE Retiree Dental Program |
| TRO | TRICARE Regional Office |
| TRRX | TRICARE Retail Pharmacy |
| TSC | TRICARE Service Center |

# Glossary

### *Beneficiary Counseling and Assistance Coordinator (BCAC)*
Persons at military treatment facilities and TRICARE Regional Offices who are available to answer questions, help solve health care-related problems and assist beneficiaries in obtaining medical care through TRICARE. To locate a BCAC, visit **www.tricare.mil/bcacdcao**.

### *Catastrophic Cap*
The maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible for deductibles and cost-shares based on allowed charges for the services and supplies received in a given fiscal year (October 1–September 30).

### *Continued Health Care Benefit Program (CHCBP)*
A premium-based health care program you may purchase after loss of TRICARE eligibility if you qualify. The CHCBP offers temporary transitional health coverage and must be purchased within 60 days after TRICARE eligibility ends.

### *Debt Collection Assistance Officer (DCAO)*
Persons located at military treatment facilities and TRICARE Regional Offices to assist you in resolving health care collection-related issues. Contact a DCAO if you have received a negative credit rating or have been sent to a collection agency due to an issue related to TRICARE services.

### *Defense Enrollment Eligibility Reporting System (DEERS)*
A database of uniformed services members (sponsors), family members and others worldwide who are entitled under law to military benefits, including TRICARE. Beneficiaries are required to keep DEERS updated.

### *Explanation of Benefits (EOB)*
A statement sent to beneficiaries showing that claims were processed and the amount paid to providers. If denied, an explanation of denial is provided.

### *Military Treatment Facility (MTF)*
A medical facility (hospital, clinic, etc.) owned and operated by the uniformed services—usually located on or near a military base.

### *National Guard and Reserve*
Includes the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the U.S. Coast Guard Reserve.

### *Negotiated Rate*
The rate network providers and participating non-network providers have agreed to accept for covered services.

### *Network Provider*
Network providers have a signed agreement with your regional contractor to provide care at a negotiated rate. Network providers handle claims for you.

### *Non-network Provider*
Non-network providers do not have a signed agreement with your regional contractor and are therefore "out of network." There are two types of non-network providers: participating and nonparticipating.

### *Nonparticipating Non-network Provider*
Nonparticipating providers have not agreed to accept the TRICARE allowable charge or file your claims. When you self-refer using the point of service (POS) option, nonparticipating providers may charge you up to 15 percent above the TRICARE allowable charge for services in addition to your POS deductible and cost-shares. This amount is your responsibility and will not be paid by TRICARE.

### *Other Health Insurance (OHI)*
Any non-TRICARE health insurance that is not considered a supplement acquired through an employer, entitlement program or other source. TRICARE pays second after all other health plans except for Medicaid, TRICARE supplements, the Indian Health Service, or other programs or plans identified by the TRICARE Management Activity.

### *Participate on a Claim*
When providers participate on a claim, also known as "accepting assignment," they agree to file the claim for the patient, to accept payment directly from TRICARE and to accept the amount of the TRICARE allowable charge, less any applicable patient copayment paid by you, as payment in full for their services.

### *Participating Non-network Provider*
Participating providers have agreed to file claims for you, to accept payment directly from TRICARE, and to accept the TRICARE allowable charge, less applicable cost-shares paid by you as payment in full for their services. Providers may participate on a claim-by-claim basis.

### *Point of Service (POS) Option*
The POS option allows you to receive non-emergency care from any TRICARE-authorized provider without requesting a referral from your PCM. However, POS has higher out-of-pocket costs for care.

### *Prime Service Area*
A geographic area where TRICARE Prime benefits are offered. Regional contractors are required to establish a TRICARE Prime network in TRICARE Prime Service areas.

### *Prior Authorization*
A review determination made by a licensed professional nurse or paraprofessional for requested services, procedures or admissions. Prior authorizations must be obtained prior to services being rendered or within 24 hours of an admission. Visit your regional contractor's Web site or call them for a list of services requiring prior authorization.

### *Regional Contractor*
A TRICARE civilian partner who provides health care services and support in the TRICARE regions (Health Net Federal Services, Inc.; Humana Military Healthcare Services, Inc.; and TriWest Healthcare Alliance).

### *Transitional Assistance Management Program (TAMP)*
Transitional health care for certain uniformed services members (and eligible family members) who separate from active duty.

### *TRICARE Allowable Charge*
The maximum amount TRICARE will pay for services.

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

### *TRICARE Supplement*
A health plan you may purchase specifically to supplement your TRICARE Prime coverage. It will pay second after TRICARE. A TRICARE supplement is not employer-sponsored health insurance.

# Appendix

## Sample Explanation of Benefit Statements

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

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

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

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

2
Health Net® Federal Services
WWW.HEALTHNETFEDERALSERVICES.COM

| | | |
|---|---|---|
| 3 | Date of Notice: | December 30, 2005 |
| 4 | Sponsor SSN: | 000-00-000 |
| | Sponsor Name: | NAME OF SPONSOR |
| 5 | Beneficiary Name: | NAME OF BENEFICIARY |

7 **Benefits were payable to:**

6 PATIENT, PARENT/GUARDIAN
ADDRESS
CITY, STATE ZIP CODE

PROVIDER OF MEDICAL CARE
ADDRESS
CITY, STATE ZIP CODE

8
**Claim Number: 919535695-00-00**

| Services Provided By/ Date of Services (9) | | Services Provided (10) | Amount Billed (11) | TRICARE Approved (12) | See Remarks (13) |
|---|---|---|---|---|---|
| PROVIDER OF MEDICAL CARE | | | | | |
| 12/14/2005 | 1 | Office/outpatient visit, est (99213) | 75.00 | 50.61 | 1, 2, 3, 4, 5 |
| **Totals:** | | | 75.00 | 50.61 | |

**Claim Summary** 14

| | |
|---|---|
| Amount Billed: | 75.00 |
| TRICARE Approved: | 50.61 |
| Non-Covered: | 24.39 |
| Paid by Beneficiary: | 0.00 |
| Other Insurance: | 0.00 |
| Paid to Provider: | 50.61 |
| Paid to Beneficiary: | 0.00 |
| Check Number: | |

**Beneficiary Liability Summary** 15

| | |
|---|---|
| Deductible: | 0.00 |
| Copayment: | 0.00 |
| Cost Share: | 0.00 |
| Patient Responsibility: | 0.00 |

16

**Benefit Period Summary** 17

**Fiscal Year Beginning:**
October 01, 2005

| | Individual | Family |
|---|---|---|
| Deductible: | 0.00 | 0.00 |
| Catastrophic Cap: | | 51.00 |

**Remarks** 18

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

2 - GREAT NEWS! PGBA IS MAKING TRICARE EASIER. YOU CAN NOW VIEW THE STATUS OF YOUR CLAIMS AT WWW.MYTRICARE.COM FOR MORE INFORMATION VISIT OUR WEB SITE TODAY.

3 - PLEASE ALLOW UP TO 30 DAYS FOR YOUR CLAIMS TO PROCESS.

4 - $51.00 HAS BEEN APPLIED TOWARD THE CATASTROPHIC CAP OF $1000.00.

5 - AMOUNT ALLOWED IS BASED ON A DISCOUNT AGREEMENT.

19 **1-877-TRICARE (1-877-874-2273)**

**THIS IS NOT A BILL**

**If you have questions regarding this notice, please call or write us at the telephone number/address listed above.**

TRICARE North

**Page 1 of 1**

## How to Read Your TRICARE EOB for the North Region

1. **PGBA, LLC**—PGBA processes all TRICARE claims for the region where you live.
2. **Regional Contractor**—The name "Health Net Federal Services" and the Health Net logo will appear here.
3. **Date of Notice**—PGBA prepared your TRICARE EOB on this date.
4. **Sponsor SSN/Sponsor Name**—We process your claim using the Social Security number of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor.
5. **Beneficiary Name**—The patient who received medical care and for whom this claim was filed.
6. **Mail-to Name and Address**—We mail the TRICARE EOB directly to the patient (or patient's parent or guardian) at the address given on the claim. (**Note:** Be sure your doctor has updated your records with your current address.)
7. **Benefits Were Payable To**—This field will appear only if your doctor accepts assignment. This means the doctor accepts the TRICARE maximum allowable charge as payment in full for the services you received.
8. **Claim Number**—We assign each claim a unique number. This helps us keep track of the claim as it is processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Service Provided By/Date of Services**—This section lists who provided your medical care, the number of services and the procedure codes, as well as the date you received the care.
10. **Services Provided**—This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed**—Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved**—This is the amount TRICARE approves for the services you received.
13. **See Remarks**—If you see a code or a number here, look at the Remarks section (18) for more information about your claim.
14. **Claim Summary**—Here we give you a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) that you have already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we have paid to the provider, benefits we have paid to the beneficiary. A Check Number will appear here only if a check accompanies your EOB.
15. **Beneficiary Liability Summary**—You may be responsible for a portion of the fee your doctor has charged. If so, you'll see that amount itemized here. It will include any charges that we have applied to your annual deductible and any cost-share or copayment you must pay.
16. **Patient Responsibility**—The total amount you owe for this claim.
17. **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. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the Fiscal Year Beginning date in this section for the first date of the fiscal year.
18. **Remarks**—Explanations of the codes or numbers listed in See Remarks will appear here.
19. **Toll-Free Telephone Number**—Questions about your TRICARE explanation of benefits? Please call PGBA toll-free at **1-877-TRICARE** (**1-877-874-2273**). Our professional customer service representatives will gladly assist you.

1 PGBA, LLC
TRICARE Claims Administrator For Your Region

## TRICARE EXPLANATION OF BENEFITS

**This is a statement of the action taken on your TRICARE claim.**
**Keep this notice for your records.**

2 HUMANA MILITARY HEALTHCARE SERVICES ★ ★ ★ ★ ★

| | | |
|---|---|---|
| 3 | Date of Notice: | August 02, 1999 |
| 4 | Sponsor SSN: | 000-00-0000 |
| | Sponsor Name: | NAME OF SPONSOR |
| 5 | Beneficiary Name: | NAME OF BENEFICIARY |

6 PATIENT, PARENT/GUARDIAN
ADDRESS
CITY, STATE ZIP CODE

7 **Benefits were payable to:**

PROVIDER OF MEDICAL CARE
ADDRESS
CITY, STATE ZIP CODE

8 **Claim Number: 919535695-00-00**

| Services Provided By/ Date of Services 9 | | Services Provided 10 | | Amount Billed 11 | TRICARE Approved 12 | See Remarks 13 |
|---|---|---|---|---|---|---|
| PROVIDER OF MEDICAL CARE | | | | | | |
| 07/08/1999 | 1 | Office/outpatient visit, est | (99213) | $45.00 | $38.92 | 1 |
| 07/08/1999 | 1 | Comprehen metabolic panel | (88054) | $20.00 | $19.33 | 1 |
| 07/08/1999 | 1 | Automated hemogram | (85025) | $12.00 | $12.00 | 1 |
| **Totals** | | | | **$77.00** | **$70.25** | |

**Claim Summary** 14

| | |
|---|---|
| Amount Billed: | 77.00 |
| TRICARE Approved: | 70.25 |
| Non-Covered: | 6.75 |
| Paid by Beneficiary: | 0.00 |
| Other Insurance: | 0.00 |
| Paid to Provider: | 52.69 |
| Paid to Beneficiary: | 0.00 |
| Check Number: | |

**Beneficiary Liability Summary** 15

| | |
|---|---|
| Deductible: | 0.00 |
| Copayment: | 0.00 |
| Cost Share: | 17.56 |

**Benefit Period Summary** 16

**Fiscal Year Beginning:**
October 1, 1998

| | Individual | Family |
|---|---|---|
| Deductible: | 150.00 | 150.00 |
| Catastrophic Cap: | | 856.32 |

**Enrollment Year Beginning:**
December 01, 1998

| | Individual | Family |
|---|---|---|
| POS Deductible: | 300.00 | 600.00 |
| Prime Cap: | | 856.32 |

17 **Remarks**

1 – CHARGES ARE MORE THAN ALLOWABLE AMOUNT

18 **1-800-XXX-XXXX**

**THIS IS NOT A BILL**

**If you have questions regarding this notice, please call or write us at the telephone number/address listed above.**

TRICARE South

**Page 1 of 1**

## How to Read Your TRICARE EOB for the South Region

1. **PGBA, LLC**—PGBA processes all TRICARE claims for the region where you live.
2. **Regional Contractor**—The name "Humana Military" and the Humana Military logo will appear here.
3. **Date of Notice**—PGBA prepared your TRICARE EOB on this date.
4. **Sponsor SSN/Sponsor Name**—We process your claim using the Social Security number (SSN) 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 sponsor's SSN will appear on the EOB.
5. **Beneficiary Name**—The patient who received medical care and for whom this claim was filed.
6. **Mail-to Name and Address**—We mail the EOB directly to the patient (or patient's parent or guardian) at the address given on the claim. (**Note:** Be sure your doctor has updated your records with your current address.)
7. **Benefits Were Payable To**—This field will appear only if your doctor accepts assignment. This means the doctor accepts the TRICARE allowable charge as payment in full for the services you received.
8. **Claim Number**—We assign each claim a unique number. This helps us keep track of the claim as it is processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Service Provided By/Date of Services**—This section lists who provided your medical care, the number of services, and the procedure codes, as well as the date you received the care.
10. **Services Provided**—This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed**—Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved**—This is the amount TRICARE approves for the services you received.
13. **See Remarks**—If you see a code or a number here, look at the Remarks section (17) for more information about your claim.
14. **Claim Summary**—Here we give you a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount that you have already paid to the provider (if any), amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we have paid to the provider, and benefits we have paid to the beneficiary. A check number will appear here only if a check accompanies your EOB.
15. **Beneficiary Liability Summary**—You may be responsible for a portion of the fee your doctor has charged. If so, you'll see that amount itemized here. It will include any charges that we have applied to your annual deductible and any cost-share or copayment you must pay.
16. **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. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the Fiscal Year Beginning date in this section for the first date of the fiscal year.
17. **Remarks**—Explanations of the codes or numbers listed in the "See Remarks" section will appear here.
18. **Toll-Free Telephone Number**—If you have questions about your TRICARE explanation of benefits, please call PGBA at this toll-free number. Our professional customer service representatives will gladly assist you.

## *West Region Explanation of Benefits Statement Sample*

*Figure 9.3*

TRICARE West

**TRICARE EXPLANATION OF BENEFITS**
Administered by: TriWest Healthcare Alliance
This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

(1) John B. Nice
123 Apple Lane
Huntsville, WA 12345-6789

| | |
|---|---|
| (2) Date of Notice | 08/14/2002 |
| (3) Sponsor SSN | 234567890 |
| Sponsor Name | John B. Nice |
| (4) Patient Name | John B. Nice |
| (5) Claim Number | 2002212 053 0017930 |
| (6) Check Number | C0001545337 |
| Provider Number | 752906887 76550 0001 |
| Provider Name | ABC Valley Clinic |

(7) If you have any questions about this notice, please call toll-free at **1-888-TRIWEST** (874-9378). You can also visit us online at **www.triwest.com**.

**THIS IS NOT A BILL**

| (8) SERVICES PROVIDED BY | (9) DATE OF SERVICE | (10) AMOUNT BILLED | (11) TRICARE ALLOWED | (12) REMARKS |
|---|---|---|---|---|
| Michael Smith, MD | 03/23/02–03/27/02 | $000,000.00 | $000,000.00 | 003 |
| Total | | $000,000.00 | $000,000.00 | |

| (13) CLAIM SUMMARY | | (14) BENEFICIARY SHARE | |
|---|---|---|---|
| TRICARE Amount Billed | $000,000.00 | Cost-Share/Copay | $000,000.00 |
| TRICARE Allowed | $000,000.00 | Deductible | $000,000.00 |
| TRICARE Paid | $000,000.00 | Beneficiary Responsibility | $000,000.00 |
| Other Insurance Allowed | $000,000.00 | | |
| Other Insurance Paid | $000,000.00 | | |
| Other Insurance Patient Responsibility | $000,000.00 | | |
| Amount Applied to Offset | $000,000.00 | | |

(15) **OUT OF POCKET EXPENSE:**

| | Beginning October 1, 2002 | | Beginning October 1, 2001 | | Beginning October 1, 2000 | |
|---|---|---|---|---|---|---|
| | Limit | Met to Date | Limit | Met to Date | Limit | Met to Date |
| Individual Deductible | $ 000.00 | $ 000.00 | $ 000.00 | $ 000.00 | $ 000.00 | $ 000.00 |
| Family Deductible | $ 000.00 | $ 000.00 | $ 000.00 | $ 000.00 | $ 000.00 | $ 000.00 |
| Catastrophic cap | $0,000.00 | $0,000.00 | $0,000.00 | $0,000.00 | $0,000.00 | $0,000.00 |

(16) **Remark Codes:**
003: See item 5 on reverse. If you are not satisfied with our determination, you have the right to request a review within 90 days of the notice.

| (17) PAID TO | AMOUNT PAID | BENEFICIARY RESPONSIBILITY |
|---|---|---|
| Skagit Valley Clinic | $000,000.00 | $000,000.00 |

(18) TriWest Healthcare Alliance®

## How to Read Your TRICARE EOB for the West Region

1. **Mail-to Name and Address**—We mail the TRICARE EOB directly to the patient (or patient's parent or guardian) at the address given on the claim. **Note**: Be sure your doctor has updated your records with your current address.
2. **Date of Notice**—The date we prepared your TRICARE EOB.
3. **Sponsor SSN/Sponsor Name**—We process your claim using the Social Security number of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor.
4. **Patient Name**—The patient who received medical care and for whom this claim was filed.
5. **Claim Number**—We assign each claim a unique number. This helps us keep track of the claim as it is processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
6. **Check Number**—A Check Number will appear here only if a check accompanies your EOB.
7. **Toll-Free Number/Web Address**—How you can reach us (TriWest) if you have questions.
8. **Service Provided By**—Who provided your medical care, the number and type of services and the procedure codes
9. **Date of Services**—The date you received the care.
10. **Amount Billed**—Your doctor, hospital, or lab charged this fee for the medical services you received.
11. **TRICARE Allowed**—This is the amount TRICARE approves for the services you received.
12. **Remarks**—If you see a code or a number here, look at the Remark Codes section (16) for more information about your claim.
13. **Claim Summary**—Here we give you a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) that you have already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we have paid to the provider, benefits we have paid to the beneficiary.
14. **Beneficiary Share**—You may be responsible for a portion of the fee your doctor has charged. If so, you'll see that amount itemized here. It will include any charges that we have applied to your annual deductible and any cost-share or copayment you must pay.
15. **Out of Pocket Expense**—This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the Fiscal Year Beginning date in this section for the first date of the fiscal year.
16. **Remark Codes**—Explanations of the codes or numbers listed in Remarks (12) will appear here.
17. **Paid To**—The name of the provider or facility who the claim was paid to.
18. **Regional Contractor**— The name "TriWest Healthcare Alliance" and the TriWest logo will appear here.

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# *Patient Bill of Rights and Responsibilities*

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

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

For more information about your rights, visit www.tricare.mil/Patientrights/default.cfm.

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

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

**You also have the responsibility to:**

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

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

Printed: October 2006

# www.tricare.mil

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

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

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

TRICARE

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