Welcome To
The TRICARE® Fundamentals Course
January–March 2017

This course takes 3 days. You have to pass a 50-question final exam and score at least 80% to pass. You also have to fill out an online evaluation to get your training certificate. We'll e-mail your certificate within 7 business days of completing the evaluation.

This TFC Participant Guide is a training and reference tool. It's updated quarterly. To get the most current version, visit www.tricare.mil/tricareu/participant-guide.aspx.

Once you go back to work:

- Visit www.tricare.mil for benefit information and sign up for TRICARE e-mails at https://public.govdelivery.com/accounts/USMHSTMA/subscriber/new
- Visit the customer service community website at: https://info.health.mil/agency/mhs/CSC
- Visit http://www.tricare.mil/bcacdcao_user to sign up for e-mails sent to customer service staff

---

At the time of printing, the information in this Participant Guide is current, but must be read in light of governing statutes and regulations and is not a substitute for legal advice from qualified counsel, as appropriate. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact the managed care support contractor for your region.

Table of Contents

TRICARE Fundamentals Course

Key TRICARE Concepts and Terms

1

Participant Guide

References

2008 TRICARE Operations Manual
2008 TRICARE Policy Manual
2008 TRICARE Reimbursement Manual
2008 TRICARE Systems Manual
10 USC
32 CFR § 199, 199.2
HA Policy 11-005

Module Objectives

- **Identify the four TRICARE regions**
- **Identify who determines TRICARE eligibility**
- **Explain the purpose of DEERS**
- **Describe the types of TRICARE-authorized providers**
- **List terms commonly associated with TRICARE costs**

Key Terms

- **Military Health System (MHS)**
- **TRICARE**
- **TRICARE Regional Office (TRO)**
- **TRICARE Overseas Program (TOP)**
- **TRICARE Area Office (TAO)**
- **Defense Enrollment Eligibility Reporting System (DEERS)**
- **DMDC**
- **Military Hospital or Clinic**
- **Authorized Provider**
- **Network Provider**
- **Non-Network Participating Provider**
- **Non-Network Non-Participating Provider**
- **Non-Authorized Provider**
- **Access to Care**
- **Emergency Care**
- **Urgent Care**
- **Routine Care**
- **Specialty Care**
- **Preventive Care**
- **Billed Charge**
- **TRICARE-Allowable Charge**
- **Deductible**
- **Cost-Share**
- **Copayment**
- **Premium**
- **Enrollment Fee**
- **Catastrophic Cap**
- **Balance Billing**
- **Explanation of Benefits (EOB)**
- **Foreign Fee Schedule**

?	Throughout this module, you will answer scenario questions on TRICARE beneficiary Alice White, the wife of Captain White, an active duty service member (ADSM) in the United States Army.

1.0 The Military Health System (MHS) and TRICARE

1.1 The Military Health System (MHS)

- The Military Health System (MHS) is a global, comprehensive, integrated system. It includes combat medical services, peacetime health care delivery, public health services, medical education and training, and medical research and development.
- The MHS is made up of 2 components:
  - Direct care—health care within Department of Defense (DoD)-operated and staffed health care facilities, e.g. military hospitals and clinics (including Coast Guard clinics), also called military treatment facilities (MTFs).
  - Purchased care— Civilian health care overseen and administered through TRICARE regional contracts, e.g. health care from civilian TRICARE-authorized or overseas providers.

1.2 TRICARE

- TRICARE is the DoD's purchased health care benefits program. It serves eligible active duty service members (ADSMs), Guard/Reserve members, retirees, family members, survivors, certain former spouses, and others determined by DoD to be entitled to TRICARE benefits.
- TRICARE sets up networks of civilian health care providers, pharmacies, and suppliers. These networks increase access to health care services beyond what's available at military hospitals or clinics.
- There are 4 TRICARE regions: 3 in the United States, 1 overseas. Each region's contractor manages and coordinates services between uniformed/military and civilian providers. (In this book, managed care support contractors and the overseas health services support contractor are referred to as "regional contractors".)

1.2.1 Stateside

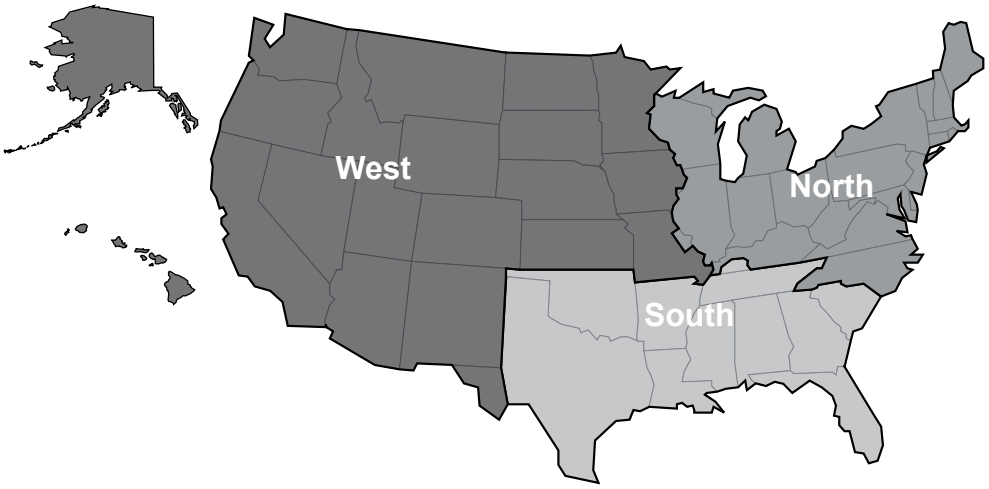
Each region has a TRICARE Regional Office (TRO) that oversees management and administration of health care services within that region. Customer service staff should first contact a regional contractor when they need help with beneficiaries' questions. If the contractor can't help, staff should then contact the TRO.

- **North Region**: Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (Rock Island Arsenal area), Kentucky (except Fort Campbell area), Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, and Wisconsin.
- **South Region**: Alabama, Arkansas, Florida, Georgia, Kentucky (Fort Campbell area) Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (excluding the El Paso area).
- **West Region**: 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 (including El Paso), Utah, Washington, and Wyoming.

Notes:

- On July 21, 2016, the DoD awarded 2 stateside regional contracts: The East Region (a merger of existing North and South Regions) and The West Region (unchanged). A protest was filed, and so the award is going through the appropriate review channels. We are providing updates to the customer service community as we learn more. For now, let beneficiaries know their TRICARE benefit isn't changing and they don't need to take action at this time. For more information, beneficiaries may visit: http://www.tricare.mil/About/Partners/Changes
- In addition, the TRO-North and TRO-South offices merged to create TRO-East. TRO East-Falls Church oversees the North Region. TRO East-San Antonio oversees the South Region.

TRICARE Stateside Regions



1.2.2 Overseas

- The TRICARE Overseas Program (TOP) is TRICARE's health care program outside the 50 United States and the District of Columbia. The TOP supports health care services for those living or traveling overseas.
- There is 1 Overseas Region. It's divided into 3 overseas areas:
  - **TRICARE Eurasia-Africa**: Africa, Europe, and the Middle East
  - **TRICARE Latin America and Canada (TLAC)**: Canada, the Caribbean basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands
  - **TRICARE Pacific**: Asia, Guam, India, Japan, Korea, New Zealand, Australia, and Western Pacific remote countries
- TRICARE Area Offices (TAOs) oversee the contractor's performance and provide operational support to military hospitals and clinics and beneficiaries in their geographical area.

TRICARE Overseas Region

2.0 TRICARE Eligibility

- **Only the 7 uniformed services determine TRICARE eligibility:**
  - Army
  - Marine Corps
  - Navy
  - Air Force
  - Coast Guard
  - U.S. Public Health Service (PHS)
  - National Oceanic and Atmospheric Administration (NOAA)
- The Defense Enrollment Eligibility Reporting System (DEERS), a personnel data system, shows the beneficiary's status, which affects his or her health care benefits. It also shows key TRICARE information.

Beneficiary Status	TRICARE Information
● Uniformed service members ● Uniformed service retirees ● U.S.-sponsored foreign military members ● DoD and uniformed services civilians ● Eligible family members ● Others as directed by the DoD	● Eligibility–start and end dates; eligibility notices ● Health care benefit status–direct care and TRICARE options; dental program coverage ● Primary care manager (PCM) assignment ● Catastrophic caps, deductibles, enrollment fee/ premium payment ● Other health insurance (OHI) ● Enrollment cards (printable); eCorrespondence

- **DEERS doesn't determine eligibility. It only reports it!**
- DMDC manages and oversees DEERS.
- Beneficiaries with eligibility questions should contact the DMDC Support Office (DSO), or a uniformed services ID card facility.

2.1 Updating DEERS After a Status Change or Qualifying Life Event

- Beneficiaries must make sure DEERS is always current. This is their responsibility!
- The services input personnel changes in DEERS for the sponsor.
- Other updates require beneficiaries to present certain documents to the sponsor's personnel unit or an ID card facility (e.g., marriage, birth, or divorce certificates). Individuals should call the ID card facility to find out what documents they need to bring. See the table below for key DEERS updates.

Sponsor Status Changes	Qualifying Life Events
● Activation or reenlistment ● Deactivation ● Separation or retirement ● Medicare eligibility ● Move or change in mailing or e-mail address ● Death	● Marriage or divorce ● Birth or adoption ● Death ● Move or change in mailing or e-mail address ● Medicare or OHI gain or loss ● Dependent child's enlistment in a uniformed service ● Student status*

* *To stay TRICARE eligible after age 21, a child must be enrolled as a full-time student in an approved institution of higher learning. The sponsor must provide more than 50% of the child's income. Eligibility ends on the 23rd birthday or when the "student" graduates or leaves school, whichever comes first.*

2.2 Updating Contact Information in DEERS

Beneficiaries need to keep contact information (mailing addresses, phone numbers, and e-mail addresses) up-to-date. The 4 ways to update personal information are:

- **In Person—**Go to the nearest ID card facility
- **By Internet—**Submit changes at http://milconnect.dmdc.mil. Must be a registered user.
  - Users log in with a CAC, DFAS (myPay) account, or with a DS Logon. They then select the "Update Address" link.
- **By Fax—**DSO: 1-831-655-8317
- **By Mail—**Mail changes to:

DMDC Support Office
ATTN: COA
400 Gigling Road
Seaside, CA 93955-6771

2.3 DMDC Support for TRICARE Eligibility Issues

- ID card facility information is at www.dmdc.osd.mil/rsl
- DMDC Support Office (DSO): 1-800-538-9552 (for the hearing impaired: 1-866-363-2883)
- DMDC support **for MHS support staff only**: 1-800-361-2508 (Field Support Help Desk)

Note: ID cards list the DoD Benefits Number (DBN) on the back of the card. This may be used in place of a Social Security Number (SSN) when getting health care services. ID cards show eligibility end dates, as well as military and civilian coverage status.

?	The White's just moved from Topeka, Kansas to St. Louis, Missouri. Did their TRICARE region change? Following their move, do they need to change any information in DEERS? If so, how can they make sure these changes show in DEERS?

3.0 TRICARE and Veterans Affairs Benefits

- Certain retired former service members are eligible for both TRICARE and Veterans Affairs (VA) benefits.
- These beneficiaries can use their TRICARE benefit for TRICARE-covered services, even if the VA already treated them for the same condition. However, they can't use TRICARE and VA at the same time for the same condition.
- TRICARE doesn't pay for VA care (direct or authorized) or beneficiaries' VA cost shares.
- The VA can't bill Medicare. TRICARE For Life (TFL), the program that covers those who have both Medicare and TRICARE entitlement, pays as primary payer. TFL **only** pays what it would have as second payer to Medicare. Let's say a TFL beneficiary goes to the VA for shoulder surgery:
  - Medicare won't pay anything.
  - TFL pays. It pays only what it would have if Medicare **had** paid on the claim. This is typically 20% of the TRICARE-allowable charge.
  - The VA then determines what it will bill the veteran/TFL beneficiary of the remaining 80% (what Medicare would have paid), i.e. VA applicable deductibles, cost shares, etc.
- In some situations, VA-TRICARE/TFL beneficiaries must get a referral and prior authorization for care at a VA clinic or hospital. See the *TRICARE and Medicare* module for more information.

4.0 TRICARE Providers

4.1 Military Uniformed Service Hospitals or Clinics

- Military hospitals or clinics are usually on or near a base or post. These facilities employ military and civilian providers and support staff. Most have pharmacy services.

4.2 Authorized Providers (Civilian)

- An authorized provider is an individual, institution, or supplier. They are licensed, accredited, or meet other standards of the medical community.
- It's up to the beneficiary to make sure a provider is TRICARE-authorized. The beneficiary may confirm a provider's status by calling their regional contractor or asking the provider.
- Regional contractors verify a provider's authorized status before they authorize care or pay on a claim.

4.2.1 Types of Authorized Providers

Provider Type	Stateside	Overseas—TRICARE Overseas Program (TOP)
Network Provider*	• Signs a contract with a TRICARE contractor (regional, pharmacy, etc.) • A network provider files and accepts the contracted rate† as payment in full (e.g., the negotiated rate)	• Has an agreement with the TOP contractor • Provides "cashless, claimless" ‡ authorized care to TOP Prime option enrollees
Non-Network Participating Provider	• Doesn't contract with a TRICARE regional contractor • Accepts the TRICARE-allowable charge as payment in full • May require beneficiaries to pay up front and file their own claims	• Doesn't have an agreement with the TOP contractor • May require beneficiaries to pay up front and file their own claims
Non-Network Non-Participating Provider	• Doesn't accept the TRICARE-allowable charge as payment in full • May bill beneficiaries up to 15% above the TRICARE-allowable charge	• Not applicable

* *Network providers are only "network" for the region where they have a contract. (For example, a North region network provider isn't "network" for South Region Prime enrollees.)*

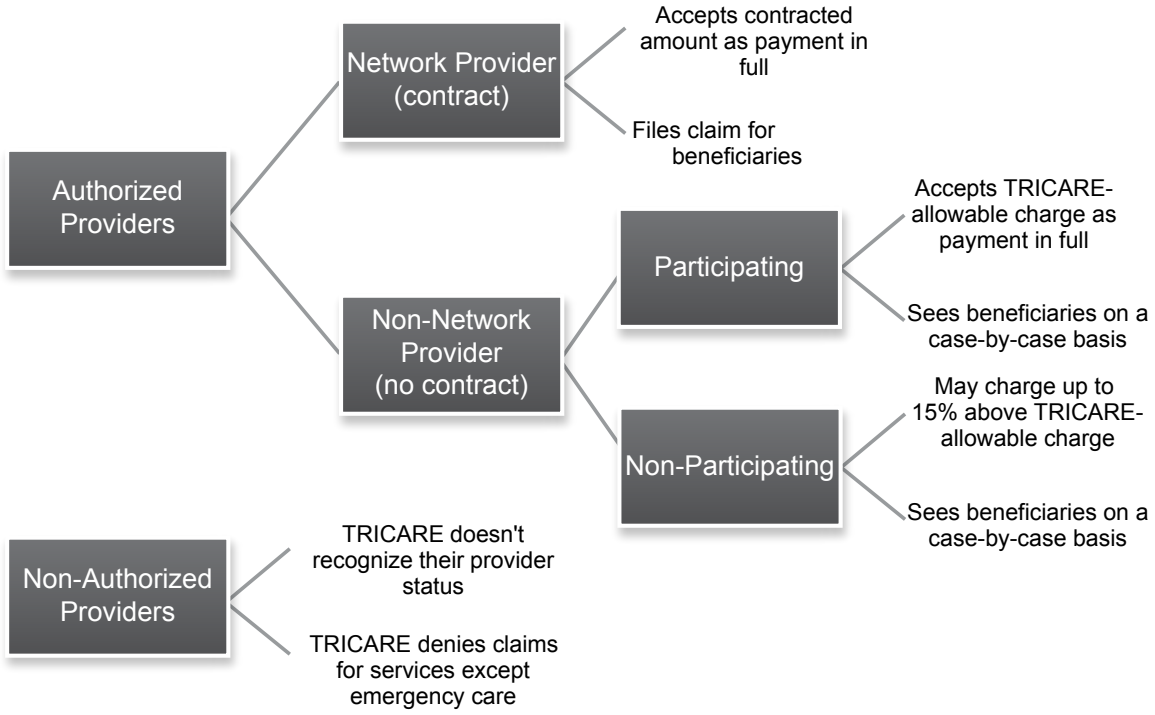
† *The "contracted rate" is the TRICARE paid portion plus the beneficiary's portion.*

‡ *"Cashless, claimless" means the overseas contractor authorizes a visit and pays the overseas provider. The enrollee doesn't pay up front for services.*

4.2.2 Non-Authorized Providers

- Providers are non-authorized if they:
  - Don't meet state licensing or training requirements
  - Don't want to or decline to treat TRICARE-eligible beneficiaries
  - Aren't in a provider group recognized by TRICARE (e.g., a chiropractor)
  - Provide care that isn't a TRICARE benefit (e.g., acupuncture)
- TRICARE doesn't pay on claims from non-authorized providers, unless it's for emergency care. TRICARE may pay after the contractor receives and reviews documents showing the care was emergency care.
- Providers can learn how to become authorized by visiting www.tricare.mil/providers or calling the regional contractor.

4.2.3 Illustration of Provider Types



?	Mrs. White is searching for a new dermatologist. If she chooses a non-network, non-participating provider, what is the most the provider can expect to be paid?

4.3 Finding a Provider

- Stateside: Beneficiaries should always check to see if a provider is a network or participating provider. Beneficiaries pay less out of pocket when they see these types of providers. These providers can't bill the extra 15%.
- To find providers, go to these websites or contact the regional contractor:
  - TRICARE Website: www.tricare.mil/findaprovider
  - TRICARE North Region: www.hnfs.com/apps/providerdirectory
  - TRICARE South Region: www.humana-military.com (Select "Find a Provider" on the Beneficiary tab.)
  - TRICARE West Region: www.uhcmilitarywest.com (Select "Find a Provider" under Popular Topics)
  - TRICARE Overseas Region: www.tricare-overseas.com/ProviderSearch/SearchContent.aspx

Note: Provider directories may change. A listing doesn't mean the information is current. Beneficiaries should call the provider and ask about the provider's status and if the provider is still seeing TRICARE beneficiaries.

5.0 Types of Care

- **Emergency care** Refers to medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that:
  - He or she has a serious medical condition
  - Without immediate treatment he or she could possibly die, or lose a limb or eyesight
  - He or she needs sedation to relieve pain.
- **Urgent care** refers to sudden, non-emergency ("acute") illness or injury that needs medical treatment, but won't cause a disability or death if not treated immediately. The individual should see a provider within 24 hours to avoid problems.
- **Routine care** is also known as primary care. It includes general office visits for the treatment of symptoms, chronic or acute illnesses and diseases, and follow-up care for an ongoing medical condition. A primary care manager/provider is the primary source for routine care.
- **Specialty care** refers to care given by physicians who get additional training and education to be eligible for board certification in a specific branch of medicine, such as internal medicine or surgery.
- **Preventive care** refers to care a person gets to prevent illnesses or diseases, including services such as shots, mammograms, pap smears, cholesterol testing, etc.

5.1 TRICARE Prime Access Standards

"Access to care" refers to established appointment and distance standards that ensure Prime enrollees get care in a timely manner and within a reasonable distance. (These standards only apply to TRICARE Prime, which you will learn more about in the next module.)

	Urgent Care	Routine Care	Referred/Specialty	Wellness/ Preventive
Appointment Wait Time	Within 24 hours	Within 7 days	28 calendar days (4 weeks)	28 calendar days (4 weeks)
Drive Time	Within 30 minutes of enrollee's home		Within 60 minutes of enrollee's home	Within 30 minutes of enrollee's home
Wait Time in Office	No more than 30 minutes for non-emergency situations			

6.0 Common TRICARE Costs

Billed Charge	The provider's proposed total cost, with no discounts or reduced fees.
TRICARE-Allowable Charge	The TRICARE-determined level of payment based on one of TRICARE's approved reimbursement methods. It equals what the government pays plus the beneficiary's cost share. Law ties it to Medicare's rates when practical. The TRICARE-allowable charge varies based on the location, place of service, date of service, and provider.
Deductible	The amount a beneficiary pays for covered outpatient services. Beneficiaries must pay their deductible before TRICARE can start paying on claims. ● Deductibles apply primarily to TRICARE Standard options. ● Prime option enrollees pay a deductible when using the point-of-service (POS) option or a non-network pharmacy.
Beneficiary Cost-Share	The percent of the TRICARE-allowable charge beneficiaries pay. TRICARE bases overseas cost share on: Stateside allowable charge or the lower actual billed charge (Puerto Rico, U.S. Virgin Islands, American Samoa, the Northern Mariana Islands, and Guam), billed charges, or foreign-fee schedules (Philippines, Panama).
Copayment	● The fixed amount certain TRICARE Prime option enrollees pay when seeing civilian providers. ● The fixed amount beneficiaries pay for drugs (home delivery or retail pharmacies)
Premium	The amount some individuals pay to have TRICARE medical or dental coverage for a certain amount of time.
Enrollment Fee	The amount some beneficiaries pay to enroll in TRICARE Prime, including the US Family Health Plan (USFHP).
Catastrophic Cap	The most an individual/family pays for TRICARE-covered services or supplies per fiscal year (October 1–September 30). Payments that count toward the catastrophic cap include: ● Deductibles ● Cost-shares ● Prescription copayments ● Prime enrollment fees and copayments
Balance Billing	When a non-network, non-participating provider bills the beneficiary the difference between billed charges and the TRICARE-allowable charge (stateside only).
Explanation of Benefits (EOB)	Statements created by TRICARE and insurance companies showing what services were covered and how much was paid to the provider and is owed by the individual.
Foreign Fee Schedule (Overseas Specific)	A country-specific payment method that calculates deductibles and cost-shares (currently only used in the Philippines and Panama).
Transitional Survivor	The initial status of a spouse and unmarried dependent child(ren) of a sponsor who died on active service. Spouses keep their transitional survivor status for up to 3 years from the date of the sponsor's death. Unmarried dependent children are transitional survivors until they lose TRICARE eligibility. Benefits are the same as active duty family members (ADFMs). (See Appendix A for more information.)
Survivor	The status of surviving spouses and incapacitated children (if applicable) after the 3-year anniversary of the active duty sponsor's death. Also the status of former dependent children, up to age 26, who aged out of TRICARE before the active duty sponsor's death. Survivor benefits are the same as retired family members. (See Appendix A for more information.)

Module Objectives

- **Identify the four TRICARE regions**
- **Identify who determines TRICARE eligibility**
- **Explain the purpose of DEERS**
- **Describe the types of TRICARE-authorized providers**
- **List terms commonly associated with TRICARE costs**

Key Terms

- **Military Health System (MHS)**
- **TRICARE**
- **TRICARE Regional Office (TRO)**
- **TRICARE Overseas Program (TOP)**
- **TRICARE Area Office (TAO)**
- **Defense Enrollment Eligibility Reporting System (DEERS)**
- **DMDC**
- **Military Hospital or Clinic**
- **Authorized Provider**
- **Network Provider**
- **Non-Network Participating Provider**
- **Non-Network Non-Participating Provider**
- **Non-Authorized Provider**
- **Access to Care**
- **Emergency Care**
- **Urgent Care**
- **Routine Care**
- **Specialty Care**
- **Preventive Care**
- **Billed Charge**
- **TRICARE-Allowable Charge**
- **Deductible**
- **Cost-Share**
- **Copayment**
- **Premium**
- **Enrollment Fee**
- **Catastrophic Cap**
- **Balance Billing**
- **Explanation of Benefits (EOB)**
- **Foreign Fee Schedule**

Appendix A: Special Eligibility and DEERS Registration Categories

Making Status Updates After a Qualifying Life Event

Status updates usually involve presenting paperwork to validate the change. Sponsors and family members should go to the sponsor's personnel unit or ID card facility with the following (as needed):

- Marriage certificate
- Birth certificate
- Death certificate
- *Certificate of Release or Discharge from Active Duty* form (DD Form 214)
- Medicare card
- *Notice of Disapproved Claim* from the Social Security Administration (SSA) if the beneficiary isn't eligible for Medicare Part A at age 65
- Letter from a college, university, or approved institution of higher learning showing a young adult dependent is a full-time student and the anticipated graduation date

Newborns, Pre-Adoptive, Adopted Children, and Court-Ordered Wards

The DoD requires DEERS registration for all TRICARE-eligible beneficiaries. This includes newborns, pre-adoptive and adopted children, and court-ordered wards. Parents and legal guardians can avoid eligibility and claims problems by registering the newborn or adopted child in DEERS as soon as possible.

- Newborns are eligible for TRICARE for 365 days from birth. On day 366, if they're not in DEERS, they lose TRICARE benefits. TRICARE won't pay on their claims. (See the *TRICARE Options* module for more on newborn coverage under TRICARE Prime.)
- Pre-adoptive, adopted children, and court-ordered wards must be registered in DEERS to be TRICARE eligible. There's no automatic 365 days of coverage. Claims deny until the sponsor registers the child.

Note: Pre-adoptive children are children whose legal adoption isn't final.

- TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR)-enrolled sponsors can purchase coverage after a child's birth or adoption. (For more information qualifying life events under TRS/TRR, see the *National Guard and Reserve* module.)
- Families should call the closest uniformed services ID card facility to see what paperwork they need to present to establish a child's eligibility. To find an ID card facility, visit www.dmdc.osd.mil/rsl.

Dependent Parents and Parents-In-Law

Although dependent parents and parents-in-law aren't TRICARE eligible, they may be able to get care at a military hospital or clinic.

- They must be registered in DEERS. The sponsor's service determines if they qualify to be dependents. Sponsors should ask their service what they need to do to make their parents or parents-in-law their dependents.
- As dependents, parents or in-laws may get care at a military hospital or clinic.
- Dependent parents and parents-in-law may only get prescriptions filled at a military hospital or clinic pharmacy. When they become Medicare-eligible they can get prescriptions filled through TRICARE Home Delivery or at TRICARE network pharmacies as long as they have Medicare Part B.

Transitional Survivors and Survivors

Surviving family members of sponsors who died while on active service may get TRICARE benefits. The sponsor's service determines eligibility and reflects it in DEERS.

Transitional Survivors

"Transitional survivors" refers to the spouse and child(ren) of a deceased active duty sponsor.

- They get active duty family member (ADFM) benefits.
  - Spouses are transitional survivors for up to 3 years from the date of the sponsor's death.
  - Unmarried dependent children are transitional survivors until they lose TRICARE eligibility. This occurs at age 21, or 23 (if enrolled as a full-time student in an approved institution of higher learning and the sponsor provided at least 50% of the student's income).
  - If entitled to Medicare Part A, they must sign up for Medicare Part B within 8 months of the sponsor's death to avoid the Part B late enrollment premium surcharge (See the *TRICARE and Medicare* module.)
- Incapacitated children are dependent children who, before age 21, are unable to support themselves due to a mental or physical condition and rely on the sponsor for at least 50% of their income. These children are covered as transitional survivors until age 21 (or 23), or up to 3 years from the death of the sponsor, whichever is later.
  - The sponsor's service confirms the child's incapacitation status.
  - Incapacitated children change to survivor status after age 21 or the 3-year period if the service decides they're still eligible for benefits.
- Transitional survivors may enroll in TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TRICARE Overseas Program (TOP) Prime, or TOP Prime Remote (shows as TPR in DEERS).
  - Transitional survivors living overseas don't need command-sponsorship to enroll in a TOP Prime option.
  - Transitional survivors don't pay enrollment fees or copayments for Prime-option benefits. They pay ADFM cost-shares and deductibles if they use TRICARE Standard, TOP Standard, the point-of-service (POS) option, or a non-network pharmacy.
- Transitional survivors pay for TRICARE pharmacy benefits.

Survivors

"Survivor" refers to the spouse's and incapacitated child's eligibility status 3 years after the active duty sponsor's death, or the status of former dependent children (up to age 26) who aged out of TRICARE before the active duty sponsor's death and who qualify to purchase TRICARE Young Adult (TYA) coverage.

- TRICARE benefits are the same as retired family members.
  - They're not eligible for active-duty specific programs (such as TPR, TPRADFM, TOP Prime, and TOP Prime Remote).
  - They're not eligible for active-duty specific benefits, such as the Extended Care Health Option (ECHO). They may continue Applied Behavior Analysis (ABA) under the Autism Care Demonstration and basic TRICARE benefit.
- Survivors can be TRICARE Standard or TOP Standard. They pay retiree cost-shares and deductibles for TRICARE-covered services.
- Survivors may enroll in TRICARE Prime. They have to re-enroll when their status changes to survivor.
  - They pay retiree enrollment fees and copayments. Fees are frozen at the rate in place when they become survivors and start paying Prime enrollment fees.
- Survivors must purchase Medicare Part B when they are entitled to Medicare to keep their TRICARE benefits.
- Survivors pay for TRICARE pharmacy benefits.

Unremarried Former Spouses

- Certain unremarried former spouses are TRICARE-eligible after a divorce. The former sponsor's service determines and reflects their eligibility in DEERS.
- The 20-20-20 rule. For continuous TRICARE eligibility as an unremarried former spouse:
  - The sponsor must have 20 years of creditable service (active or reserve) towards determining retirement pay.
  - The former spouse and sponsor were married for at least 20 years.
  - All 20 years of marriage overlap 20 years of the sponsor's creditable service.
- The 20-20-15 rule. Some former spouses qualify for TRICARE benefits for 1 year from the date of the divorce.
  - The sponsor must have 20 years of creditable service (active or reserve) towards determining retirement pay.
  - The former spouse and sponsor were married for at least 15 years.
  - All 15 years of marriage overlap 20 years of the sponsor's creditable service.
- The sponsor or former spouse must present the following paperwork at an ID card facility to determine if the former spouse is eligible for benefits:
  - Marriage certificate and divorce decree
  - *DD Form 214* from the sponsor's service
- If the service determines the unremarried former spouse is eligible, the service sends the spouse a letter confirming eligibility.
- Unremarried former spouses should pick up new ID cards under their own name. They then use their own SSN or DBN when seeking care.

Unremarried Former Spouse Loss of Eligibility

TRICARE-eligible unremarried former spouses lose TRICARE eligibility if:

- They remarry, even if the remarriage ends in divorce or death of the new spouse.
- They purchase or are covered by an employer-sponsored health plan

Note: If offered group health coverage through their employer, unremarried former spouses may be able to decline it and keep their TRICARE coverage.

Additional Special Eligibility Categories

Beneficiaries who fall under the categories below should go to the nearest uniformed service personnel office or ID card facility for eligibility assistance:

- Certain family members of former active ADSMs who were discharged due to a court-martial conviction or separated for child or spousal abuse.
- Certain spouses, former spouses, and dependent children of ADSMs who were eligible for retirement, but lost their retirement status due to child or spousal abuse.
- Foreign Force members and their families when in the U.S. by official invitation or on official military business.
  - This includes all countries that participate in a Reciprocal Health Care Agreement, the North Atlantic Treaty Organization (NATO), a Status of Forces Agreement, or a Partnership for Peace Agreement.
  - Foreign Force members and their dependents seeking routine care may contact their home country embassy for help with health care coverage.
  - For information about military hospital or clinic care or TRICARE coverage for foreign force members and their families, register for an account at https://rhca.dhhq.health.mil.

TRICARE Fundamentals Course

TRICARE Options

2

Participant Guide

References

10 USC
32 CFR § 199, 199.2
National Defense Authorization Act (NDAA)
2008 TRICARE Policy Manual, Chapters 10, 12
2008 TRICARE Reimbursement Manual, Chapters 1, 2
2008 TRICARE Operations Manual, Chapters 6, 24

Brainteasers

Each of the 8 items below is a separate puzzle.

How many can you figure out?

1.  	2. sailing ccccccc	3. M E N T	4. knee light
5. TIMING TIMING	6. MAN BOARD	7. SSSSSSSSSSE	8. $0 all all all all

1. Go long

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Module Objectives

Stateside Objectives:

- **Explain the differences between TRICARE Standard®, TRICARE Extra, TRICARE Prime®, and the US Family Health Plan (USFHP)**
- **Explain the costs associated with the basic TRICARE options**
- **Describe the point-of-service (POS) option**
- **Describe the TRICARE Prime Travel Benefit**

Overseas Objectives:

- **Describe the TRICARE Overseas Program (TOP)**
- **Explain TOP health care coverage options**
- **State the relationship between command sponsorship and TOP**

Key Terms

- **TRICARE Standard**
- **TRICARE Overseas Program (TOP) Standard**
- **TRICARE Extra**
- **TRICARE Prime**
- **TOP Prime**
- **US Family Health Plan (USFHP)**
- **Primary Care Manager (PCM)**
- **Point-of-Service Option (POS)**

1.0 Introduction to TRICARE Options

- TRICARE offers health coverage with several health programs, which are described throughout this course. If new to TRICARE, visit http://www.tricare.mil/Plans/New to learn more or visit http://www.tricare.mil/Plans/ComparePlans to compare the options.

2.0 TRICARE Standard and Extra and TRICARE Overseas Program (TOP) Standard

- The term “Standard” refers to both TRICARE Standard and Extra and TOP Standard.

?	Throughout this module, you’ll answer scenario questions on Senior Airman Matthews, who’s transferring to a new assignment with his family.

2.1 Eligibility and Enrollment

- TRICARE-eligible beneficiaries (except active duty service members [ADSMs]) are covered under Standard until enrolled in a Prime option
- Beneficiaries don’t have to enroll—coverage is automatic as long as they show eligible in the Defense Enrollment Eligibility Reporting System (DEERS).
- Beneficiaries must show a valid Uniformed Services ID card as proof of eligibility when getting care.
- There’s no enrollment fee or form.

2.2 Benefits

- Beneficiaries can see any TRICARE-authorized (network or non-network) or overseas provider. If beneficiaries visit a:
  - **Non-network provider**, they’re using the **Standard option**.
  - **Network provider**, they’re using the **Extra option**. There’s a 5% discount in their cost-share.
    - TRICARE Extra isn’t available overseas.
- Standard beneficiaries may get care at a military hospital or clinic on a “space available” basis.
- For emergency care, they should go to the closest emergency room or call the local emergency number for the country they’re in.
- Beneficiaries don’t need referrals, but they must get prior authorization from their TRICARE contractor for:
  - Adjunctive dental care, both inpatient and outpatient (e.g., temporomandibular joint disorders)
  - Dental anesthesia
  - Admission for inpatient non-emergency mental health care or at a substance abuse facility
  - Psychoanalysis
  - Skilled Nursing Facility (SNF) care for Medicare-TRICARE beneficiaries
  - Organ and stem cell transplants
  - Home infusion therapy
  - Outpatient mental health care (after the 8th visit in a fiscal year [October 1–September 30])
  - Hospice care
  - Extended Care Health Option (ECHO) services (some services not available overseas)
  - Provisional coverage for emerging services and supplies

Note: The beneficiary’s regional contractor may have additional prior authorization requirements. Beneficiaries should contact their contractor for a list.

2.3 TRICARE Standard and Extra Costs

	Active Duty Family Member (ADFM) E-1–E-4	Active Duty Family Member (ADFM) E-5 and Up	Retirees, Retiree Family Members, and Survivors
Enrollment Fee	N/A	N/A	N/A
Annual Deductible	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Cost-Shares	**TRICARE Standard:** 20% of TRICARE-allowable charge **TRICARE Extra:** 15% of negotiated fee		**TRICARE Standard:** 25% of TRICARE-allowable charge **TRICARE Extra:** 20% of negotiated fee
Catastrophic Cap	$1,000 per family per fiscal year		$3,000 per family per fiscal year
Civilian Inpatient Cost-Share	**TRICARE Standard and TRICARE Extra**: $18.20* or $25 per admission, whichever is greater; no charge for separately billed professional charges		**TRICARE Standard:** ● $848* or 25% for institutional charges, whichever is less, plus 25% of the TRICARE-allowable charge for separately billed professional services **TRICARE Extra:** ● $250* or 25% of total charges (based on the fee schedule negotiated by the contractor), whichever is less, plus 20% for separately billed professional services (based on the fee schedule negotiated by the contractor).
Civilian Inpatient Mental Health	**TRICARE Standard and TRICARE Extra**: $18.20* or $25 per admission, whichever is greater		**TRICARE Standard:** ● High Volume Hospitals—25% hospital specific per diem plus 25% of the TRICARE- allowable charge for separately billed professional services ● Low Volume Hospitals—$235* or 25% of billed charges, whichever is less plus 25% of the TRICARE-allowable charge for separately billed professional services ● Partial Hospitalization—25% of the TRICARE-allowable charge, plus 25% of the TRICARE-allowable charge for separately billed professional services **TRICARE Extra:** ● 20% of total charges (based on the fee schedule negotiated by the contractor), plus 20% for separately billed professional services (based on the fee schedule negotiated by the contractor).

* *Per diem rates are found at: http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/Diagnosis-Related-Group-Rates. To view ADSM Standard and Extra rates, select the "Uniformed Services Hospital Daily Charge Amounts" link. To view Retiree, Retiree Family Member, and Survivor Standard and Extra rates, see the "Other Information" section.*

- When using the Standard option, some overseas and stateside providers may have beneficiaries pay up front for care. Beneficiaries who pay up front have to file claims for reimbursement.
  - Costs may change each fiscal year (October 1–September 30).
  - Under Standard, beneficiaries pay an outpatient deductible each fiscal year. After that, the government and the beneficiary share costs.
    - Deductibles and cost-shares count towards the catastrophic cap.

Note: For a complete, up-to-date list of Standard Overseas costs, see http://www.tricare.mil/Costs/HealthPlanCosts/TSO

2.3.1 Balance Billing Limit (Stateside Only)

- A non-network provider may choose not to "participate" or not "accept assignment." In other words, the provider doesn't accept the TRICARE-allowable charge as payment in full.
- Under federal law, stateside providers can't bill beneficiaries more than 15% above the TRICARE-allowable charge. This doesn't apply if the beneficiary signs a statement agreeing to pay more than the limit (15%).
- If beneficiaries get a bill from their provider, they should compare the bill to their explanation of benefits (EOB). They need to make sure the provider isn't billing them more than 15% above the TRICARE-allowable. If there's a difference, they've paid more than the limit, or they're unclear, they should call their TRICARE contractor.

2.3.2 TRICARE Standard Billing Example

A TRICARE Standard E-5 ADFM visits a non-network provider for an outpatient cardiology visit. The cardiologist "doesn't participate" on the claim. The provider charges $1,000. TRICARE's allowable charge is $850. Remember, the provider can bill the beneficiary 15% above the TRICARE-allowable charge. How much does the family member owe?

Provider Billing	Cost
Billed amount for the cardiology appointment	$1,000.00
TRICARE-allowable charge	$850.00
Additional 15% the provider is allowed to bill per federal law	$127.50 (15% of $850)
Total amount the provider can legally be paid	$977.50 ($850.00 + $127.50)
Settling the Payment with the Provider	
TRICARE-allowable charge	$850.00
Beneficiary pays annual deductible	$150.00
Remaining balance	$700.00
TRICARE's cost-share	$560.00 (80% of $700)
Beneficiary's cost-share	$140.00 (20% of $700)
Beneficiary's total out-of-pocket cost	$417.50 ($150.00 + $140.00 + $127.50)

Note: Although the billed amount is $1,000, legally the provider can't make the beneficiary pay the total amount. The beneficiary owes his or her deductible, cost-share, and 15% above the TRICARE-allowable charge.

2.4 TRICARE Standard Exercise

Mrs. Teal, an E-4 ADFM, and her 3 children have TRICARE Standard.

Mrs. Teal saw her family doctor for a routine visit. Her doctor is a TRICARE participating provider. This was the first outpatient visit of the fiscal year for the Teal family. The TRICARE-allowable charge for the visit was $50.

She had 1 follow-up visit. The TRICARE-allowable charge for that visit was $40. Between her 2 visits, the same doctor saw her 3 children for routine visits. The TRICARE-allowable charge for each of their visits was $40.

	What is the allowable charge per visit?	How much of each charge applies to the annual outpatient deductible?	What is the cost-share percentage?	How much does the family pay per visit?
Mrs. Teal's First Visit				
Child #1's Visit				
Child #2's Visit				
Child #3's Visit				
Mrs. Teal's Follow-Up Visit				

2.5 TRICARE Extra Exercise

Mrs. Jade, an E-5 ADFM, and her 3 children have TRICARE Standard.

Mrs. Jade saw her family doctor for a routine visit. Her doctor is a TRICARE network provider. This was the first outpatient visit of the fiscal year for the Jade family. The negotiated fee for Mrs. Jade's first visit was $100.

She had 1 follow-up visit. The negotiated fee for that visit was $75. Between her 2 visits, the same doctor saw her 3 children for routine visits. The negotiated fee for each of their visits was $75.

	What is the negotiated fee per visit?	**How much of each charge applies to the annual outpatient deductible?**	**What is the cost-share percentage?**	**What does the family pay per visit?**
Mrs. Jade's First Visit				
Child #1's Visit				
Child #2's Visit				
Child #3's Visit				
Mrs. Jade's Follow-Up Visit				

?	SrA Matthews' son, Bill, has severe asthma. Having many providers to choose from is important to SrA Matthews and his wife. Should they think about TRICARE Standard? What happens to their costs if they use a network provider?

3.0 TRICARE Prime and TRICARE Overseas Program (TOP) Prime

The term “Prime” refers to both TRICARE Prime and TOP Prime.

- Prime is a managed care option, similar to a civilian health maintenance organization (HMO). Under Prime, enrollees see their primary care manager (PCM) for all routine and urgent health care needs. In most cases, enrollees need a referral from their PCM before seeing other providers (except in an emergency and for many preventive care services).
- Prime is available in certain geographic locations, known as Prime Service Areas (PSAs).
    - PSAs include zip codes within 40 miles of a military hospital or clinic or a former Base Realignment and Closure (BRAC) site.
    - Beneficiaries can use the PSA Look-up Tool (www.tricare.mil/PSAZIP) to find out if they live in a PSA.
- ADSMs and ADFMs enrolled in Prime have the highest priority for care at a military hospital or clinic.

Note: There are no PSAs overseas.

3.1 The Role of the Primary Care Manager (PCM)

- Each Prime enrollee has an assigned PCM
    - When enrolling, beneficiaries may note the type of PCM they would like.
    - The contractor assigns a PCM based on the sponsor’s status, beneficiary’s address, PCM availability, and the military hospital or clinic’s commander guidance (given to the contractor for processing military hospital or clinic enrollments and assigning PCMs).
- PCMs:
    - Provide routine, non-emergency, and urgent health care
    - Submit referrals for specialty care and establish medical necessity when needed
- PCMs are:
    - Military hospital or clinic providers (stateside and overseas)
    - Civilian network providers (doesn’t apply overseas)
    - A team who takes care of the enrollee if the individual’s PCM isn’t available
- PCMs may be:
    - Internists, family practitioners, pediatricians, general practitioners, or obstetricians/gynecologists
    - Physician assistants, nurse practitioners, and certified nurse midwives

3.2 Prime Eligibility

Stateside	● ADSMs and ADFMs ● Transitional survivors and survivors ● Certain unremarried former spouses ● Retirees and retiree family members ● Certain National Guard/Reserve members and their eligible family members when: ○ The sponsor is on active service for more than 30 consecutive days; or ○ The sponsor is issued delayed-effective date orders for active service for more than 30 consecutive days in support of a contingency operation ▪ In either case, the sponsor must show as eligible in DEERS (See the *National Guard and Reserve* module for more information.) ● Medal of Honor recipients and their eligible family members
Overseas	● ADSMs permanently assigned to and living near a military hospital or clinic ● ADFMs or family members of activated National Guard/Reserve members on permanent change of station orders and command sponsored to go with the sponsor overseas* ● ADFMs on service-funded orders to an overseas location without the sponsor ● National Guard or Reserve members on active service for more than 30 consecutive days and showing as eligible in DEERS, with final assignment to a TOP Prime location ● Family members of activated National Guard or Reserve members, if they lived with the Guard or Reserve member in a TOP Prime location at the time of the sponsor's activation

* *Only ADFMs who meet the Joint Federal Travel Regulation (JFTR) definition of command sponsored are eligible to enroll in TOP Prime, except for transitional survivors and certain Guard or Reserve family members. JFTR defines command-sponsored as, "entitled to travel to overseas commands at government expense and endorsed by the appropriate military commander to be present in a family member status."*

3.3 Prime Enrollment and PCM Assignment

- Enrollment is required.
- ADSMs are mandated to enroll in Prime or follow service-specific guidance based on their assignment and location. They aren't automatically enrolled.
- All active duty, whether enrolled or not, have to get referrals and authorizations for other than routine care (line or duty, fitness for duty review). **Their claims process with no copay for covered services**.
  - ADSMs stationed in Canada and their command-sponsored ADFMs get care from Canadian Forces Health Care Facilities. (See Appendix A of this module for more information.)
- Non-ADSMs can voluntarily enroll on an individual or family basis.
- Beneficiaries can enroll by:
  - Calling the regional contractor
  - Using the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe. BWE may be available overseas for those located near a military clinic or hospital in early 2017.
  - Mailing a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) with the initial enrollment fee (if needed) to the regional contractor
- PCM assignment starts the date the contractor gets the enrollment request.
- Upon request, the contractor will assign a PCM at a military hospital or clinic for ADFMs of E-1–E-4 sponsors as long as the ADFMs live within a PSA.

3.3.1 For Other than Active Duty Service Members (ADSMs)

- **Stateside**: The regional contractor must get the enrollment request and fee (if needed) by the 20th of the month for Prime to start on the first day of the following month. If the contractor gets the enrollment request after the 20th, Prime starts on the first day of the second month (20th-of-the month rule).
    - Example: If the contractor receives the application on December 19, Prime enrollment is effective January 1. If the contractor receives the application on December 22, Prime enrollment is effective February 1.
- **Overseas**: TOP Prime starts on the day the contractor receives all necessary information. The enrollment request must have the command-sponsorship orders for family members. If using BWE (when available) or enrolling by phone, the sponsor or family just has to note the sponsor's order number and date.
    - The 20th-of-the-month rule doesn't apply to TOP Prime.
- Eligible beneficiaries have TRICARE Standard until TRICARE Prime starts.
- Each enrollment period is 1 fiscal year (October 1–September 30).
- Enrollment renews automatically, unless:
    - The enrollee chooses to disenroll (ADSMs can't disenroll)
    - The enrollee is no longer eligible for Prime or TRICARE benefits (i.e., member retires, the Guard or Reserve member is deactivated, family members age out or aren't command sponsored)

3.3.2 Prime Enrollment Fees

- ADSMs and ADFMs don't pay enrollment fees.
- All others pay an annual enrollment fee (individual or family) per fiscal year. Enrollment fees usually change each fiscal year.
    - Survivors of active duty sponsors along with medically retired uniformed service members and their eligible family members have their enrollment fees frozen at the rate in effect at the time they become survivors or medically retired and enroll in Prime. (Doesn't apply to TRICARE Young Adult (TYA) Prime. See the *Other Benefits* module for more information on TYA.)
        - The fee stays frozen as long as the spouse or 1 family member is Prime.
    - Enrollees may pay fees on an annual or quarterly basis, or by monthly allotment.
    - Enrollees who pay monthly must include an initial 3-month payment with their completed enrollment form. All ongoing payments must be electronic.
        - Electronic payments include credit/debit cards, electronic fund transfers (EFTs), or allotment from retirement pay (set up through the regional contractor or through uniformed service finance centers).
- The enrollment fee is waived for any enrollee who has Medicare Part B and is under age 65.
- TRICARE has a limited refund policy. In most cases, the contractor won't refund enrollment fees. Beneficiaries who are close to turning 65 shouldn't choose the annual payment option.
- Prime isn't an option for beneficiaries eligible for premium-free Medicare Part A at age 65 or older.
- For current Prime enrollment fees visit www.tricare.mil/primecosts.

3.3.3 Prime Lockout and Disenrollment

- Prime enrollees (other than ADSMs) can disenroll at any time. The regional or TOP contractor may deny re-enrollment (enrollment lockout) for 12 months to:
    - ADFMs of sponsors E-5 and above who enroll and disenroll more than twice in an enrollment year
        - This doesn't apply to ADFMs of sponsors E-1 through E-4
    - Those who voluntarily disenroll before the annual enrollment renewal date (October 1)
    - Those who don't pay their required enrollment fees
- The TOP contractor disenrolls TOP Prime enrollees 60 days after an overseas assignment.

4.0 Prime Costs

- ADSMs and ADFMs have no costs for TRICARE-covered services, as long as they get non-emergency, routine care from their PCM and have the right referrals and authorizations for specialty or urgent care not available from their PCM.
- All enrollees except ADSMs pay pharmacy cost-shares. (See the *Pharmacy* module for more information.)

Status	ADFM E-1–E-4	ADFM E-5 and Up	Retirees/Family Members, Eligible Former Spouses, and Survivors
Enrollment Fee	$0		For the most up-to-date enrollment fees, visit www.tricare.mil/primecosts
Copayments	$0		● $12 per outpatient visit ● $12 per outpatient mental health visit ● $20 per ambulance service occurrence ● $30 per emergency room visit
Deductibles	N/A		N/A
Catastrophic Cap	$1,000 per family, per fiscal year		$3,000 per family, per fiscal year
Network Inpatient Cost-Share (Stateside)	$0 per admission		$11 per day or $25 per admission, whichever is greater; no charge for separately billed professional charges
Network Inpatient Mental Health (Stateside)	$0 per admission		$11 per day or $25 per admission, whichever is greater; no charge for separately billed professional charges
Overseas Provider	$0 per admission		N/A

4.1 Point-of-Service Option

- The point-of-service (POS) option lets Prime enrollees get non-emergency care from any TRICARE-authorized or overseas provider without a referral.
  - ADSMs can't use the POS option. If ADSMs get care without the proper referral authorization, TRICARE may deny the claim.
- Enrollees pay more out of pocket using the POS option. POS has its own deductible. POS out-of-pocket costs don't apply to the annual catastrophic cap.

4.1.1 POS Costs

POS Charges	Individual	Family
Deductible Per Fiscal Year	$300	$600
Cost-Shares for Outpatient Claims	50% of TRICARE-allowable charge after meeting the POS deductible*	
Cost-Shares for Inpatient Claims	50% of TRICARE-allowable charge*	

* *50% cost-share applies even after the beneficiary met the catastrophic cap for the fiscal year.*

4.1.2 POS Doesn't Apply in the Following Situations:

- Emergency department services for emergency care
- Certain preventive care services from network providers
- The first 8 outpatient behavioral health visits from a network provider
- TOP Prime-enrolled ADFMs who get TRICARE-authorized care within 60 days of permanent transfer to the U.S.
- Care for newborns and adopted children during the first 60 days stateside or 120 days overseas when they're deemed Prime (See Section 7.0 of this module for more information.)
- When an enrollee has other health insurance (OHI)

4.1.3 POS Example

- A TRICARE-authorized provider sees a Prime-enrolled ADFM for medically necessary, TRICARE-covered specialty care.
- The family member didn't get a referral from his or her PCM or authorization from the regional contractor.
- TRICARE's allowable charge is $850.00. Remember, under POS, the enrollee pays the POS deductible and a 50% cost-share.

TRICARE-allowable charge	$850
Beneficiary pays POS deductible (individual rate)	$300
TRICARE-allowable charge after the deductible	$550
Beneficiary pays 50% cost-share of TRICARE-allowable charge after the deductible	$275 (50% of $550)
Balance	**$275** **($550 - $275)**
TRICARE pays the other 50%	$275 (50% of $550)
Beneficiary's total out-of-pocket cost ($300 deductible + $275 cost-share)	**$575**

?	The Matthews are moving to a PSA. What are the difference(s) between their TRICARE Prime and Standard benefits? What do the Matthews have to do to show as Prime in DEERS?

5.0 Prime Types of Care

5.1 Getting Urgent Care

Prime enrollees have 3 options for urgent care:

- Get urgent care from their PCM
- Get a referral from their PCM or a pre-authorization from the Nurse Advice Line (NAL) to get urgent care from a different provider
    - Stateside beneficiaries or overseas beneficiaries traveling or moving stateside may call the NAL 24 hours a day, 7 days a week for advice on urgent health concerns.
    - Registered nurses help beneficiaries decide if self-care is the best option, or if they need a health care provider.
    - If immediate treatment is needed, the NAL helps beneficiaries find the nearest health care facility or facilitates a referral for urgent care.
    - The NAL number is 1-800-874-2273, option #1.
    - Beneficiaries living in the Eurasia-Africa region have access to an overseas NAL. (See Appendix B for country-specific numbers.)
- Get urgent care from any TRICARE-authorized provider through the Urgent Care Pilot Program
    - Each enrollee gets 2 urgent care visits per fiscal year without a referral or authorization
        - POS deductible and cost shares don't apply for the 2 visits
    - Applies to:
        - TRICARE Prime enrollees (except ADSMs)
        - TRICARE Prime Remote enrollees (including ADSMs)
        - TYA Prime enrollees
        - TOP Prime & TRICARE Prime Remote Overseas enrollees but **only when traveling stateside** (there's no limit to the number of unauthorized urgent care visits).
    - Under the Pilot, enrollees can see any of the provider types below as long as they're part of the TRICARE network or TRICARE-authorized:
        - Urgent Care Center
        - Convenience Clinic
        - General and/or Family Practice
        - Internal Medicine
        - Pediatrician
        - Obstetrician/Gynecologist
        - Physician Assistant
        - Certified Nurse Midwife

5.2 Getting Emergency Care

- Prime enrollees should go to the nearest emergency room.
  - **Stateside**: Enrollees are encouraged to contact their PCM or regional contractor within 24 hours of getting emergency care or admission to an inpatient facility. This is especially important for claims processing and follow-up care (if needed).
  - **Overseas**: Enrollees should call the TOP Regional Call Center or country-specific call center within 24 hours of getting emergency care or admission to an inpatient facility (stateside or overseas).
- The contractor may need copies of emergency treatment records to process the claim. If the ER diagnosis doesn't support the need for emergency services, the claim may process as POS.

Note: See Appendix A of this module for information on active duty emergency care when assigned to Canada.

5.3 Referrals and Authorizations for Specialty Care

- When Prime enrollees need specialty care, their PCM writes a referral. The enrollee should have an authorization ***before*** making an appointment to avoid POS charges.
- Enrollees may be directed to get specialty care at a military hospital or clinic.
- Getting the referral authorized is a multi-step process:

Stateside	● The PCM sends the referral electronically or by fax to the regional or overseas contractor. ○ Under right of first refusal (ROFR), the military hospital or clinic has 90 minutes to accept urgent referrals and 2 business days to accept routine referrals. If the facility doesn't accept the referrals within those times, the referral is considered denied by the hospital or clinic and returns to the contractor for action. ○ Regional contractor staff conducts a benefit review and approves (authorizes) or denies the care. ● The regional contractor sends a letter to the enrollee with the name of the provider (military hospital or clinic or civilian network) and the referral authorization. The letter notes the dates the authorization covers, to include the type and number of visits. ○ Enrollees may check on the authorization's status by calling the regional contractor's toll-free number or checking the contractor's website (if available). ● Enrollees must contact the specialty provider(s) listed on the authorization letter to make an appointment or call the regional contractor to ask for a different provider. ● Enrollees should take their PCM's or regional contractor's phone number (listed on their enrollment card) to their specialty appointment in case there are questions.
Overseas	● TOP Prime enrollees referred to an overseas provider can expect a "cashless, claimless" episode of care, as long as the care is properly coordinated and authorized through the TOP contractor. ● All referred care, whether written by a military hospital or clinic or overseas provider, must be authorized. ○ The TOP contractor conducts a benefit review and approves (authorizes) or denies the care. ● If approved, the TOP contractor arranges for care from an overseas provider, gives the TOP Prime enrollee information on that provider, and may help coordinate the appointment. ○ Before making an appointment, the enrollee must confirm the authorization through his or her regional or country-specific call center. **Note:** See Appendix A of this module for information on getting specialty care in Canada.

- Authorizations don't carry over from 1 region to another. Authorizations also don't carry over when an enrollee goes from active duty to retiree status or from active duty to inactive status after separation.
- When enrollees move to a new region, they need to get new specialty care referrals and authorizations from their new PCM or regional contractor.
- If TOP Prime family members seek any TRICARE-covered, non-emergency care without a referral, they have 3 business days to request a referral from their PCM.
  - If the PCM provides a referral, the claim processes as TOP Prime.
  - If more than 3 days pass or the PCM denies the referral request, the claim processes as POS.
  - If the PCM issues a referral after 3 days, it must be reviewed and approved by the TAO or TOP Office.

Note: The contractor may authorize the enrollee to see a non-network specialist if there's no network specialist within access standards.

?	Bill's current treatment isn't effective, so his PCM writes a referral to a specialist. What steps should the Matthews take to ensure Bill has an appointment?

5.3.1 Stateside TRICARE Prime Travel Benefits for Specialty Care

- Stateside Prime enrollees, except for ADSMs, qualify for the Prime Travel Benefit
  - This benefit isn't available overseas.
  - Service personnel and medical assets arrange for ADSM medical travel. The travel must follow JFTRs.
- The Prime Travel Benefit reimburses enrollees for their travel expenses when:
  - Their PCM refers them for medically necessary, non-emergency care
  - The specialty care provider is more than 100 miles (1-way) from their PCM's office
    - The contractor uses the Defense Table of Official Distance to determine the distance.
    - Rule is set in statute and not negotiable
    - There is an exception for Coast Guard ADSMs. (See the *2008 TRICARE Reimbursement Manual*, Chapter 1, Section 30.)
  - There is no other specialty care provider (uniformed service, network, or non-network) within 100 miles
- Military hospital or clinic-assigned enrollees should contact the Prime travel benefit point of contact (POC) for information on the benefit and payment process as soon as they are referred and before they travel.
- Civilian PCM-assigned enrollees must contact the travel benefit POC at the TRICARE Regional Office (TRO) for their region.
- For more information on the Prime travel benefit, visit www.tricare.mil/travelreimbursement

6.0 TRICARE Prime Portability

Prime coverage is portable, meaning Prime enrollment can move with an enrollee to a new location— with no break in Prime coverage—as long as Prime is available in the new location.

- Enrollees can either transfer enrollment (move between regions) or choose new PCMs (move within a region) to avoid POS charges and a break in Prime coverage when they move.
- Stateside and overseas Prime enrollees may complete both enrollment transfers and PCM changes by:
  - Calling the losing or gaining contractor
  - Using the BWE website at www.dmdc.osd.mil/appj/bwe
  - Mailing a new *DD Form 2876* to the contractor
- Enrollees can use the methods to transfer between Prime and Prime Remote.

6.1 Transferring Prime within the Same Region

- Enrollees must update their address in DEERS (use BWE, milConnect, or call DMDC) or notify the regional contractor of their address change.
- Enrollees confirm PCM assignment by calling the contractor or checking milConnect.

6.2 Transferring Prime to a Different Region

- When moving to a new region, Prime enrollees **shouldn't** disenroll from their current region until they arrive at their new location. Staying enrolled ensures they have no break in Prime coverage. Enrollees must update their address in DEERS for the transfer to take place.
- While traveling to the new location, enrollees must get referrals from their PCM and authorization from their current regional contractor before getting non-emergency, specialty, or inpatient care to avoid POS charges.
- Enrollment transfers are effective the date the gaining regional contractor confirms the transfer via phone call or processes a completed enrollment. (ADSMs and ADFMs may also start and confirm their transfer with their old regional contractor.)
- The gaining regional contractor assigns a new PCM and provides region- or site-specific TRICARE educational materials and key telephone numbers.

6.3 Transfer Frequency and Enrollment Fees

- The number of moves within the same region per enrollment year is unlimited; enrollees must update their address in DEERS. Enrollees must request a PCM change if they move to a new PSA.
- Prime-enrolled retirees and their family members who move from 1 region to another and back to their original region can transfer their enrollment twice per enrollment year. Getting the same PCM isn't guaranteed.
- After transferring to a new region, enrollment fees are billed by and paid to the gaining regional contractor.

6.4 Moving to a Location Outside of a Prime Service Area

- Enrollees can be covered by TRICARE Prime while moving to a location that isn't a PSA.
- Upon arrival at the new location, enrollees must update their address in DEERS and call the regional contractor or go to the BWE website to:
    - Transfer their enrollment to TRICARE Prime Remote/TRICARE Prime Remote for ADFMs, or TOP Prime Remote (ADSMs and qualifying ADFMs only)
    - Disenroll and use Standard and Extra (other than ADSMs)
- If an enrollee moves outside of a PSA, but wants to stay Prime, he or she must note on their enrollment form they are willing to waive Prime drive time standards. Enrollment is then based on where they live and if there are Prime network providers available within 100 miles of their residence. The uniformed service facility commander or TRO must approve the enrollment request.
    - If approved, enrollees travel a longer distance to see their assigned PCM and network specialty providers. Prime rules still apply (e.g., using a PCM for routine care, getting specialty referrals and authorizations).

6.5 Split Prime Enrollment between Different TRICARE Regions

- Split enrollment offers families the option to enroll 1 or some members in a different Prime region than other family members. The sponsor or legal guardian must enroll family member(s) to the region where other family member(s) live.
- Enrollment fees:
    - The family may pay a family enrollment fee to 1 regional contractor or split the family fee between 2 contractors. Regional contractors can help with this process.
    - Enrollment fee payment is recorded in DEERS.

?	6 months after the family's first move, SrA Matthews is told he's being transferred to a PSA in a different region. What should his family do to ensure a smooth transfer to the new region without a break in Prime coverage?

7.0 Traveling with Prime

7.1 Stateside Prime Enrollees Getting Care When Traveling Overseas

When traveling overseas, Prime enrollees have the same access to care at military hospitals or clinics as TOP Prime enrollees.

- Enrollees should schedule all routine care before traveling to avoid POS charges.
    - Routine care generally isn't authorized when traveling outside an assigned enrollment region. Exceptions are made on a case-by-case basis and include a PCM referral and authorization from a regional contractor.
- When overseas, Prime enrollees must contact the TOP contractor to get an authorization when getting urgent or specialty care.
    - Prime enrollees must send all claims for overseas care to the overseas claims processor, not the stateside claims processor where they're enrolled.
- When Prime enrollees get care onboard commercial seagoing vessels outside U.S. territorial waters, they pay up front and then file a claim with the overseas claims processor.

7.2 TOP Prime Enrollees Getting Care When Traveling Stateside

When traveling in the U.S., TOP Prime enrollees have the same access to care at military hospitals and clinics as stateside TRICARE Prime enrollees.

- Enrollees should schedule all routine care before traveling stateside to avoid POS charges.
    - Routine care is generally not authorized stateside for TOP Prime enrollees. Exceptions are made on a case-by-case basis.
    - Routine care stateside requires a referral from the TOP Prime enrollee's PCM, with appropriate justification of the circumstances, and an authorization from the TOP contractor.
- When stateside, TOP Prime enrollees must contact their overseas regional call center or the TOP contractor's **stateside** call center for authorization for services other than emergency care. Visit the TOP contractor's website at www.tricare-overseas.com/contactus for contact information.
- TOP enrollees must send all claims to the overseas claims processor. Enrollees should give their overseas residential address and the TOP Prime claims address to stateside providers.
- TOP Prime enrollees traveling or between duty stations should try to get all non-emergency care at military hospitals or clinics whenever possible.
    - Non-emergency and urgent care outside of a military hospital or clinic requires authorization from the TOP contractor. Visit the TOP contractor's website at www.tricare-overseas.com/contactus for contact information.

Note: A TOP authorization for care overseas doesn't carry over to a stateside provider. Equally, a stateside care authorization doesn't carry over to an overseas provider. Enrollees need new referrals and authorizations if getting care outside of their region.

8.0 TRICARE Coverage for Newborns, Pre-Adoptive, and Adopted Children

8.1 Newborn Coverage

- Beneficiaries are encouraged to enroll their newborn in Prime as soon as possible so the child is assigned a PCM for appropriate and timely well-child care.
- By policy, TRICARE Prime covers a newborn for 60 days after birth, as long as another family member is already enrolled in a Prime option ("deemed Prime").
- After the first 60 days, newborn claims process as TRICARE Standard until the newborn is registered in DEERS and enrolled in TRICARE Prime.
    - The TRICARE Regional Director or TRICARE Area Office (TAO) Director may extend Prime for up to 120 days on a case-by-case or regional basis. Currently, there's a regional 120-day waiver for all overseas locations.
- TRICARE eligibility ends on day 366 for any newborn not registered in DEERS

8.2 Pre-Adoptive and Adopted Children Coverage

- Pre-adoptive and adopted children must be registered in DEERS as soon as possible. If not, the child doesn't show as TRICARE eligible.
- Once registered, pre-adoptive and adopted children are covered under TRICARE Prime for 60 days stateside or 120 days overseas as of the date of placement by the court or approved adoption agency, as long as another family member is enrolled in a Prime option.

9.0 US Family Health Plan (USFHP)

The US Family Health Plan (USFHP) is a TRICARE Prime-like option available at community-based, not-for-profit health care systems in 6 service areas of the United States. These areas are based on ZIP code.

9.1 USFHP Designated Providers

Johns Hopkins Medicine Serving Maryland, Washington DC, and parts of Pennsylvania, Delaware, Virginia, and West Virginia 1-800-808-7347 (toll free) www.hopkinsmedicine.org/usfhp	**Martin's Point Health Care** Serving Maine, New Hampshire, Vermont, upstate and western New York, and the northern tier of Pennsylvania 1-888-241-4556 (USFHP line) www.usfhp.com/martinspoint	**Brighton Marine Health Center** Serving Massachusetts (including Cape Cod), Rhode Island and northern Connecticut 1-800-818-8589 1-888-815-5510 www.usfamilyhealth.org
CHRISTUS Health Serving southeast Texas and southwest Louisiana 1-800-67USFHP (1-800-678-7347) http://christus.usfhp.com	**Pacific Medical Centers (PacMed Clinics)** Serving the Puget Sound area of Washington State 1-888-958-7347 www.pacificmedicalcenters.org	**Saint Vincent Catholic Medical Centers of New York** Serving New York City, Long Island, Southern Connecticut, New Jersey, and Philadelphia and area suburbs 1-800-241-4848 www.usfhp.net

9.2 USFHP Eligibility

Eligible beneficiaries must be registered in DEERS and live within 1 of the designated USFHP service areas.

Eligible	Not Eligible
● ADFMs, transitional survivors, and incapacitated children until they lose eligibility (See Appendix A of the *Key TRICARE Concept and Terms* module for more information.) ● Young Adults who qualify for TYA Prime. ● Retired service members, their spouses, and unmarried dependent children (until they lose eligibility) ● Medicare-TRICARE eligible beneficiaries under age 65 (and those 65 or older who enrolled in USFHP **before** September 30, 2012) ○ Medicare-TRICARE eligible beneficiaries under age 65 who enroll in USFHP after September 30, 2012 can't stay enrolled in USFHP when they turn 65. They become TRICARE For Life (TFL) as long as they have Medicare Part B. ● Eligible unremarried former spouses of active duty or retired service members ● Certain former ADSMs, including Guard/Reserve members and eligible family members during their Transitional Assistance Management Period (TAMP).	ADSMs Selected Reserve Members Retired Reserve Members Retirees and their eligible family members who are 65 and older can't enroll in USFHP

9.3 USFHP Enrollment

- Enrollment is open all year.
- There are no enrollment fees for ADFMs or Medicare-eligible beneficiaries who have Medicare Part B. All others pay an annual enrollment fee that is the same as the TRICARE Prime enrollment fee. For current USFHP enrollment fees visit www.tricare.mil/costs.
- Beneficiaries may enroll in one of 3 ways:
  - Calling the USFHP contractor
  - Online through the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe
  - Mail a *DD Form 2876,* along with any enrollment fees (if needed) to the USFHP contractor
- Enrollment renews automatically each fiscal year, unless:
  - The enrollee chooses to disenroll
  - The enrollee isn't eligible for USFHP or TRICARE benefits (i.e., lives outside the USFHP area, a sponsor separates or is deactivated, family members age out)

9.4 USFHP Coverage

- USFHP relies on PCMs to arrange all of an enrollee's health care needs.
- Covered benefits are available **only** from USFHP-approved providers.
  - USFHP enrollees must get specialty referrals from their PCM and use USFHP network providers and facilities for specialty services.
  - USFHP offers the POS option, allowing enrollees to seek specialty care without a referral.

9.5 USFHP Costs

- USFHP-approved providers file claims for enrollees. Enrollees are only responsible for applicable copayments and POS costs.
- USFHP costs are the same as TRICARE Prime.

9.6 USFHP Prescription Coverage

- USFHP offers beneficiaries various ways to get medications, including a home delivery program (See www.usfhp.com for more information).
- USFHP prescription coverage is unique, but the costs are the same as the TRICARE Pharmacy Program.

9.7 Benefit Limitations

USFHP enrollees agree not to use the following health care options:

- TRICARE Standard and Extra, TFL, and other TRICARE programs
- TRICARE Pharmacy Program (including Home Delivery, TRICARE network pharmacies, and military pharmacies)
- Military hospitals or clinics, with the following exceptions:
    - Enrollee needs emergency care and the nearest emergency room is in a military hospital or clinic
    - Enrollee needs services USFHP doesn't cover, such as routine hearing tests (if there's space available at a military hospital or clinic)
    - Enrollee has a referral and authorization to get care at a military hospital or clinic, based on a memorandum of agreement between the hospital or clinic and USFHP
- Medicare Part A or Part B (except for services USFHP doesn't routinely cover, such as chiropractic care)

Note: Beneficiaries may compare USFHP to other TRICARE plans at www.tricare.mil/compareplans

9.8 USFHP Portability

- When enrollees move within their current USFHP's zip code-defined service area, they must notify USFHP of their new address and choose a new PCM (if desired).
    - USFHP sends a new membership card with the new PCM's name and phone number.
- Prime enrollees may also transfer between Prime and USFHP as long as it's available in their area.
- If enrollees move to an area where USFHP is offered through a different USFHP system, they may transfer their enrollment.
- If enrollees move to an area where USFHP isn't available and they qualify for TRICARE Prime or Prime Remote, they can transfer their enrollment to those plans. Otherwise, they disenroll and are covered under TRICARE Standard and Extra or TFL, depending on their Medicare status.

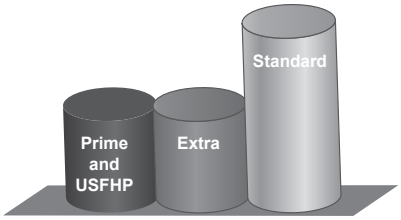
9.9 Getting Medical Care While on Vacation

For medical emergencies, USFHP enrollees should go to the nearest civilian medical facility or military hospital or clinic. Enrollees, or an authorized representative, should call the USFHP provider's toll-free number (located on the back of the USFHP enrollment card) or their PCM within 24 hours, even when traveling overseas. Claims (stateside and overseas) should be sent to the address on the enrollee's USFHP enrollment card.

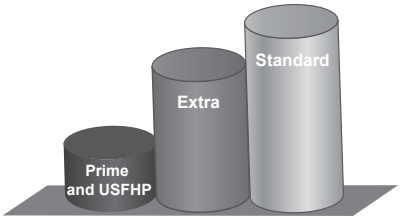
10.0 TRICARE Options Overview

- **TRICARE Standard** offers the freedom to get care from any TRICARE-authorized provider.
  - Available overseas (including U.S. territories) as TOP Standard
  - No enrollment forms or fees
  - Deductibles and cost-shares apply
  - Beneficiaries may have to file claims
- **TRICARE Extra** offers Standard beneficiaries a cost-share discount for using a TRICARE network provider.
  - Not available overseas
  - No enrollment forms or fees
  - Deductibles and cost-shares apply
  - 5% percent cost-share discount
  - No claims to file (network provider files for beneficiary)
- **TRICARE Prime** is an option where a PCM coordinate's the enrollee's care.
  - Available stateside in PSAs
  - Available in designated areas overseas as TOP Prime
  - Enrollment required
  - Specialty care requires a PCM or regional call center referral and contractor authorization
  - No copayments for ADSMs or ADFMs (fixed copayment for most services for all others)
  - No claims to file if using network providers, who file claims for enrollees
- **USFHP** is a Prime-like option available at community-based, not-for-profit health care systems in 6 areas of the United States.
  - Beneficiaries must live within the designated USFHP service area
  - Enrollment required
  - Specialty care requires a PCM referral and USFHP authorization; have to use USFHP providers
  - Not available overseas
  - Costs are the same as TRICARE Prime
  - No claims to file (USFHP provider files for enrollees)

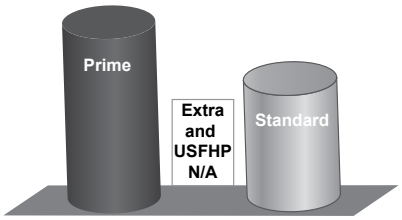
10.1 Comparing TRICARE Options



Freedom of Choice



Out-of-Pocket Costs



Access to MTF

- If freedom of choice is the most important factor to a beneficiary (other than an ADSM), he or she should choose TRICARE Standard
- If cost savings is the most important factor, TRICARE Prime or USFHP (if available) is the best option. TRICARE Extra is next best option because of the cost-share discount.
- If getting care at a military hospital or clinic is the most important factor, TRICARE Prime is the best option. Prime gives enrollees higher priority for care within a military hospital or clinic.

Module Objectives

Stateside Objectives:

- **Explain the differences between TRICARE Standard®, TRICARE Extra, TRICARE Prime®, and the US Family Health Plan (USFHP)**
- **Explain the costs associated with the basic TRICARE options**
- **Describe the point-of-service (POS) option**
- **Describe the TRICARE Prime Travel Benefit**

Overseas Objectives:

- **Describe the TRICARE Overseas Program (TOP)**
- **Explain TOP health care coverage options**
- **State the relationship between command sponsorship and TOP**

Key Terms

- **TRICARE Standard**
- **TRICARE Overseas Program (TOP) Standard**
- **TRICARE Extra**
- **TRICARE Prime**
- **US Family Health Plan (USFHP)**
- **TOP Prime**
- **Primary Care Manager (PCM)**
- **Point-of-Service Option (POS)**

Appendix A: Getting Care in Canada

Routine Care in Canada

- An informal agreement, based on historical reciprocal health care agreements between the United States and Canada, letting ADSMs stationed in Canada and their command-sponsored ADFMs get inpatient and outpatient no-cost medical services at Canadian Forces Healthcare Facilities (CFHFs).
- ADSMs can also get no-cost dental care at CFHFs.
- Service areas include these Canadian provinces:

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

Emergency Care in Canada

- ADSMs and command-sponsored ADFMs must contact the CFHF or U.S. Embassy within 24 hours, or as soon as possible, after getting emergency care or when admitted as an inpatient. Timely reporting of emergency care is needed for possible transfer to another Canadian facility or to the United States.
- TOP Prime enrollees who are age 17 or younger and live in Ottawa should get emergency care from Children's Hospital of Eastern Ontario (if it's the nearest emergency facility).

Specialty Care in Canada

- To get specialty care outside of the CFHF, ADSMs and their enrolled family members must get Canadian Blue Cross Blue Shield (BCBS) insurance.
    - To do this, ADSMs and eligible family members need to complete a BCBS registration form and get it to their TOP POC. The POC then faxes it to the to the Canadian BCBS Headquarters. The TOP POC is at the nearest U.S. embassy.
- The CFHF refers beneficiaries to overseas providers for specialty care.
- Service and family members must present their BCBS card to the overseas provider when checking in for an appointment.

Note: "Cashless, claimless" care is coordinated by the TAO or Canadian Forces—not the overseas contractor.

Appendix B: Overseas Nurse Advice Line (NAL) Directory

DNIS Name	Universal International Free Number (UIFN) Phone #	AT&T Direct Service Access Code (Dial access code then 1+800#)	ASIT (International) 800 Number	Call Center 800# routing
Bahrain	no UIFN#	N/A	8000-0453 = ITFS	888-475-9233
Belgium	00-800-4759-2330	00-800-4759-2330	0800-71920 = ITFS	800-625-7472 (Also GIS #0800 80149)
Denmark	00-800-4759-2330	800-100-10	800-17357 = ITFS	888-217-0048
Germany	00-800-4759-2330	0-800-225-5288	0800-825-1600 = ITFS	800-625-7461
Greece	no UIFN#	00-800-1311	00-800-11-815-3044 = ITFS	888-835-0923
Italy	00-800-4759-2330	800-172-444	800-877660 = ITFS	800-625-7478
Italy	800-788847	N/A	N/A	888-456-1114 (UIFN local free number)
Netherlands	00-800-4759-2330	0800-022-7111	0800-022-7944 = ITFS	800-711-6093
Norway	00-800-4759-2330	800-190-11	800-12635 = ITFS	888-217-0047
Spain	00-800-4759-2330	900-99-0011	900-93-1193 = ITFS	888-835-0925
Turkey	no UIFN#	0811-288-0001	00-800-13-815-9042 = ITFS	888-835-0960
United Kingdom	00-800-4759-2330	0800-89-0011	0800-96-3115 = ITFS	800-625-7458
Portugal	00-800-4759-2330	800-800-128	N/A	888-866-7943

TRICARE Fundamentals Course

Prime Remote Options

3

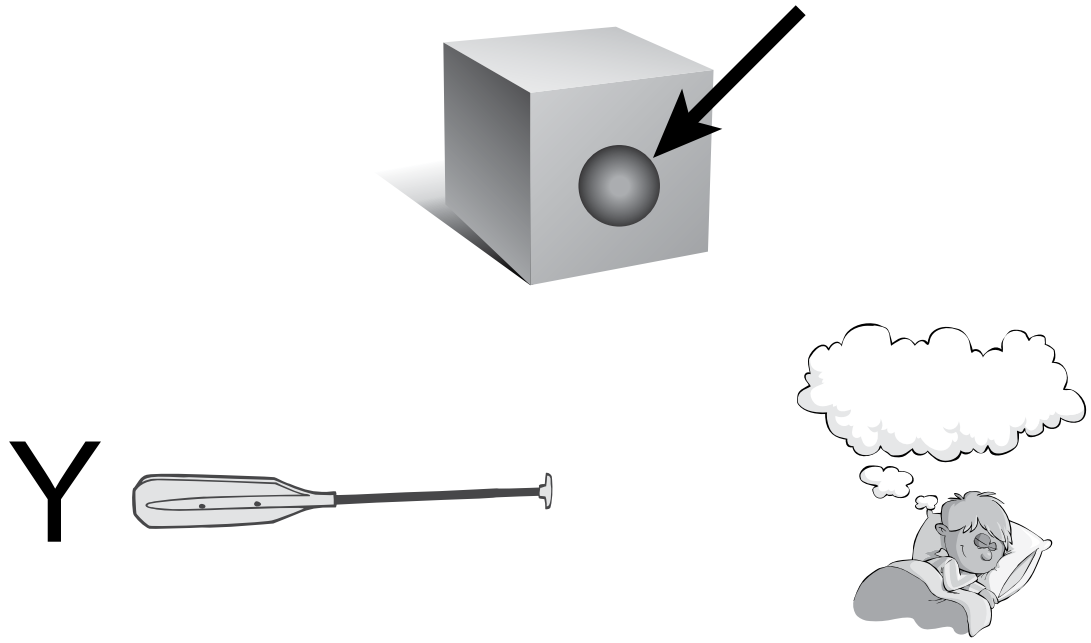
Participant Guide

References

10 USC
32 CFR § 199, 199.20
National Defense Authorization Act (NDAA)
2008 TRICARE Operations Manual, Chapter 16; Chapter 24: Sections 12, 18

Brainteaser

What phrase is represented below?



Riddle

It is the beginning of eternity, the end of time and space, the beginning of the end, and the end of every space. What is it?

Module Objectives

- **Define the TRICARE Prime Remote Options**
- **Identify who is eligible for Prime Remote**
- **Explain how Prime Remote enrollees access health care**
- **Describe the role of the Defense Health Agency – Great Lakes (DHA-GL) (formerly known as MMSO) or TRICARE Overseas Program (TOP) Points of Contact (POCs)**

Key Terms

- **TRICARE Prime Remote (TPR)**
- **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)**
- **TRICARE Overseas Program (TOP) Prime Remote**
- **Defense Health Agency – Great Lakes (DHA-GL)**
- **TOP Point of Contact (POC) Program**

?	Throughout this module, you'll answer scenario questions on active duty service member Corporal Williams and his wife.

1.0 TRICARE Prime Remote Options

Under Prime Remote:

- Enrollees get primary, preventive, and specialty care as if they are Prime. Enrolled family members don't pay for most health care services.
  - They pay copays when they use retail pharmacies or TRICARE Pharmacy Home Delivery
  - They also pay copays when they get care under the point-of-service (POS) option
  - Active duty service members (ADSMs) pay out of pocket when they don't get prior authorization for non-routine care.
- Enrollees can call their regional contractor or go online for help
- **Overseas:** The contractor handles enrollees' medical transportation needs.

Current unit and personal contact information must be in the Defense Eligibility Enrollment Reporting System (DEERS). This determines if ADSMs and active duty family members (ADFMs) should be Prime or Prime Remote.

1.1 TRICARE Prime Remote (TPR) (United States)

TRICARE Prime Remote (TPR) is a stateside option for ADSMs. ADSMs have to live and work in TPR-designated ZIP codes (greater than 50 miles or 1-hour drive time from a military hospital or clinic).

1.2 TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

TRICARE Prime Remote for Active Duty Family Members (TPRADFM) is a Prime-like option for eligible ADFMs. Family members have to live with their active duty sponsor in stateside TPR locations. There are some exceptions for Guard/Reserve members. (See the table on the next page.)

1.3 TRICARE Overseas Program (TOP) Prime Remote

TRICARE Overseas Program (TOP) Prime Remote offers Prime coverage to ADSMs assigned to specific remote locations. Only command-sponsored ADFMs can enroll in TOP Prime Remote (as defined in the Joint Federal Travel Regulation [JFTR]). Transitional survivors and certain Guard/Reserve family members don't have to be command-sponsored.

Note: In this module, "Prime Remote" refers to TPR, TPRADFM, and TOP Prime Remote unless otherwise stated.

2.0 Prime Remote Enrollment Eligibility

Who Can Enroll	Who Can't Enroll
● ADSMs ● Guard/Reserve members on active service for more than 30 consecutive days ● Eligible family members ● Transitional survivors	● Retirees and their eligible family members ● Survivors ● Unremarried former spouses ● ADSMs and ADFMs during their Transitional Assistance Management Program (TAMP) ● ADFMs who: ○ Don't live with the sponsor ○ Aren't command sponsored

Stateside (TPR/TPRADFM) Enrollment Eligibility

TPR

- ADSMs and eligible Guard/Reserve members must be permanently assigned to and live more than 50 miles or more than a 1-hour drive from a military hospital or clinic (based on ZIP code).
  - To see if they qualify for TPR, send ADSMs to the TPR ZIP Code Look-up Tool at www.tricare.mil/tpr.
- If living within 50 miles of a military hospital or clinic, most ADSMs can't enroll in TPR. However, if they have to drive more than 1 hour to get care, they can ask to enroll in TPR and get a civilian network provider.
  - These ADSMs should complete a *TRICARE Prime Remote (TPR) Determination of Eligibility Enrollment Request Form*. They submit it through their unit commander to the TRICARE Regional Office (TRO). For information and the form, direct service members to:
    - North Region: www.tricare.mil/TPRFormNorth
    - South Region: www.tricare.mil/TPRFormSouth
    - West Region: www.tricare.mil/TPRFormWest

TPRADFM

The following may enroll in TPRADFM:

- ADFMs, as long as:
  - The sponsor has TPR
  - They reside (live) with the sponsor ("resides with" is defined as the address where the family lives while the sponsor is TPR, as recorded in DEERS)
  - They don't live in a Prime Service Area (PSA)
- Transitional survivors living in defined Prime Remote-locations
- Activated Guard/Reserve family members, as long as:
  - They lived with the Guard/Reserve sponsor when he or she was activated
  - The activated sponsor's address in DEERS was in a TPR ZIP code
  - The family members continue to live at that same address
  - They don't live in a PSA
  - Activated Guard/Reserve don't need to be enrolled in TPR for family members to enroll in TPRADFM.

Overseas (TOP Prime Remote) Enrollment Eligibility

The following may enroll:

- ADSMs on permanent assignment to a designated remote overseas location
- Guard/Reserve members on active service for more than 30 consecutive days with a permanent duty assignment at a remote overseas location
- Command-sponsored ADFMs or Guard/Reserve family members whose sponsor is assigned overseas*
- ADFMs on service-funded orders to move to a remote overseas location without the sponsor
- Transitional survivors who live in TOP Prime Remote-designated locations
- Activated Guard/Reserve family members, as long as the family members lived with the sponsor in a TOP Prime Remote location when he or she was activated

* *JFTR defines command sponsored as, "entitled to travel to overseas commands at government expense and endorsed by the appropriate military commander to be present in a family member status."*

?	Corporal Williams transfers to a new duty station in a mountainous, rural area. The nearest military hospital/clinic is 45 miles away. Due to the terrain, it takes about 90 minutes to drive there. Can Corporal Williams and his wife enroll in TPR? If so, what do they need to do?

3.0 Enrollment

- When an ADSM or activated Guard/Reserve member qualifies for TPR or TOP Prime Remote, he or she must enroll unless there is other service-specific guidance. The ADSM can waive the drive time standard and ask to enroll in Prime at the closest military hospital or clinic. (This requires unit commander and TRO approval.)
- The contractor usually uses the sponsor's work unit location, not his or her home address, for the basis for TPR enrollment (less time away from the duty location when getting routine, urgent, and preventive care).
- ADFMs can decide if they want to enroll in TPRADFM. They may enroll on an individual or family basis.
    - If they don't enroll, they are covered under TRICARE Standard and Extra.

3.0.1 Ongoing Stateside Enrollment

- If a TPR sponsor gets unaccompanied orders (i.e., family can't go with the sponsor), the family can stay in TPRADFM. DEERS has to show they live at the same TPR address they had before the sponsor left.
- Guard/Reserve family members can stay in TPRADFM at the TPR address while the sponsor is on active service. It doesn't matter where the sponsor is assigned, enrolled, or temporarily living.

3.0.2 Ongoing Overseas Enrollment

- When a TOP Prime Remote sponsor goes to a new location that doesn't allow for command-sponsored family members, family member(s) can stay in TOP Prime Remote. They can't move and they have to remain command sponsored.

Note: These family members can stay in TOP Prime Remote while the sponsor is on unaccompanied orders for no more than 2 years. (Most unaccompanied tours are less than 24 months.)

?	Corporal Williams' wife, Allison, isn't sure she wants to enroll in TPR. Does she have other options?

3.1 Enrollment Processing

- Beneficiaries may enroll:
    - By calling the regional contractor
    - Online using Beneficiary Web Enrollment (https://www.dmdc.osd.mil/appj/bwe). BWE may be available overseas for those located near a military clinic or hospital in early 2017.
    - By mailing a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) to the regional contractor.
- Coverage starts:
    - TPR—the date the contractor gets the *DD Form 2876*, BWE transaction, or the member calls to enroll.
    - TPRADFM—the next month or the month after that. (See the *TRICARE Options* module for more on the 20th-of-the-month rule.)
    - TOP Prime Remote—the date the sponsor calls or TOP contractor gets the *DD Form 2876* and orders showing command sponsorship. There is no 20th-of-the-month rule overseas.

- Prime Remote enrollment renews automatically until the sponsor or family member moves, the sponsor's status changes (from active duty to retiree), or the enrollee loses TRICARE eligibility.
- Overseas—Points of Contact (POCs) assist ADSMs and their command-sponsored family members in TOP Prime Remote sites. These POCs can accept and forward enrollment forms and orders to the overseas contractor.

Note: If enrolling by phone, ADFMs confirm command sponsorship by giving the contractor their sponsor's order number and the date on the orders.

3.2 Lockouts and Disenrollment

- The same lockout and disenrollment rules for Prime apply to Prime Remote enrollees. (See the *TRICARE Options* module for more information on Prime.) Enrollees get disenrolled when:
  - The sponsor retires. Prime Remote options are only available to ADSMs and ADFMs. If the family doesn't move when the sponsor retires, the family changes to TRICARE Standard and Extra.
  - The sponsor separates from uniformed service (loss of eligibility).
  - Family members lose command-sponsorship or TRICARE eligibility

4.0 Transferring Prime Remote Options

- Enrollees may transfer Prime Remote coverage within or between regions, or between Prime and Prime Remote. Enrollees have to meet enrollment criteria for where they live. (e.g., Where does the sponsor live and work? Do family members reside with their sponsor? Are they command sponsored?)
- With permanent change of station moves, ADSMs must transfer to another Prime option and location (stateside or overseas), or follow service guidance.
- ADFM enrollment transfers start on the date requested, as long as the family's address in DEERS reflects the new location. Command sponsorship must be in place for TOP Prime Remote.
- When moving or traveling, Prime Remote enrollees follow TRICARE Prime and TOP Prime rules. (See the *TRICARE Options* module on transferring TRICARE coverage when moving and while traveling.)

5.0 Primary Care Management

Stateside (TPR/TPRADFM)
● Enrollees' assigned PCMs are usually local network providers. ● If there's no network provider in the area, enrollees can choose any TRICARE-authorized provider as their primary care provider—they have no assigned PCM. ● TPR/TPRADFM enrollees can ask to change their provider at any time. The new PCM or primary care provider has to be accepting new enrollees.
Overseas (TOP Prime Remote)
● The overseas contractor's call centers serve as the TOP Prime Remote enrollee's PCM. ● The contractor coordinates all medical and dental care for ADSMs. The contractor coordinates only medical care for TOP Prime Remote-enrolled ADFMs. ● The contractor contacts qualified overseas providers and issues care authorizations. With prior authorization, the enrollee's care is "cashless, claimless". ○ "Cashless, claimless" means the TOP Prime Remote enrollee doesn't pay up front for TRICARE covered services. The provider files the claim and the contractor pays the provider.

6.0 Defense Health Agency – Great Lakes (DHA-GL) (Stateside)

- DHA-GL coordinates health care services for most TPR-enrolled ADSMs stateside.
  - Regional contractors send TPR care authorization requests for the Coast Guard through DHA-GL, but the Coast Guard reviews their own TPR ADSM claims if there are problems.
  - The U.S. Public Health Service (PHS) and the National Oceanic and Atmospheric Administration (NOAA) oversee their TPR enrollees.
- DHA-GL authorizes TPR ADSM specialty care. DHA-GL serves as a connector between remote ADSMs, the services, and regional contractors.
- DHA-GL reviews:
  - Referrals and medical claims to assess the ADSM's fitness-for-duty. It may direct the member to go to a military hospital or clinic for care.
  - Certain medical claims held by regional contractors. It approves or denies payment (e.g., claim sent in before DHA-GL authorized the care, the provider didn't get prior authorization, etc.)
- Direct questions to:
  - Defense Health Agency-GL Suite 304

    2834 Green Bay Road

    North Chicago, IL 60064-3091
  - 1-888-647-6676
  - www.health.mil/GreatLakes
  - U.S. Coast Guard: (757) 628-4379
  - PHS: 1-800-368-2777, option #2
  - NOAA: 1-800-224-6622 (NOAA Commissioned Personnel Center)

Notes:

- Please contact DHA-GL for help with TPR ADSM cases. (See the *2008 TRICARE Operations Manual,* Chapter 16, Section 2, Paragraphs 5.2 and 5.3 for basic guidelines on services that need fitness-for-duty review.)
- DHA-GL is also known as the Military Medical Support Office (MMSO)

7.0 Getting Care, Referrals, and Authorization

Under the Prime Remote options, enrollees get routine, urgent, emergency, and specialty care services. Prime Remote is like Prime, with a few exceptions.

7.1 Routine Care

Stateside Routine Care (TPR/TPRADFM)
● TPR/TPRADFM enrollees set up appointments with their assigned PCM or chosen primary care provider.
Overseas Routine Care (TOP Prime Remote)
● A U.S. Embassy (provider or clinic) is the usual source for enrollees' routine health care. If there's no Embassy or it can't meet an enrollee's needs, enrollees must contact the overseas contractor's call center to get an authorization for civilian care. Staff there arranges appointments with local providers.

7.2 Urgent Care

Stateside Urgent Care (TPR/TPRADFM)
● Prime Remote enrollees first contact their PCM, primary care provider, or regional contractor. ● If the PCM/provider can't see or treat the enrollee, the enrollee needs a referral from his or her PCM/ provider. Without a referral, the claims processor may deny payment (ADSMs) or process the claim as POS (ADFMs). ● The regional contractor gets the referral and decides whether to authorize the care. Treatment must be medically necessary and a covered service. ○ The contractor forwards TPR-enrolled ADSMs' referrals to DHA-GL. DHA-GL addresses fitness-for-duty and decides whether to authorize the care. ▪ DHA-GL may require ADSMs to go to a military hospital or clinic, or authorize care from a civilian provider. ○ Enrollees and PCMs/providers should work directly with the regional contractor or DHA-GL on care authorizations.
Overseas Urgent Care (TOP Prime Remote)
● Urgent care is coordinated through the overseas contractor's call centers.

Note: See the *TRICARE Options* module for information on the Urgent Care Pilot Program.

7.3 Specialty Care

- All Prime Remote enrollees must get a referral and authorization before getting specialty care.
  - If approved, the authorization lists the provider's name, the type and frequency of visits, and the end date for services. The contractor sends copies to the enrollee, as well as the referring and specialty provider.
  - If denied (i.e., non-covered service, not medically necessary), the contractor sends notice to the provider and the enrollee telling them of the denial decision.
- If a Prime Remote-enrolled ADFM gets specialty care without a referral, POS charges apply. (See the *TRICARE Options* module for more on POS.)

Stateside Specialty Care (TPR/TPRADFM)
TPR ADSMs ● The regional contractor sends the PCM's/primary care provider's referral to DHA-GL. ● DHA-GL determines if there is a fitness-for-duty impact and decides whether to authorize the care. Staff sends their decision to the regional contractor. ● The contractor sends an authorization notice to the enrollee and the provider(s). **TPRADFM** ● The PCM/primary care provider sends the referral to the regional contractor. ● The regional contractor reviews it. Staff determines if the care/treatment is medically necessary and a covered benefit. ● The regional contractor sends an authorization notice to the enrollee, the referring provider, and the specialty provider (if approved).

Overseas Specialty Care (TOP Prime Remote)
● Enrollees coordinate specialty care through the overseas contractor's call centers. Specialty care overseas includes diagnostic tests. ● Enrollees may set up their own authorized specialty care appointments. They need to give the overseas contractor at least 48 hours advanced notice. This gives the contractor time to prepare the authorization and to give it to the specialty care provider. ● Appointments are "cashless and claimless" if coordinated through the call centers. ○ The TOP contractor sends the authorization notice and payment to the overseas specialty care provider. ● TOP Prime Remote enrollees who get care without prior authorization may have to pay up front and file their own claims. POS charges apply to enrolled ADFMs. TRICARE denies payment on ADSMs' claims if there's no authorization on file.

?	Corporal Williams enrolls in TPR. Not long after, his PCM discovers an irregular heartbeat and refers him to a specialist. Who should his PCM send the referral to? What do they do with it? Who provides care authorization details?

7.4 Emergency Care

- When they need emergency care, Prime Remote enrollees should go to the nearest emergency care setting. They don't need to call their PCM/primary care provider beforehand.
- True emergency care (based on the diagnosis and treatment on the claim) is a TRICARE-covered benefit.

Stateside Emergency Care (TPR/TPRADFM)
TPR ADSMS ● Enrolled ADSMs should contact their PCM/primary care provider or regional contractor during, or as soon as possible after getting emergency care. The PCM/primary provider needs to write and send a referral to the regional contractor and coordinate follow-up care (if needed). ● DHA-GL reviews the referral and makes an authorization determination. ● Any additional care goes through the usual referral and authorization process. ○ Emergency care staff may tell the member he or she needs to see a specialist. If so, the enrolled ADSM must see his PCM/primary provider first. Without a specialty care referral and authorization, the regional claims processor may deny payment. The ADSM is then responsible for the costs. **TPRADFM** ● Enrolled ADFMs should contact their PCM/primary care provider during, within 24 hours of, or the next business day after getting emergency care. They need to get referrals and authorizations for follow-up specialty care.

Overseas Emergency Care (TOP Prime Remote)
● If there's time, enrollees may contact the overseas contractor's call center to find the nearest emergency care setting. ● Enrollees must contact a call center during, within 24 hours of, or the next business day after getting emergency care. ○ Enrollees should get the emergency care setting's contact information. They need to give this and/or a copy of the bill to the overseas contractor. This makes it easier for the regional contractor and claims processor to pay the overseas provider. ○ Enrollees should also contact the overseas contractor's call center to coordinate and authorize ongoing care (routine and specialty). ● ADSMs must contact their parent service unit as soon as possible before, during, or after receiving emergency care. ● If enrollees follow these steps, they are less likely to pay out-of-pocket for TRICARE-covered services.

8.0 The TOP Point of Contact (POC) Program (Overseas)

- The TOP Point of Contact (POC) Program is a liaison service for TOP Prime Remote enrollees. POCs help with enrollment, medical travel, and TRICARE claims processing.
  - Various government agencies choose who acts as a location's TOP POC. The POC:
    - Helps with timely completion and filing of TOP claims forms
    - Secures and safeguards Protected Health Information (PHI), Personally Identifiable Information (PII), and Sensitive Information
    - Helps ADSMs and TOP Prime Remote enrollees with return travel after medical evacuation or hospital discharge
  - TRICARE Area Offices (TAOs) develop and deliver area-specific POC Program booklets outlining POC duties and responsibilities. The TAO offices also conduct area-specific POC training.
  - POCs should reach out to TAO staff when they need help (See Appendix C for contact information.)

9.0 Medical Travel for Active Duty Service Members (ADSMs) Overseas

9.1 When Care Isn't Available in the TOP Prime Remote Area

- When needed care (including diagnostic services) isn't available in an overseas remote location, the overseas contractor contacts the TAO to find out if care is available in a different location. The services provide funding orders for travel to the nearest military hospital or clinic or overseas medical facility with the needed services. Staff determines medical necessity. Facility choice is based on available care, distance, and per diem costs.
  - ADSMs put on medical Temporary Additional Duty/Temporary Duty (TAD/TDY) should work with their POC to get care. The ADSM and POC also work on getting command or service-level funding for travel, per diem, and other costs.
- If TOP Prime Remote enrollees need specialty or diagnostic services (e.g., follow-up appointments, MRIs, CT scans) the enrollee or provider set up new referrals/authorizations. The authorization may cover multiple visits based on the treatment plan.

9.2 Aeromedical Evacuation

Aeromedical evacuation funding is service-specific. Remote POCs may work with the service to get funding.

9.2.1 Role of the TOP Contractor in Aeromedical Evacuation

- The TOP contractor's Regional Call Center arranges cashless, claimless medically necessary aeromedical evacuations for:
  - TOP Prime and TOP Prime Remote enrollees
  - ADSMs who are deployed to, TAD/TDY, or in an authorized leave status while overseas
  - TRICARE-eligible ADFMs traveling overseas (includes TRICARE Standard and TOP Standard ADFMs)
- The TOP contractor:
  - Determines medical necessity
  - Identifies the appropriate method of evacuation
  - Schedules the evacuation to the closest location that can meet the health care needs
  - Authorizes necessary care
  - Arranges transfer of medical records
  - Coordinates transfers with the receiving health care provider or institution
  - Ensures the ADSM's unit is aware of the medical evacuation

9.2.2 Role of POCs in Aeromedical Evacuations

- POCs determine command/service-specific fund sites for out-of-country medical travel.
  - Enrollees must travel with their TOP Prime Remote enrollment card, uniformed services ID card, and travel orders.
  - Enrollees must review their travel orders and itinerary before traveling.
  - Enrollees should be told that any change from the approved itinerary won't be paid for.
- POCs should give enrollees the number of the travel order-issuing authority. Enrollees may then contact the travel authority if the approved itinerary doesn't provide enough travel time in either direction.
- POCs should tell enrollees that the fund site only covers the commercial travel noted in the memorandum; The site won't cover commercial travel to other than the listed TAD/TDY location.

9.2.3 Aeromedical Evacuations and Fund Sites

The services issue a fund site to pay claims for approved medically necessary evacuations for TOP Prime Remote enrolled ADSMs.

- TOP POCs usually work with 2 types of fund sites to cover certain costs for health care and medical travel for ADSMs. This is for services not covered under TOP Prime Remote
  - Service-specific fund sites: for TRICARE-covered services received in remote locations with no contractor coordination
  - Command/service fund sites: travel for specialty care/diagnostic tests
- The fund site holder approves payment. Medical travel funds cover travel and per diem, but don't cover rental cars, telephone calls, or personal expenses.

9.3 Care Onboard Commercial Seagoing Vessels

- If outside of U.S. territorial waters, Prime Remote enrollees pay the full cost up front and file a claim with the TOP claims processor.
  - Claims process as foreign claims
    - If the provider is a licensed U.S. provider, the TOP contractor bases payment on that provider's address.
    - If the provider isn't licensed to practice in the U.S., payment follows overseas providers' claims rules (See the *Claims* module for more information.)

10.0 TOP Prime Remote Physical Exams (Overseas)

- TOP Prime Remote enrollees may require physical exams:
  - Fitness-for-duty/flight physicals
  - Routine
  - Retirement
  - School*
  - Sports and others*

* *TRICARE doesn't cover all types of physical exams. TRICARE coverage information can be found at www.tricare.mil/CoveredServices or by contacting the overseas contractor.*

10.1 Service-specific Guidance on ADSM Physicals (flight, periodic, retirement):

TOP POCs and the service member should work with the ADSM's service (e.g., Army, Marine Corps, etc.) for guidance on ADSM physicals and travel. They should contact the overseas contractor for authorizations and appointments if an overseas provider can do the physical, such as the 3–5 year routine exam.

Note: When physicals can't be performed in-country and TAD/TDY funds to the United States aren't available, the physical must be prior-authorized by the TOP Call Center. The authorization shows the ADSM's physical may be done during non-medical stateside TAD/TDY or while on leave in the U.S.

10.2 Retirement Physicals

- Retirement physical guidelines vary among the services.
- TOP POCs should direct ADSMs to their service representative for help.

10.3 School Physicals for ADFMs

- TRICARE covers physicals for TOP Prime Remote enrollees when the school requires them.
- Enrollees schedule these appointments through the overseas contractor.

10.4 Sports and Other Physical Exclusions

- TRICARE doesn't cover sports physicals. (They're not considered medically necessary.)
- TRICARE doesn't cover physicals for administrative purposes (e.g., visa and passport physicals).

11.0 Overseas Maternity Care

TOP Prime Remote covers maternity care, including prenatal care, delivery, and postpartum care.

11.1 Getting Care

- If enrolled to or near a military hospital or clinic that offers maternity care, Prime Remote enrollees get care there.
- Otherwise, they have to get a PCM referral and contractor authorization to get care from an overseas provider.
  - TOP Prime Remote ADFMs contact the TOP Regional Call Center for help getting set up with a provider.
- TOP Prime Remote ADFMs may use the POS option to self-refer for maternity care

11.2 Stork's Nest Program

- The Stork's Nest Program provides temporary housing to ADSM and ADFM maternity patients and those with high-risk conditions. The program lets them stay on or near a military hospital or clinic with maternity services.
- Stork's Nest facilities are Landstuhl Regional Medical Center in Landstuhl, Germany, and the U.S. Naval Hospital in Okinawa, Japan.
- For more information, enrollees should contact the overseas contractor's call center.

12.0 TRICARE and Non-Combatant Evacuation Operations (NEO)

- NEO guidelines ensure family members have no break in their TRICARE coverage due to an evacuation.
    - Special policies apply to ADFMs evacuated from overseas locations (See *Health Affairs Policy 03-006,* available at www.health.mil.)
    - TOP Prime and TOP Prime Remote enrollees have up to 210 days from the date of the initial evacuation order to travel and to transfer enrollment to a new area or region.

13.0 TPR Application Exercises

First Lieutenant John Smith, an Army National Guard member, lives with his wife and two children in Brookline Station, Missouri. This is a TPR-designated location. He was called to active service for 365 consecutive days. Tomorrow he reports to Fort Smith, Arkansas for 15 days, with follow-on deployment to Afghanistan.

He and his wife agree the family should stay where they are during his deployment.

Given what you've learned about TRICARE Prime Remote, answer the following questions. Be ready to explain your answers.

Q1. Is the Smith family eligible for TPRADFM during Lieutenant Smith's deployment?

Q2. Can Lieutenant Smith's family enroll in TPRADFM even if he isn't enrolled in TPR?

Q3. How do you know if they're eligible?

Module Objectives

- **Define the TRICARE Prime Remote Options**
- **Identify who is eligible for Prime Remote**
- **Explain how Prime Remote enrollees access health care**
- **Describe the role of the Defense Health Agency – Great Lakes (DHA-GL) (formerly known as MMSO) or TRICARE Overseas Program (TOP) Points of Contact (POCs)**

Key Terms

- **TRICARE Prime Remote (TPR)**
- **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)**
- **TRICARE Overseas Program (TOP) Prime Remote**
- **Defense Health Agency – Great Lakes (DHA-GL)**
- **TOP Point of Contact (POC) Program**

Appendix A: TOP Prime Remote Resources

Eurasia-Africa	Latin America and Canada	Pacific
Africa, Europe, and the Middle East	Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands	Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries
TOP Regional Call Center 1-877-678-1207 (stateside) +44-20-8762-8384 (overseas) tricarelon@internationalsos.com Medical Assistance: +44-20-8762-8133	**TOP Regional Call Center** 1-877-451-8659 (stateside) 1-215-942-8393 (overseas) tricarephl@internationalsos.com Medical Assistance: 1-215-942-8320	**TOP Regional Call Centers** Singapore: 1-877-678-1208 (stateside) +65-6339-2676 (overseas) sin.tricare@internationalsos.com Sydney: 1-877-678-1209 (stateside) +61-2-9273-2710 (overseas) sydtricare@internationalsos.com Medical Assistance: Singapore: +65-6338-9277 Sydney:+61-2-9273-2760
TRICARE Area Office Toll Free Phone (Stateside): 1-888-777-8343 Commercial Phone: 0049-6371-9464-2999 DSN: 1-314-590-2999 Commercial Fax: +49-(0)6302-67-6378 DSN Fax: 1- 314-496-6378 E-mail: tma.sembach.medcom-ermc.mbx.teoweb-tao-ea@mail.mil Web: www.tricare.mil/eurasiaafrica Address: TAO-Eurasia-Africa Unit 10310 APO AE 09136-0130	**TRICARE Area Office** Toll Free Phone (Stateside): 1-888-777-8343 Commercial Phone: +1-210-292-8520 DSN: 94-554-8520 Commercial Fax: +1-210-292-3224 E-mail: taolac@tma.osd.mil Web: www.tricare.mil/tlac Address: TAO-Latin America & Canada 7800 IH-10 West, Suite 400 San Antonio, TX 78230	**TRICARE Area Office** Toll Free Phone (Stateside): 1-877-777-8343 Commercial Phone: + 81-98-970-9155 DSN: 315-643-2036 Commercial Fax: +81-6117-43-2037 DSN Fax: 315-643-2037 E-mail: tpao.csc@med.navy.mil Web: www.tricare.mil/pacific Address: TAO-Pacific NH Okinawa PSC 482, Box 2749 FPO AP 96362
Overseas Claims Information		
All Overseas Active Duty Claims TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 1-608-301-2311, opt 2		
All Other Claims (Separated by Region)		
TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 1-608-301-2310, opt. #2	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-608-301-2311, opt. #2	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-608-301-2311, opt #2
Website: www.tricare-overseas.com		

Appendix B: Medical Matrix Homework

Medical Benefit Program Matrix Homework Instructions

- Using your TRICARE Fundamentals Course Participant Guide and class notes, write the answer in each square on the Program Matrix.
- Answers for the matrix:
  - Can be either “Yes,” “No,” or “N/A” (not applicable)
  - May require dollar amounts only
    - Some costs are covered in this book; others may require you to do additional research on the TRICARE Costs website (www.tricare.mil/costs)
  - Some “Yes” answers may require additional information
- **Suggestion:** Complete the homework as part of a study group

	Prime			Prime Remote			Standard/Extra		
	ADSM	**ADFM**	**Retired**	**ADSM**	**ADFM**	**Retired**	**ADSM**	**ADFM**	**Retired**
Available to Beneficiary Type									
Enrollment Required									
Enrollment fee									
PCM assigned									
Deductible									
Copays									
Civilian Outpatient Cost-Shares									
Civilian Inpatient Cost-Shares									
Civilian Inpatient Mental Health Costs									
Catastrophic Cap									
Who Files Claims (Beneficiary or Provider)									
Military Hospital/Clinic Access									
Portable									
Available Overseas									
Command Sponsorship Req'd Overseas									
Advantages									

TRICARE Fundamentals Course

Transitional Benefits

4

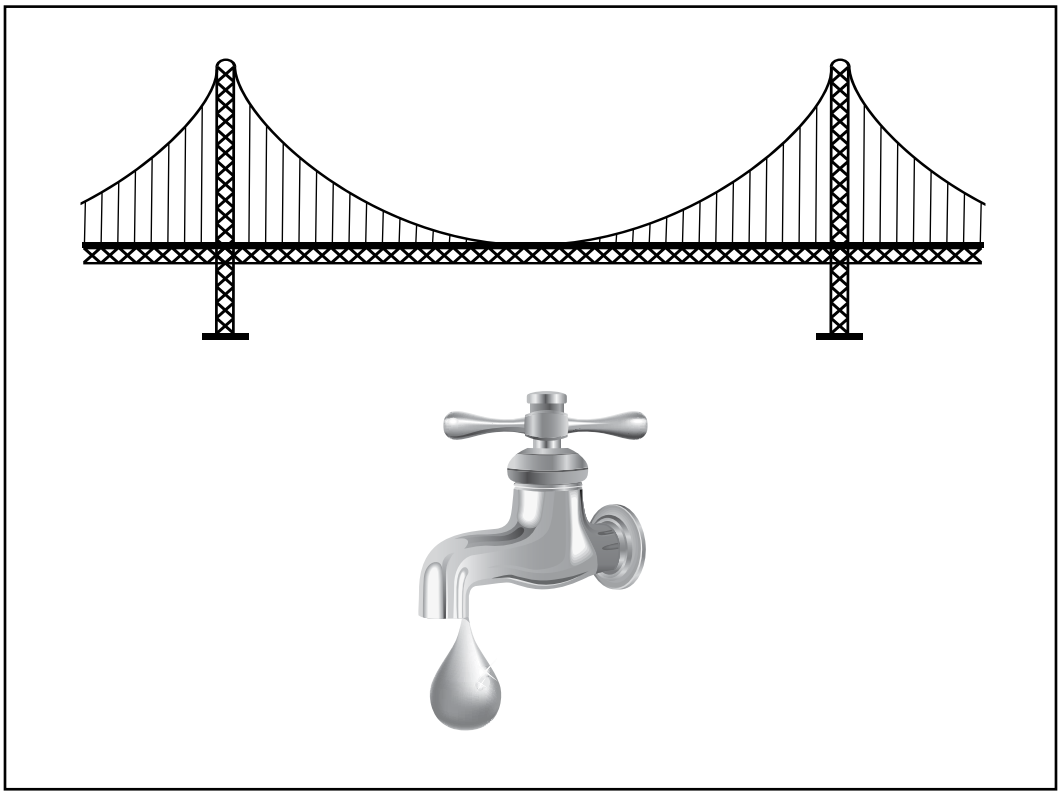
Participant Guide

References

10 USC
32 CFR §§ 199.20, 199.3
Public Law 102-484, 102-125, 103-337,108-375,101-510
National Defense Authorization Act, FY 1993
2008 TRICARE Policy Manual, Chapter 10

Brainteaser

What phrase is represented below?



Riddle

I have three changing faces. When I give my signal, I start races. What am I?

Module Objectives

- **Explain the purpose of the Transitional Assistance Management Program (TAMP)**
- **Explain who is eligible for Transitional Care for Service-Related Conditions (TCSRC)**
- **State who is eligible for the Continued Health Care Benefit Program (CHCBP)**

Key Terms

- **Transitional Assistance Management Program (TAMP)**
- **Transitional Care for Service-Related Conditions (TCSRC)**
- **Continued Health Care Benefit Program (CHCBP)**

?	Throughout this module, you will answer questions on former active duty service member Sergeant McDonald and his family.

1.0 TRICARE Transitional Health Care Coverage

TRICARE offers health care to certain people who lose TRICARE eligibility. It offers coverage through:

- Transitional Assistance Management Program (TAMP)
- Transitional Care for Service-Related Conditions (TCSRC)
- Continued Health Care Benefit Program (CHCBP)

Note: Transitional benefits typically don't apply to retired service members. They stay TRICARE eligible when moving from active duty to retiree status. (See the *National Guard and Reserve* module and the *TRICARE and Medicare* module for more information.)

2.0 Transitional Assistance Management Program (TAMP)

The Transitional Assistance Management Program (TAMP) provides 180 days of health care coverage to certain former members and their families

2.1 TAMP Eligibility

The services determine eligibility. A uniformed service member and his or her eligible family members can receive TAMP coverage if the service member is:

- A separating National Guard or Reserve member who served more than 30 consecutive days in support of a contingency operation
- An active duty service member (ADSM) who joins the Selected Reserve immediately upon separation from service (no gap in service)
- An ADSM involuntarily kept on active service (retained under stop-loss) in support of a contingency operation
- An ADSM involuntarily separated from active service under honorable conditions
    - This includes members who receive a voluntary separation incentive, or voluntary separation pay and aren't entitled to retired or retainer pay when they separate.
- An ADSM who voluntarily agreed to stay on active service for less than 1 year in support of a contingency operation
- A member discharged under a sole survivorship discharge. This means he or she is the only surviving child in a family in which the mother, father, or one or more sisters or brothers served in the Armed Forces, and while on active service, either died or were severely injured and have a permanent disability.

Note: Service members should contact their service personnel office with TAMP eligibility questions or concerns.

2.2 Health Care Coverage During TAMP

- TAMP provides coverage under:
    - TRICARE Standard and Extra
    - TRICARE Prime (enrollment/re-enrollment required)
    - TRICARE Overseas Program (TOP) Standard
    - TOP Prime (enrollment/re-enrollment required)
    - US Family Health Plan (USFHP) (enrollment/re-enrollment required)
- During TAMP, former members and families can't enroll in TRICARE Prime Remote (TPR), TRICARE Prime Remote for Active Duty Family Members (TPRADFM), or TOP Prime Remote. (The sponsor is no longer on active duty.)

?	Sergeant McDonald separated from active duty after volunteering to stay on active duty for 6 months in support of Operation Inherent Resolve. Is he TAMP eligible? If so, how many days does he have coverage? Can he be Prime?

2.2.1 Enrollment in TRICARE Prime, TOP Prime, and USFHP During TAMP

- The following applies to those eligible for TAMP who enroll or re-enroll in TRICARE Prime, TOP Prime, or USFHP after the sponsor separates from active duty. Enrollment procedures are as follows:

Stateside	Overseas
● Those enrolled in TRICARE Prime or USFHP before the sponsor's separation may reenroll without a break in coverage if they live in a Prime Service Area (PSA). The regional contractor must receive their enrollment request before their TAMP period ends. They can't re-enroll in TPR or TPRADFM. ● To enroll/re-enroll: ○ Call the regional contractor ○ Use the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe ▪ Only available to those who live or want to enroll in a PSA ○ Mail a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) to the regional contractor ● The enrollment date is the date the sponsor separated from active service. ● Those not enrolled in a Prime option or USFHP before the sponsor's separation may enroll in TRICARE Prime or USFHP (if available at their location) during TAMP. Enrollment is subject to the "20th-of-the-month" rule. (See the *Definitions* module.)	● Those enrolled in TOP Prime before the sponsor's separation may re-enroll without a break in coverage. The TOP contractor must receive the enrollment request before their TAMP period ends. ● Family members eligible for TAMP who didn't enroll in TOP Prime before the sponsor separated may submit a new enrollment request. ● To re-enroll/enroll: ○ Call the overseas contractor's call centers ○ Use the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe. BWE may be available overseas for those located near a military clinic or hospital in early 2017. ○ Mail a *TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form* (DD Form 2876) to the overseas contractor ● The enrollment date is the date the sponsor separated from active service. ● Coverage begins when the completed enrollment request and command sponsorship for family members is received and verified. ● Family members eligible for TAMP who **weren't** eligible to enroll in TOP Prime before their sponsor's separation (e.g., because they weren't command sponsored) can't enroll in TOP Prime during the TAMP period. They are covered under TOP Standard.

- If a sponsor is recalled to active service for more than 30 consecutive days during the TAMP period, the following applies to **eligible family members**:
  - They may continue TRICARE Prime or USFHP enrollment, with no break in coverage, if they re-enroll within 30 days of the sponsor's active service date.
  - If they don't submit a new enrollment within 30 days, they're covered under TRICARE Standard or TOP Standard.
  - If they enroll more than 30 days after the sponsor's active service date, the "20th-of-the-month" rule applies. This results in a break in Prime coverage (stateside only).

?	Before Sergeant McDonald separated from active duty, he and his family were TRICARE Prime. They would like to continue their enrollment. Can they enroll in Prime under TAMP? If so, how can they avoid a break in coverage?

2.3 Dental Coverage During TAMP

- During TAMP, former ADSMs can get dental care at military dental treatment facilities (DTFs). They are seen on a space-available basis.
  - Once a full-time member separates, family members aren't eligible for the TRICARE Dental Program (TDP). Families need to understand their TDP coverage ends when the sponsor separates. They should get a written notice telling them this.
  - If the former ADSM goes into the Guard or Reserve, he or she may be able to buy TDP. The member and family enroll separately.
- Guard/Reserve members eligible for TAMP who served for more than 30 consecutive days in support of a contingency operation keep active duty dental benefits during TAMP.
  - They can get care at a DTF or authorized dental care from local civilian dental providers. Coverage is through the Active Duty Dental Program (ADDP).
  - All orthodontics, implants, and certain complex treatments must have prior authorization. Treatment has to be able to be completed within the TAMP period.
  - This coverage is only for the sponsor. It doesn't apply to family members. National Guard/Reserve family members may be enrolled in TDP during the sponsor's TAMP period. (See the *Dental* module for more information.)

2.4 Claims

During TAMP, the sponsor's status isn't active duty or retiree. Under TAMP, all claims, including the former member's, process as ADFM claims. ADFM deductibles, copayments, and cost-shares apply. When those with TAMP have other health insurance (OHI), TRICARE pays after the OHI.

2.5 TAMP Application Exercises

Q1. True or False: The purpose of TAMP is to provide permanent health care coverage for transitioning service members and their family members.

Q2. Lieutenant Karen Anderson is an active duty navy officer. She's pregnant and separates from active duty this month. Is she eligible for TAMP? Explain.

Q3. Active duty Air Force Senior Airman John Stephenson failed to meet Air Force fitness standards. He is being processed for honorable involuntary separation today. Is Senior Airman Stephenson eligible for TAMP? Explain.

Q4. Marine Corps Lance Corporal Amy Roberts was on active duty for 9 months. One month before her separation date, she was extended another 6 months under stop-loss. She separates from active duty today. Is she eligible for TAMP? Explain.

Q5. Army Reserve Staff Sergeant Roger Burke was activated in support of a contingency operation for 1 year. One month before separation, he volunteered to serve another 180 days. He separates from active service tomorrow. Is he eligible for TAMP? Explain.

3.0 Transitional Care for Service-Related Conditions (TCSRC)

The Transitional Care for Service-Related Conditions (TCSRC) benefit extends transitional coverage to certain former service members.

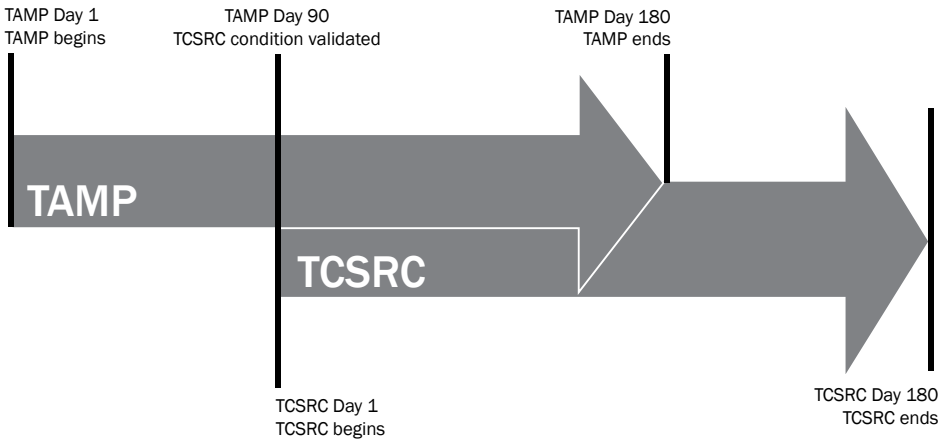
3.1 Eligibility

- Only TAMP-eligible former service members with a "newly diagnosed" or "newly discovered" medical condition can get the TCSRC benefit.
- The medical condition must be:
  - service-related
  - diagnosed during the TAMP period
  - validated by a Department of Defense (DoD) physician (done through DHA-Great Lakes [DHA-GL])
  - treatable
  - able to be resolved within 180 days of the validation date
- Former members get care for that condition and that condition only.
- Former members may have multiple conditions covered under TCSRC. Each condition must meet the criteria for coverage. Conditions may have different coverage start and end dates.
- Information on how to apply for the TCSRC benefit is at www.tricare.mil/tcsrc. The former member has to get and send supporting documents to DHA-GL to be considered for the benefit.

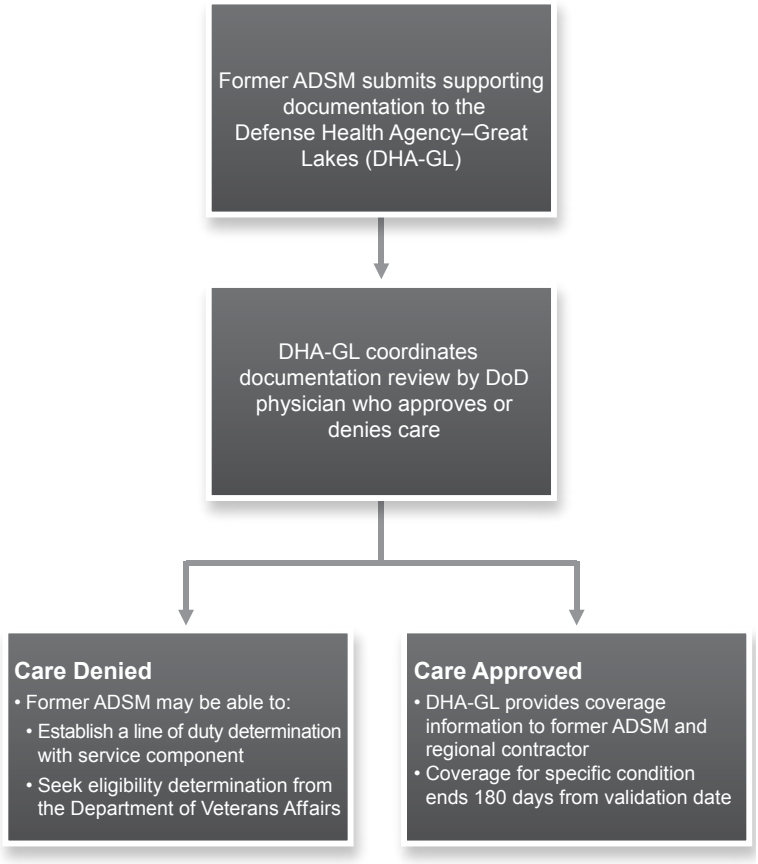
Note: If a former ADSM has a service-related condition that can't be resolved within 180 days, he or she may be able to get care through the Department of Veteran's Affairs (VA). The VA determines eligibility for VA benefits. These members should call 1-877-222-8387 or visit www.va.gov for more information.

3.2 TCSRC Example

A former ADSM is diagnosed with a service-related condition 90 days into his TAMP period. TAMP ends 180 days after his separation. TCSRC coverage ends 180 days from the DoD physician's validation date.



3.3 TCSRC Process



?	A month into Sergeant McDonald's TAMP period, he starts experiencing extreme soreness in his right shoulder, which is diagnosed as ligament damage. Aware of the Sergeant's active duty history, his family physician suspects the condition is service-related. Is Sergeant McDonald eligible for the TCSRC benefit? Will DHA-GL accept the diagnosis by Sergeant McDonald's family physician?

4.0 Continued Health Care Benefit Program (CHCBP)

- The Continued Health Care Benefit Program (CHCBP) is a premium-based program for individuals who lose TRICARE eligibility.
- Beneficiaries can buy individual or family coverage.
- CHCBP follows TRICARE Standard and Extra rules and procedures, except:
  - CHCBP requires premium payments
  - Beneficiaries can only use military hospitals or clinics for emergency care. They can't use military hospital or clinic pharmacies.
- Beneficiaries have to use TRICARE-authorized providers.
- Health care is limited to TRICARE-covered services.
- For CHCBP questions, tell beneficiaries to call the CHCBP contractor at 1-800-403-3950. (See the *Resources and Tools* module for more information).

4.1 CHCBP Eligibility

Beneficiaries must purchase CHCBP within 60 days after losing TRICARE eligibility or coverage. This includes loss of TAMP, TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and TRICARE Young Adult (TYA).

Those who may purchase CHCBP:

- Former ADSMs and their family members
- Certain former active duty Guard/Reserve members and their family members
- Certain unremarried former spouses
- Children who lose eligibility due to age
- Certain unmarried children by adoption or legal custody (i.e., non-biological children)

Note: Service members must separate under "other than adverse conditions." They must have an "honorable" or "general" discharge.

4.2 CHCBP Coverage

CHCBP is time-limited.

18-Month Limit	36-Month Limit
● Former ADSMs and their eligible family members	● Emancipated children ● Unmarried children by adoption or legal custody ● Certain unremarried former spouses

In some cases, unremarried former spouses may continue CHCBP beyond 36 months if they meet certain criteria.

Note: For specific eligibility information, see the *TRICARE Operations Manual, Chapter 10, Section 4.1*

4.3 CHCBP Enrollment Requirements

To enroll, individuals must send the CHCBP contractor:

- The *Continued Health Care Benefit Program Application* (DD Form 2837), available at www.tricare.mil/forms
- Payment for the first 90 days of coverage
- Documents noted on the enrollment form, including copies of:
  - *Certificate of Release or Discharge from Active Duty* (DD Form 214)
  - Final divorce decree (if applicable)

?	When Sergeant McDonald's TAMP coverage ends, he and his wife enroll in CHCBP. How is this coverage different from Prime during TAMP? How long does their CHCBP coverage last?

4.4 CHCBP Premiums

- The first quarter (90 day) premium must be part of the application.
- Payment must be by check or money order made out to "The Treasury of the United States" or by credit/debit card.
- Quarterly premiums may change each fiscal year (October 1–September 30). The CHCBP contractor bills beneficiaries quarterly until CHCBP coverage ends.
- Visit www.tricare.mil/chcbp for current premium rates.

4.5 CHCBP Claims Processing

- TRICARE-authorized providers may file claims for enrollees, but don't have to. CHCBP members must make sure all claims, including provider and pharmacy claims, are filed :
  - Stateside (including U.S. territories)—within 1 year from the date of service
  - Overseas—within 3 years from the date of service
- To file a claim, the member must submit:
  - *A TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment* (DD Form 2642)
  - The provider's bill or pharmacy receipt
  - A copy of their CHCBP enrollment card
- Beneficiaries mail all CHCBP claims to:

  CHCBP Claims
  PGBA
  P.O. Box 7031
  Camden, SC 29021-7031

- For CHCBP claims questions, members and providers should call the CHCBP contractor at 1-800-403-3950 or visit www.myTRICARE.com.
- For more on CHCBP, visit: www.tricare.mil/chcbp.

Module Objectives

- **Explain the purpose of the Transitional Assistance Management Program (TAMP)**
- **Explain who is eligible for Transitional Care for Service-Related Conditions (TCSRC)**
- **State who is eligible for the Continued Health Care Benefit Program (CHCBP)**

Key Terms

- **Transitional Assistance Management Program (TAMP)**
- **Transitional Care for Service-Related Conditions (TCSRC)**
- **Continued Health Care Benefit Program (CHCBP)**

TRICARE Fundamentals Course

Pharmacy

5

Participant Guide

References

10 USC 32 CFR § 199
2008 TRICARE Policy Manual, Chapter 8
2008 TRICARE Operations Manual, Chapter 23
www.tricare.mil
http://member.express-scripts.com
Defense Health Agency Great Lakes Process Guide

Brainteaser

Each of the eight items below is a separate puzzle.

How many can you figure out?

1. TOOL O O O O LOOT	2. Bathing Suit	3. gone let gone gone be gone	4. N N N N N N N A A A A A A A C C C C C C C
5. (ice)^3	6. Gun Jr.	7. GI cccc	8. **BLOOD** WATER

1. Toolbox _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Module Objectives

- **Describe the TRICARE Pharmacy Program**
- **Identify who is eligible for pharmacy benefits**
- **Compare the pharmacy options**
- **List pharmacy costs**

Key Terms

- **TRICARE Formulary**
- **Basic Core Formulary**
- **Home Delivery**
- **Network Pharmacy**
- **Non-network Pharmacy**

1.0 Pharmacy Benefits

- The TRICARE Pharmacy Program covers most prescription drugs approved for marketing by the U.S. Food and Drug Administration (FDA).
- Prescriptions must be written by providers licensed in the U.S. or U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands)
- The TRICARE Pharmacy Program has 4 pharmacy options:
  1. Military pharmacies
  2. Home Delivery, including specialty drugs
  3. TRICARE network pharmacies (U.S. and U.S. territories)
  4. Non-network pharmacies
  - Overseas pharmacies are non-network pharmacies. Beneficiaries pay the total cost for the drug. They then file a claim with the overseas contractor for TRICARE to pay them (less their deductible, copay, cost share).
- All beneficiaries have to get select maintenance drugs through Home Delivery or at a military pharmacy (if the pharmacy carries the drug). Maintenance drugs are drugs taken on a regular basis for a chronic condition (i.e., high blood pressure, high cholesterol).
  - This doesn't apply to:
    - Active duty service members (ADSMs)
    - Beneficiaries living overseas
    - Beneficiaries who have other health insurance (OHI) with a prescription benefit (See Section 10.)
  - Beneficiaries can check to see if this affects a drug they are or may be taking in the future by visiting http://www.health.mil/selectdruglist. They can also call the pharmacy contractor.
- Pharmacy benefit information is at http://www.tricare.mil/CoveredServices/Pharmacy.aspx

?	Throughout this module, you will answer scenario questions on Tech Sergeant Michelle Clarkson.

2.0 Formularies

2.1 TRICARE and Basic Core Formulary

- The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee decides which drugs TRICARE covers, when they're covered, and if there are specific coverage rules.
- A formulary is a list of medications. The P&T places drugs on 1 of 3 formulary tiers:
  - Tier 1: Generic Formulary
  - Tier 2: Brand-Name Formulary/TRICARE preferred
  - Tier 3: Non-Formulary/TRICARE non-preferred
- The DoD P&T Committee also decides which drugs go on the Basic Core Formulary. The Basic Core Formulary is a list of drugs full-service military pharmacies must carry.

2.2 TRICARE Formulary Search Tool

- The TRICARE Formulary Search Tool is at: https://www.express-scripts.com/static/formularySearch/2.2.1/#/formularySearch/drugSearch
- Beneficiaries and providers can use the Search Tool to:
  - See what drugs are on the Basic Core Formulary

- Find out if TRICARE covers a certain drug
- See the costs for the different pharmacy options
- Learn about generic alternatives for brand-name drugs, quantity limits, medical necessity, and prior-authorization requirements
- View and print forms

2.2.1 Generic Drug Policy

- Before drug approval, the FDA tests that active ingredients in generic drugs are as strong, pure, safe, and reliable as brand-name drugs. TRICARE generally requires beneficiaries prescribed a brand-name drug be given a generic alternative preferred drug unless:
  - There's no equal generic version.
  - Their provider submits and the pharmacy contractor approves a prior authorization request and/or proof of medical necessity. If not approved, beneficiaries pay the full cost of the brand-name drug.

2.2.2 TRICARE Formulary and Medical Necessity

- The DoD P&T Committee determines medical necessity criteria for non-formulary drugs.
- The definition of medical necessity (sometimes called clinical necessity) is: "accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care." (American College of Medical Quality)
- Providers must prove medical necessity for a beneficiary to get a TRICARE non-formulary/non-preferred drug at the formulary/preferred copay, or at no cost if it's for an ADSM.
- To prove medical necessity, a provider has to show it meets 1 or more of the following criteria:
  - The preferred formulary drug can't be clinically used for a beneficiary's treatment
  - The beneficiary experiences, or is likely to experience, undesirable effects from the preferred formulary drug, and is likely to tolerate the non-preferred drug
  - The preferred formulary drug doesn't have the right effects, and the beneficiary is likely to get benefits from the non-preferred drug
  - In the past, the beneficiary had a positive response to the non-preferred/non-formulary drug, and being on the preferred formulary drug would pose a clinical risk
  - There is no preferred alternative
- Providers must complete the medical necessity form for the non-formulary/non-preferred drug. Forms are linked to a drug's listing in the Formulary Search Tool: https://www.express-scripts.com/static/formularySearch/2.2.1/#/formularySearch/drugSearch

2.2.3 Prior Authorization and Quantity Limits

TRICARE requires prior authorization to make sure a drug's use is safe, effective, medically necessary, and cost effective

- Beneficiaries have to get prior authorization for drugs that:
  - Have dangerous side effects or can be harmful when used with other drugs
  - Should only be used for certain health conditions
  - Are often misused or abused
  - Have age limits
  - The quantity on the prescription is for more than the usually prescribed amount

- Some drugs have “quantity limits” to make sure they’re used safely. This means beneficiaries only get a set amount each time they fill that prescription.
  - The TRICARE Formulary Search Tool shows quantity limits for specific drugs.
  - A provider may decide there are circumstances that qualify a beneficiary to get higher quantities of a drug. The provider establishes medical necessity and requests prior authorization (coverage review).
- To find out if a drug needs prior authorization, use the TRICARE Formulary Search Tool or call the pharmacy contractor at 1-877-363-1303.

?	TSgt Clarkson is an ADSM. Her doctor gave her a prescription for a brand-name FDA-approved drug to treat high cholesterol. Can TSgt Clarkson get the brand-name drug? What determines if she gets a brand-name or generic version?

3.0 Eligibility

- All TRICARE eligible beneficiaries can use TRICARE pharmacy benefits. The pharmacy contractor uses the Defense Enrollment Eligibility Reporting System (DEERS) to confirm eligibility.
  - Foreign Force Members (FFMs) and their dependents from countries with a North Atlantic Treaty Organization (NATO), Status of Forces Agreement (SOFA), or Partnership For Peace (PFP) are eligible to get retail pharmacy benefits. Claims process as if they were active duty/active duty family members using TRICARE Standard.
  - Guard or service members with a line of duty/notice of eligibility determination (LOD/NOE) may get ongoing pharmacy benefits after separation to treat their LOD/NOE illness or injury. They don’t show as eligible in DEERS so they have to pay for their drugs. They send their claims to DHA-Great Lakes (DHA-GL), who confirms eligibility and forwards the claim to the pharmacy contractor. The contractor pays the member. See the *Guard and Reserve* module for more on LOD/NOE and pharmacy benefits.
- TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and TRICARE Young Adult (TYA) members and Continued Health Care Benefit Program (CHCBP) enrollees are eligible for pharmacy benefits.

?	After being on the cholesterol drug for 6 months, TSgt Clarkson gets married. Her spouse is TRICARE-eligible as an active duty family member (ADFM). He needs a monthly maintenance drug. When is he eligible for TRICARE pharmacy benefits?

3.1 Pharmacy Benefits for Dependent Parents and Parents-in-Law

- Parents and parents-in-law may fill prescriptions at military pharmacies when:
  - They meet service criteria to be a dependent
  - They show as direct care only in DEERS
  - Their sponsor is on active service for more than 30 days
- Dependent parents and parents-in-law with Medicare Parts A and B may get prescription drugs at TRICARE network pharmacies or through Home Delivery.

Note: Dependent parents and parents-in-law who turned 65 before April 1, 2001 don’t need to have Part B.

4.0 Military Pharmacies

- Each military pharmacy has to stock the Basic Core Formulary drugs
  - Non-formulary/non-preferred drugs generally aren’t available at military pharmacies. Based on the type of care the military hospital or clinic provides and the beneficiary population it serves, a military pharmacy can add certain drugs to its formulary.
- Beneficiaries can get up to a 90-day supply. There may be limits on controlled substances (prescription drugs identified by the Drug Enforcement Agency (DEA) as having potential for abuse) and narcotics.

- Military pharmacies can fill prescriptions written by licensed military and civilian providers.
- Local civilian providers may electronically send prescriptions to military pharmacies.
- US Family Health Plan (USFHP) beneficiaries **can't** get prescriptions filled at military pharmacies. They must use USFHP network pharmacies (See Section 12.0 for USFHP network pharmacy information)

?	TSgt Clarkson and her husband live in a Prime Service Area (PSA), 10 miles from a military pharmacy. Recently, TSgt Clarkson's was authorized to see a civilian provider, who gave her a new prescription. Can the military pharmacy fill this prescription? How much does TSgt Clarkson pay out of pocket at the military pharmacy?

5.0 Home Delivery

- The Home Delivery option is a way for beneficiaries to get medications sent to their home. It costs less and may be an easier way for beneficiaries to get drugs they take on a regular basis.
- Beneficiaries may get specialty drugs through Home Delivery if the drugs are TRICARE Formulary/Preferred.
    - Specialty drugs are self-administered, high-cost, oral, or injectable drugs (shots) that treat serious chronic conditions.
    - A 90-day supply and 3 refills are common for most specialty drugs.
    - Some, such as controlled substances, may have a 30-day or other limit based on federal law or TRICARE quantity limits.

5.1 Home Delivery—Overseas

- There are limits on Home Delivery overseas (not including U.S. territories). Prescription drugs are subject to local customs and policies.
    - Outside of the U.S. and U.S. territories, Home Delivery is only available to beneficiaries with Army Post Office (APO), Fleet Post Office (FPO), or Diplomatic Post Office (DPO) addresses.
    - Home Delivery isn't available in Germany (even to APO/FPO/DPO addresses). German law doesn't allow shipping of prescription drugs through the postal service.
    - The contractor can't ship refrigerated drugs to APO/FPO/DPO addresses.
    - U.S.-licensed providers must write these prescriptions.
- Overseas beneficiaries can update their APO/FPO/DPO and e-mail addresses at: www.express-scripts.com/TRICARE or www.dmdc.osd.mil/appj/bwe.
- Deployed service members may get prescription drugs mailed overseas through the Deployment Prescription Program (DPP). (See Appendix A.)

5.2 Creating an Online Home Delivery Account

- To use Home Delivery, beneficiaries must register for an online account. Families must create separate accounts for each family member. There are 3 ways to register:
    - Online: www.express-scripts.com/TRICARE
    - Phone: Stateside call toll-free: 1-877-363-1303 (for overseas, see Appendix B of this module)
        - Telecommunications Device for the Deaf (TDD): 1-877-540-6261
    - Mail: Download the registration form on www.express-scripts.com/TRICARE and mail it to:

      Express Scripts, Inc.
      P.O. Box 52150
      Phoenix, AZ 85072
- Registered users have online access to account and general prescription drug information.

5.3 Using Home Delivery

- There are 3 ways to fill a new prescription with the pharmacy contractor:
  - Electronically – the provider sends it via an online application.
  - Fax – the beneficiary's provider faxes it with a fax cover sheet.
  - Mail – the beneficiary mails in the prescription. Beneficiaries must fill out the *New Patient Order Form*. Each written prescription must have:
    - The beneficiary's full name
    - Date of birth
    - Address
    - Identification number—their sponsor's social security number (SSN) or their own DoD Benefits Number (DBN). (The DBN is on the back of the uniformed service ID card.)
    - Provider's name, address, phone number, license, and DEA number
    - Provider's handwritten signature
  - Beneficiaries mail the completed form, written prescription(s), and copayment(s) to the pharmacy contractor.
  - Payment can be by credit/debit card, check, or money order.
- Once the prescription processes (usually 10-14 days), the contractor sends the drug to the beneficiary.
- TRICARE recommends beneficiaries have a 30-day supply on hand while they set up their Home Delivery account.

Note: Beneficiaries must send all prescriptions for controlled substances by mail.

5.3.1 Refills

- Refill dates and numbers are on the drug container's label. There are 4 ways to order prescription refills through Home Delivery:
  - Online—through the pharmacy contractor's website.
  - Express Scripts Mobile App—Beneficiaries download the "Express Scripts" Mobile App from their device's app store.
  - Phone—Beneficiaries must have their identification number (sponsor's SSN or their own DBN), their prescription(s), and credit card ready.
  - Mail—Beneficiaries fill out the *Prescription Refill Form* they get with their first prescription. Beneficiaries mail the completed form and copayment to the pharmacy contractor.
- If beneficiaries have a credit/debit card on file, the pharmacy contractor bills the card.
- Beneficiaries can also set up auto-refills. The pharmacy contractor then sends refills on set dates.
- Beneficiaries can switch retail or military pharmacy prescriptions to Home Delivery online or by contacting the pharmacy contractor.

6.0 Network Pharmacy

6.1 Network Pharmacy

- The network pharmacy option lets beneficiaries fill prescriptions at network pharmacies in the U.S. and U.S. territories. (Currently, there are no network pharmacies in American Samoa)

6.2 Using Network Pharmacies

- Beneficiaries must show their uniformed services ID card and written prescription. They must have the prescription number if getting a refill.
    - Licensed providers may e-prescribe, fax, or phone-in prescriptions, depending on pharmacy laws for that state or territory.
- Beneficiaries can find network pharmacies by using the Pharmacy Locator at www.express-scripts.com/TRICARE or by calling 1-877-363-1303.

7.0 Non-network Pharmacy

- A non-network pharmacy doesn't agree to contract to be part of the TRICARE pharmacy network.
- TRICARE Prime enrollees who use a non-network pharmacy pay point-of-service (POS) charges, with higher out-of-pocket costs. (See Section 8.1 for cost information.)
- When using a non-network pharmacy, beneficiaries, including ADSMs, pay the total cost of the drug to the pharmacy, then file claims to be repaid. They are responsible for related cost-shares, deductibles, or copays.

7.1 TRICARE Pharmacy Services in the Philippines

- TRICARE beneficiaries living or traveling in the Philippines must get prescription drugs from either a TRICARE-certified licensed retail pharmacy or TRICARE-certified hospital-based pharmacy
- TRICARE won't pay beneficiaries for drugs they buy in a Philippine provider's office
- Beneficiaries can get help finding a TRICARE-certified licensed retail pharmacy by:
    - Calling the TRICARE Overseas Program Singapore Regional Call Center at +65-6339-2676 (overseas) or 1-877-678-1208 (stateside)
    - Searching the Philippine Approved/Certified Provider Search tool at www.tricare-overseas.com/beneficiaries/philippines/philippine-provider-search

8.0 Pharmacy Program Cost Overview

8.1 U.S. and U.S. Territories

- By law, TRICARE bases yearly copay changes on retiree cost-of-living adjustments (COLAs) or congressional direction. Changes go into effect January 1 each year.

	Formulary Drug		Non-formulary Drug
	Generic	**Brand Name**	
Military Pharmacy (up to a 90-day supply)	$0	$0	Generally not available at military hospitals/clinics
Home Delivery* (up to a 90-day supply)	$0	$20	$49
Network Pharmacy* (up to a 30-day supply)	$10	$24	$50
Non-network Pharmacy* (up to a 30-day supply)	TRICARE Prime options: 50% cost-share after the meeting the point of service deductible ($300 single/$600 family) All other beneficiaries: $24 or 20% of the total cost, whichever is more (after meeting their outpatient deductible)		TRICARE Prime options: 50% cost-share after the meeting the point of service deductible ($300 single/$600 family) All other beneficiaries: $50 or 20% of the total cost, whichever is more (after meeting their outpatient deductible)

* *ADSMs don't pay anything for prescription drugs. TRICARE pays 100% of the cost even when they use a non-network pharmacy.*

Note: Pharmacy copays and cost-shares apply to the beneficiary's deductible and catastrophic cap. Once met, the beneficiary won't pay for covered services/drugs until the next fiscal year. Regional and pharmacy contractors both track this information.

8.2 Overseas

- Overseas beneficiaries using Home Delivery pay the same copays as stateside beneficiaries.
- Beneficiaries filling prescriptions at overseas pharmacies file claims with the overseas contractor.
  - TOP Prime/TOP Prime Remote enrollees: TRICARE repays 100% of the total drug cost.
  - TOP Standard ADFMs and TRS members: Pay a 20% cost-share after they pay their deductible.
  - TOP Standard or TRR members: Pay a 25% cost-share after they pay their deductible.

?	A year after her marriage, TSgt Clarkson receives orders to a non-PSA. It's too far to drive to the military pharmacy. She knows she has other options, and is trying to decide if she should sign up for Home Delivery or use her local network pharmacy. TSgt Clarkson is admittedly forgetful when it comes to ordering her refills. Which of these 2 options would be better for her? How do the costs differ?

9.0 TRICARE and Medicare Part D

- The pharmacy benefit doesn't change under TRICARE For Life (TFL).
- Medicare's prescription drug coverage is called Medicare Part D. It's only offered and required in the U.S. and U.S. territories.
    - TFL beneficiaries don't have to sign up for Medicare Part D to keep TRICARE pharmacy benefits. TRICARE is creditable coverage (i.e., equal to Medicare Part D basic coverage).
    - For most TFL beneficiaries there's almost no reason to have Medicare Part D.
    - If DEERS shows a TFL beneficiary has Medicare Part D, but he or she doesn't have it, the beneficiary should contact the DEERS Support Office.
        - Phone: 1-800-538-9552 (worldwide) or 1-866-363-2883 (TTY/TDD)
        - In person: To find a DEERS Support Office visit www.dmdc.osd.mil/rsl
- TFL beneficiaries who live overseas (other than in U.S. territories) should contact the overseas contractor with pharmacy questions. (See Appendix B for overseas contact information.)

10.0 Other Health Insurance (OHI) with Pharmacy Benefits

- For TRICARE beneficiaries who have OHI with a pharmacy benefit, law requires the OHI to be first payer, TRICARE second.
- Beneficiaries with an OHI pharmacy benefit **can't** use TRICARE's Home Delivery unless:
    - The OHI doesn't cover a drug.
    - The beneficiary already met the OHI's benefit cap for the current year.
- Beneficiaries must show both their OHI and uniformed services ID cards at retail pharmacies.
- Beneficiaries in the U.S. and U.S. territories who have OHI should go to a pharmacy that's in both their OHI's and TRICARE's network. If they don't and are TRICARE Prime, they have to pay non-network cost-shares or POS charges.
- Most TRICARE network pharmacies can coordinate benefits electronically. This means the pharmacy can process payment with the OHI and TRICARE before the beneficiary leaves the pharmacy. This is how it works:
    - The beneficiary goes to a pharmacy that accepts his or her OHI and is a TRICARE network pharmacy.
    - The beneficiary shows his or her OHI and uniformed services ID cards.
    - The pharmacy submits the claim online to both plans: OHI first, TRICARE second.
    - The pharmacy charges the beneficiary any remaining copay or cost share.

Note: Medicaid, TRICARE supplements, and Indian Health Services plans aren't considered OHI. With these plans, TRICARE pays first.

11.0 Pharmacy Claims

- Beneficiaries need to file a claim if they:
    - Get their prescription from a non-network pharmacy
    - Have OHI with pharmacy benefits
- Beneficiaries must fill out a *TRICARE DoD/CHAMPUS Medical Claim-Patient's Request for Medical Payment* (DD Form 2642), which is found at www.tricare.mil/forms

- Beneficiaries in overseas areas, except U.S. territories, must file their prescription claims with the overseas claims processor and include proof of payment with their claims. Beneficiaries must file claims:
  - Within 1 year from the date of service in U.S. and U.S. territories
  - Within 3 years from the date of service for all other overseas locations (other than U.S. territories)
  - These timelines don't apply to ADSM claims
- Claims filing addresses are at www.tricare.mil/Resources/Claims/PharmacyClaims.aspx (or in Appendix B.)
- Regional contractors process claims for medications given in a provider's office, by a home health care agency, or specialty pharmacy (not the pharmacy contractor).
- The overseas contractor processes claims for prescriptions filled at U.S. Embassy clinics.

Note: Guard or service members with a line of duty/notice of eligibility determination (LOD/NOE) may get ongoing pharmacy benefits after separation to treat their LOD/NOE illness or injury. (See the *Guard and Reserve* module for more on LOD/NOE). They don't show as eligible in DEERS so they have to pay for their drugs. They send their claims to DHA-Great Lakes (DHA-GL), who confirms eligibility and forwards the claim to the pharmacy contractor. The contractor pays the member.

11.1 Appealing a Denied Claim

- Beneficiaries can appeal a denied pharmacy claim. The appeal:
  - Must be in writing
  - Must be signed and postmarked or received by the pharmacy or overseas contractor within 90 calendar days from the date of the denial letter
  - Must include a copy of the claim denial
  - Must state why the beneficiary disagrees with the denial
- Beneficiaries who need to send more paperwork to support their appeal, but can't do it within the 90-days, can note that in their initial appeal package. They should send in the paperwork as soon as they can.
- U.S. and U.S. territories appeals go to:

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

- Overseas appeals go to the overseas claims processor. (See the *Appeals* module for appeals addresses.)

12.0 US Family Health Plan's (USFHP) Pharmacy Benefits

- USFHP enrollees use the pharmacy benefits provided through USFHP. They can use USFHP's retail, in-house pharmacies, or Mail Order options.
  - They may take or have their providers call in 1-time or urgent care prescriptions. They can get their drugs from a USFHP retail pharmacy network or a pharmacy in a USFHP hospital or clinic.
  - For long-term or maintenance drugs, USFHP encourages use of mail order pharmacy services. Under Mail Order, enrollees get a 90-day supply of drugs.

Prescription	Cost
Formulary Generic Walk in:	**$10 for up to a 30-day supply**
Formulary Generic Mail Order:	**$0 for up to a 90-day supply**
Formulary Brand Walk in:	**$24 for up to a 30-day supply**
Formulary Brand Mail Order	**$20 for up to a 90-day supply**
Non-Formulary Walk in:	**$50 for up to a 30-day supply**
Non-Formulary Mail Order	**$49 for up to a 90-day supply**

Module Objectives

- **Describe the TRICARE Pharmacy Program**
- **Identify who is eligible for pharmacy benefits**
- **Compare the pharmacy options**
- **List pharmacy costs**

Key Terms

- **TRICARE Formulary**
- **Basic Core Formulary**
- **Home Delivery**
- **Network Pharmacy**
- **Non-network Pharmacy**

Appendix A: Home Delivery and the Deployment Prescription Program

- Eligible beneficiaries can fill prescriptions through the Deployment Prescription Program (DPP) if they are:
  - A deployed service member
  - Working as a deployed contractor or civil service employee.
  - Getting health care through the Transitional Assistance Management Program (TAMP)
- Before they deploy, they must:
  - Register for a Home Delivery account
  - Register for the DPP (done at the pre-deployment site)
    - The pre-deployment site sends the *Deployment Prescription Program Registration Form*, along with any prescriptions, to the pharmacy contractor.
  - Get a 180-day supply of their drug(s) from their pre-deployment pharmacy (usually the pharmacy at a military hospital or clinic).
    - The contractor sends only requested drugs
- The pre-deployment site doesn't automatically send out drugs. Instead, the pharmacy contractor sends an e-mail to deployed beneficiaries 2 months into deployment asking them to update their online registration with their current mailing address (APO/FPO).
  - Those who don't get an e-mail 2 months after deploying should contact the DPP Team
    - Phone: Toll Free 855-215-4488 or Direct: 314-684-7506
    - E-mail: DeployedPrescriptionProgram@express-scripts.com
- The pharmacy contractor sends another e-mail to deployed beneficiaries 4 months into deployment reminding them to order their drug.
  - Beneficiaries should log in to their Home Delivery account.
  - The pharmacy contractor sends the prescription to the address the beneficiary gave when ordering the drug.
  - Average shipping time is approximately 3-4 weeks.
- These beneficiaries should keep their e-mail and mailing addresses up to date. The pharmacy contractor mails prescription drugs to the address on file.
- For questions about the DPP, beneficiaries should contact the DPP Team by:
  - Phone: Toll Free 855-215-4488 or Direct 314-684-7506
  - E-mail: DeployedPrescriptionProgram@express-scripts.com
  - Mail:

    Express Scripts, Inc.
    P.O. Box 60903
    Phoenix, AZ 85082-0903
- More information on the DPP is found at www.tricare.mil/dpp

Appendix B: Pharmacy Contact Information

Pharmacy Contact Information	
General Correspondence in the U.S. and U.S. Territories	**Phone:** 1-877-363-1303 **Online:** www.express-scripts.com/tricare **Mail:** Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072
Overseas	Dial the in-country access code listed below: **Germany:** 00+800-3631-3030 **Italy:** 00+800-3631-3030 **Japan—IDC:** 0061+800-3631-3030 **Japan—Japan Telecom:** 0041+800-3631-3030 **Japan—KDD:** 010+800-3631-3030 **Japan—Other:** 0033+800-3631-3030 **South Korea:** 002+800-3631-3030 **Turkey:** 0811-288-0001 (once prompted, input 877-363-1303) **United Kingdom:** 00+800-3631-3030 **All other overseas areas**: 1-866-ASK-4PEC/1-866-275-4732
Pharmacy Operations Division	**Phone:** 1-210-295-1271 (DSN: 421-1271) **Online:** www.health.mil/pod
TDD (Toll free)	1-877-540-6261
E-mail	DOD.customer.relations@express-scripts.com

Pharmacy Claims Filing and Contact Information: U.S. and U.S. Territories
Express Scripts, Inc. P.O. Box 52132 Phoenix, AZ 85082 1-877-363-1303 www.express-scripts.com/TRICARE

Pharmacy Claims Filing and Contact Information: Overseas Areas, Excluding U.S. Territories	
Active Duty Service Members	TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 Eurasia-Africa: 1-877-678-1207, opt 2 Latin America and Canada: 1-877-451-8659, opt 2 Pacific: 1-877-678-1208, opt 2 (Singapore) 1-877-678-1209, opt 2 (Sydney) www.tricare-overseas.com/beneficiaries.htm
Eurasia-Africa	TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 1-877-678-1207, opt 2 www.tricare-overseas.com/beneficiaries.htm
Latin America and Canada	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-877-451-8659, opt 2 www.tricare-overseas.com/beneficiaries.htm
Pacific	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 Singapore: 1-877-678-1208, opt 2 Sydney: 1-877-678-1209, opt 2 www.tricare-overseas.com/beneficiaries.htm

TRICARE Fundamentals Course

Dental

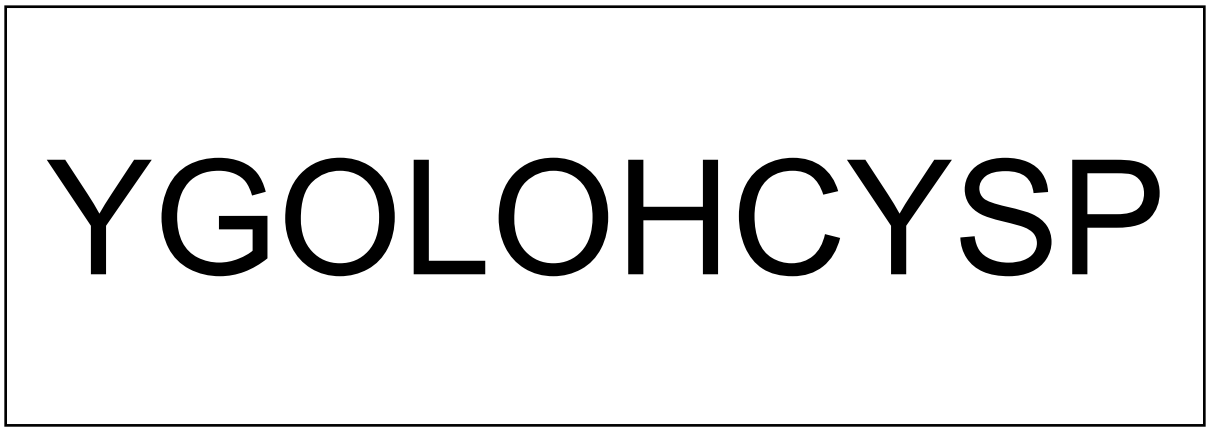
6

Participant Guide

References
10 USC
32 CFR §§ 199.13, 199.22
2008 TRICARE Operations Manual, Chapter 24, Section 10; Chapter 16, Addendum B
TRICARE Policy Manual, Chapter 12, Section 1.1
TRICARE Dental Program Benefit Booklet
www.trdp.org
www.addp-ucci.com
mybenefits.metlife.com/tricare
www.tricare.mil

Brainteasers

What phrase is represented below?



Riddle

What can run, but not walk?

Module Objectives

- **Describe active duty dental coverage**
- **Explain the TRICARE Dental Program (TDP) and who is eligible**
- **Explain the TRICARE Retiree Dental Program (TRDP) and who is eligible**
- **State how TRICARE determines premiums for the TRICARE Retiree Dental Program (TRDP)**

Key Terms

- **Dental Treatment Facility (DTF)**
- **Active Duty Dental Program (ADDP)**
- **TRICARE Dental Program (TDP)**
- **TRICARE Retiree Dental Program (TRDP)**

1.0 Introduction

Dental benefits aren't a part of TRICARE's medical coverage. TRICARE offers dental coverage through:

- Active Duty Dental Care:
  - The Active Duty Dental Program (ADDP)
  - Overseas Dental Care
- The TRICARE Dental Program (TDP)
- The TRICARE Retiree Dental Program (TRDP)

?	Throughout this module, we'll ask you questions about Chief Petty Officer Gorman and his family.

2.0 Active Duty Dental Care

Most active duty service members (ADSMs) get dental care at military dental treatment facilities (DTFs). ADSMs must get prior-authorization before seeing a civilian dentist. How they get civilian care depends on where they are.

Stateside and U.S. Territories (U.S. Virgin Islands, Guam, Puerto Rico, American Samoa, and Northern Mariana Islands)	**All Other Overseas Locations**
Active Duty Dental Program	The TRICARE Overseas Program contractor

2.1 ADDP Eligibility

- ADSMs of the uniformed services, less the U.S. Public Health Service (PHS)
  - PHS covers dental care for its Commissioned Corps officers. For more information, go to http://phsaddp.com/
- National Guard and Reserve members:
  - On active service for more than 30 straight days and showing as eligible in the Defense Enrollment Eligibility Reporting System (DEERS)
  - With delayed-effective-date duty orders, during the pre-activation ("early eligibility") period
  - When covered under the Transitional Assistance Management Program (TAMP). The ADSM's dental care must be able to be completed within the TAMP 180-day period.
  - With a valid Line of Duty (LOD) or Notice of Eligibility (NOE) determination for a dental illness or injury
- Foreign force members stationed in the U.S. whose country has a reciprocal healthcare agreement with the United States.
- Those identified in DEERS as Wounded Warriors (See https://secure.addp-ucci.com/dwaddw/adsm/article.xhtml?content=eligible-adsm for more information).

2.2 Active Duty Dental Program (ADDP)

ADDP covers:

- Stateside civilian dental care when ADSMs get a referral from a DTF to see a civilian dentist (non-remote dental care)
- Dental care for ADSMs in stateside remote locations

2.2.1 Active Duty Dental Program (ADDP) Non-Remote Care

- Non-remote ADSMs (those who live within 50 miles of a DTF), must be referred by the DTF to see civilian dentists. They have to use ADDP network dentists, unless the contractor authorizes care from a non-network dentist.
    - When seeing a civilian network dentist for **authorized** care, ADSMs have no "out-of-pocket" costs. This means they don't have to pay up front for approved dental care.
    - ADSMs who see a non-network dentist without an authorization are responsible for all costs.

2.2.2 Military Dental Treatment Facility (DTF) Referred Care

- When a DTF can't provide care, the dentist writes a referral for civilian care
    - The DTF staff enters the referral online and sends it to the ADDP contractor.
    - For authorized care, the contractor issues a Referral Request Confirmation, which contains the appointment control number (ACN) and lists which dental procedures the ADDP contractor authorized.
    - Members must have an ACN for any civilian dental care.
- ADSMs may schedule their own appointments with network dentists (this is the best option for members) or ask the ADDP contractor to do it.
    - A list of network dentists is at www.addp-ucci.com or https://secure.addp-ucci.com/find-a-dentist/
    - If the ADSM needs help finding a provider, he or she may talk to a Dental Care Finder at 1-866-984-2337 or email: addpdcf@ucci.com
    - Information on making appointments is at https://secure.addp-ucci.com/dwadd/adsm/landing/xhtml.
- ADSMs are to get appointments for routine care (exams, cleanings, fillings) within 21 calendar days and within 28 days for specialty care (e.g., crowns, bridges, dentures, periodontal treatment).
- The ADSM must take the ACN or a copy of the Referral Request Confirmation to the appointment.
- The member should only get the services listed on the referral.
- If the civilian dentist decides the ADSM needs additional treatment, the dentist must contact the DTF, who then sends a new or updated referral to the ADDP contractor.

2.2.2.1. Dental Emergencies

Emergency dental care includes treatment needed to relieve pain, treat infection, or control bleeding. (Crowns, bridges, and denture services aren't emergency services.).

- ADSMs must follow their DTF's emergency dental care procedures.
- If traveling (leave, duty-related), and not within 50 miles of a DTF, ADSMs don't need an ACN.
    - ADSMs may get emergency care from any civilian (including non-network) dentist. They must call the ADDP contractor to tell them about the visit.
    - ADSMs should use an ADDP network dentist because the ADDP contractor may not authorize them to see a non-network dentist for follow-up care.

2.2.3 The Active Duty Dental Program in Remote Areas

- ADSMs in remote areas get their dental care from civilian dentists. The ADDP contractor is responsible for this care. Eligible ADSMs (as noted in section 2.1 of this module) are "remote" if they:
  - Live and work more than 50 miles from a DTF stateside. They usually show as Prime Remote in DEERS.
  - Live and work in a U.S. territory (U.S. Virgin Islands, Guam, Puerto Rico, American Samoa, and the Northern Mariana Islands) with no DTF within 50 miles.

2.2.3.1. Routine Dental Care in Remote Areas

- ADSMs can schedule their own appointments with network dentists. Routine care is care that:
  - Costs less than $750 per procedure or appointment
  - The combined total cost for complete treatment is less than $1,500 a year
- Remote ADSMs must get an ACN. To get an instant ACN, ADSMs may:
  - Fill out the ACN Request Form online at https://secure.addp-ucci.com/daddap/public/acnform.xhtml
  - Call the ADDP contractor at 1-866-984-2337
- After getting their ACN, ADSMs may call a network dentist and book their appointment (the best option for members), or call a Dental Care Finder at 1-866-984-2337 to have the contractor book the appointment for them.

2.2.3.2. Specialty Dental Care in Remote Areas

- ADSMs must have authorization **before** getting specialty dental care (e.g. crowns, bridges, dentures, periodontal treatment) or dental care from non-network providers. Specialty care:
  - Costs more than $750 per service or appointment.
  - Costs more than $1,500 in a given year for completed treatment.
- To get an authorization, the dentist, preferably a network one, must fill out an *Authorization Request Form* (available on the ADDP website in the "Civilian Dentists" portal). They send it to the address on the bottom of the form.
  - Approval can take 3 to 5 business days
  - If the contractor approves the care, it issues an ACN and authorization to the dentist. The authorization lists the approved services.
- After getting the ACN, ADSMs can schedule their appointment

Notes:

- The unit commander, or designee, must sign a command memorandum approving an ADSM to get dental implants or orthodontic services. The Commissioned Personnel Center signs the memorandum for National Oceanic and Atmospheric Administration (NOAA) Corps members.
- Remote Coast Guard members should contact 1-800-942-2422 (1-800-9HBA-HBA) for information about dental benefits. Members may contact the ADDP contractor for information and authorizations for dental care.

2.2.3.3. Emergency Care in Remote Areas

ADSMs in remote areas don't need an ACN for emergency dental care. They should see an ADDP network dentist if possible. The ADDP contractor isn't likely to authorize follow-up care with a non-network dentist.

2.2.4 Claims

- ADDP network dentists file claims with the ADDP contractor.
- When ADSMs get emergency dental care or get authorized services from a non-network dentist, they may have to pay up front and file a claim for reimbursement. To file a claim, ADSMs or providers must:
  - Fill out an American Dental Association® or ADDP claim form, found at: https://secure.addp-ucci.com/dwaddw/adsm/article.xhtml?content=claims-adsm
  - Include copies of paperwork from the dentist showing:
    - Dates of service
    - Specific dental problem
    - Procedure codes
    - A description of the service performed, including tooth numbers
    - X-rays (if applicable)
    - Total charges
    - ACN
    - Dental Readiness Classification (if needed)
  - Include the dentist's bill or statement of charges
- The claims mailing address is:

United Concordia Companies, Inc.
ADDP Claims
P.O. Box 69429
Harrisburg, PA 17106-9429

2.2.5 Cancelled and Missed Appointments

- If ADSMs can't keep an appointment, they should cancel or reschedule at least 24 hours before the scheduled appointment.
- If ADSMs get a bill for a missed appointment, they should contact the ADDP contractor.

2.3 Active Duty Dental Care in Remote Overseas Areas

- TOP coverage includes all dental care (routine, urgent, emergency, and medically necessary transport/evacuation) for ADSMs permanently assigned to, and receiving dental care in, remote overseas areas (other than U.S. Territories).
  - Also covered are ADSMs who are Temporary Duty/Temporary Additional Duty (TDY/TAD), in an authorized leave status, deployed or deployed on liberty in remote overseas areas.
- ADSMs stationed, on TDY/TAD, or visiting overseas should get dental care from a DTF whenever possible. If they aren't near one, they have to contact the overseas contractor's call center before seeing a civilian dentist.
- The overseas contractor contacts qualified overseas dentists and issues authorizations. The care is then "cashless, claimless", meaning the ADSM doesn't pay up front for care. The dentist files the claim and the overseas contractor pays the dentist.
  - Episodes of care over $750 per visit or $1500 per year must be approved by the DHA Dental Program Office (includes routine care)
  - The overseas contractor's contact information is at www.tricare-overseas.com/contactus
- Emergency dental care doesn't need authorization, but service members should contact the overseas contractor's call center when possible to help ensure that care is "cashless, claimless".

2.3.1 Overseas Claims

- If ADSMs don't get authorization before getting care, they may have to pay up front and file a claim for reimbursement. The overseas contractor pays billed charges for overseas dental claims. To file a claim, ADSMs (or a TOP Points of Contact [POC] on behalf of the ADSM) must:
  - Fill out a *TRICARE DoD/CHAMPUS Claim Patient's Request for Medical Payment* (DD Form 2642)
  - Include copies of paper work showing:
    - Dates of service
    - Specific dental problem
    - Procedure codes
    - A description of the service performed, including applicable tooth/teeth numbers
    - Total charges
  - Include a dentist's bill or statement of charges
  - LOD or NOE documentation, if applicable
    - This is important because National Guard or Reserve members with LOD/NOE dental conditions don't show as eligible in DEERS.
    - LOD/NOE service members should work with their unit to get paperwork showing they were eligible on the date of service. Claims must include proof of eligibility (e.g., signed LOD/NOE documents, orders, roster).
- The claims mailing address is:

TRICARE Active Duty Claims
P.O. Box 7968
Madison, WI 53707-7968
USA

- The DHA Dental Program Office may issue retroactive authorizations.
- Claims without the required authorizations will be denied

?	Chief Petty Officer Gorman is on active duty when he starts having tooth pain. He lives less than 10 miles from a DTF. His dentist decides the care CPO Gorman needs isn't available at the DTF, so she refers CPO Gorman to a civilian dentist. Who issues the authorization? What steps must be taken to set up an appointment?

3.0 TRICARE Dental Program

The TRICARE Dental Program (TDP) is a voluntary, premium-based dental program. A new TDP contract begins on May 1 2017. See Section 7.0 or www.tricare.mil/tdp for updates to TDP contractor information including mailing addresses, phone numbers, and websites

3.1 Where is it available?

- **Stateside** and Puerto Rico, Guam, and the U.S. Virgin Islands
- **Overseas**: All other locations

3.2 TRICARE Dental Program Eligibility

TDP is available to:

- Active duty family members (ADFMs)
- National Guard and Reserve family members who are TRICARE eligible

- National Guard and Reserve members who aren't on active duty service or covered by TAMP
- Transitional survivors of an active duty, Selected Reserve of the Ready Reserve, or Individual Ready Reserve (IRR) (*special mobilization category*) sponsor who dies:
  - Unremarried spouses, during the first 3 years after the sponsor's death
  - Surviving children, until they lose eligibility for military benefits (e.g., age out).
- TDP uses DEERS to check enrollment eligibility. Individuals must make sure their DEERS records are up to date.

Note: To be eligible to enroll, the sponsor must have at least 12 months left on his or her military service commitment. This doesn't apply to eligible surviving family members.

3.3 Premiums

- TDP is a "pay ahead" program, meaning each payment is for the next month of coverage. Since premium rates are set each February, enrollees start paying new premiums in January (for February coverage).
- TRICARE bases TDP premiums on the sponsor's status (active duty, Selected Reserve, or IRR) and type of enrollment (single or family).

3.3.1 Payments

- Initial Payment: Enrollees can make their first premium payment by credit card, debit card, check, or money order via Beneficiary Web Enrollment (BWE), phone, or mail.
- Ongoing Payments
  - If the service member's military payroll account can cover the premium, the TDP contractor collects premiums through a uniformed services finance center.
  - If not, then the member sets up recurring payment with a credit/debit card or electronic funds transfer (EFT).

3.3.2 Non-payment

If enrollees don't pay their monthly premiums, their coverage ends. They have to wait 12 months before they can re-enroll (enrollment lock out).

3.4 Enrollment

Individuals must enroll for a minimum of 12 months. After 12 months, they can continue on a month-to-month basis.

3.4.1 Options:

- Single (1 person)
  - 1 ADFM
  - 1 National Guard or Reserve family member
  - 1 National Guard or Reserve sponsor
- Family (2 or more family members, not including the sponsor)
  - If 2 or more family members enroll, the TDP contractor enrolls **all** eligible family members
  - If 1 family member is enrolled and a child turns 4 years old, TDP enrolls the child. Premium rates go from single to family.
  - The sponsor can enroll a child under age 4 at any time, as long as the child is in DEERS.

Note: National Guard and Reserve members must enroll under a single enrollment. They submit a second enrollment request for their family members.

- Individuals can enroll:
  - By calling the TDP contractor
  - Online via the Beneficiary Web Enrollment (BWE) portal at http://dmdc.osd.mil/appj/bwe (Beneficiaries need a CAC or DS Logon to access BWE.). BWE may be available overseas for those located near a military clinic or hospital in early 2017.
  - By mailing a *TDP Enrollment/Change Authorization* request to the TDP contractor. (The request authorization is found at https://eforms.metlife.com/wcm8/PDFFiles/41075.pdf.)
- Enrollees can visit https://mybenefits.metlife.com/tricare to create an account. This online account allows enrollees with a CAC or DS Logon to:
  - View dental coverage
  - Check a claim
  - View claims history
  - View explanation of benefits
  - Find a dentist
  - File a complaint
  - View frequently asked questions
  - View oral health history
  - Download forms, documents, the TDP Benefit Handbook, and other materials

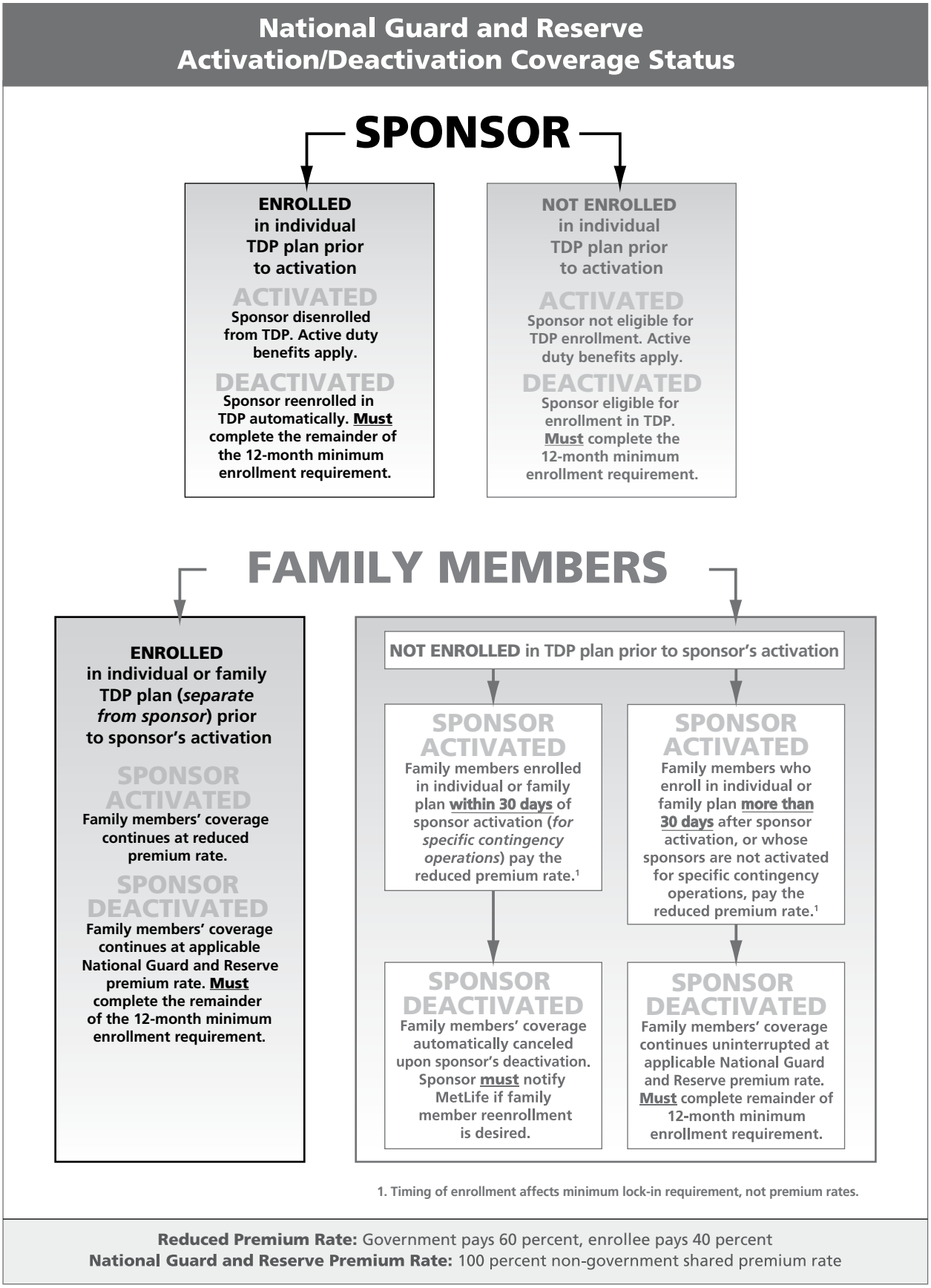
3.4.2 The TDP Contractor:

- Checks eligibility in DEERS.
- Checks that the sponsor submitted a correct premium payment. (A 1-month premium payment is due at the time of enrollment.)
- Processes the enrollment in DEERS.

3.4.3 Coverage dates

- **Coverage starts:**
  - On the **1st day of the next month** if the contractor receives the enrollment **by the 20th of the month**
  - On the **1st day of the second month** if the contractor receives the enrollment **after the 20th of the month**
- Each enrollee's TDP card shows the coverage start date. Enrollees can get initial and replacement cards by going to the BWE website. The TDP contractor doesn't issue enrollment cards.
- Special enrollment processes apply to Guard and Reserve members and their families when activating or deactivating. (See the chart on the next page.)

?	CPO Gorman's wife recently went from working full-time to part-time. As a result, she lost her employee-sponsored benefits, and now wants dental coverage though TRICARE. Is she eligible for coverage? If so, will she and CPO Gorman both be covered under the same dental program? Why or why not?


National Guard and Reserve
Activation/Deactivation Coverage Status
SPONSOR
ENROLLED
in individual
TDP plan prior
to activation
ACTIVATED
Sponsor disenrolled
from TDP. Active duty
benefits apply.
DEACTIVATED
Sponsor reenrolled in
TDP automatically. Must
complete the remainder of
the 12-month minimum
enrollment requirement.
NOT ENROLLED
in individual
TDP plan prior
to activation
ACTIVATED
Sponsor not eligible for
TDP enrollment. Active
duty benefits apply.
DEACTIVATED
Sponsor eligible for
enrollment in TDP.
Must complete the
12-month minimum
enrollment requirement.
FAMILY MEMBERS
ENROLLED
in individual or family
TDP plan (separate
from sponsor) prior
to sponsor's activation
SPONSOR
ACTIVATED
Family members' coverage
continues at reduced
premium rate.
SPONSOR
DEACTIVATED
Family members' coverage
continues at applicable
National Guard and Reserve
premium rate. Must
complete the remainder
of the 12-month minimum
enrollment requirement.
NOT ENROLLED in TDP plan prior to sponsor's activation
SPONSOR
ACTIVATED
Family members enrolled
in individual or family
plan within 30 days of
sponsor activation (for
specific contingency
operations) pay the
reduced premium rate.1
SPONSOR
ACTIVATED
Family members who
enroll in individual or
family plan more than
30 days after sponsor
activation, or whose
sponsors are not activated
for specific contingency
operations, pay the
reduced premium rate.1
SPONSOR
DEACTIVATED
Family members' coverage
automatically canceled
upon sponsor's deactivation.
Sponsor must notify
MetLife if family
member reenrollment
is desired.
SPONSOR
DEACTIVATED
Family members' coverage
continues uninterrupted at
applicable National Guard
and Reserve premium rate.
Must complete remainder of
12-month minimum
enrollment requirement.
1. Timing of enrollment affects minimum lock-in requirement, not premium rates.
Reduced Premium Rate: Government pays 60 percent, enrollee pays 40 percent
National Guard and Reserve Premium Rate: 100 percent non-government shared premium rate

3.5 Provider Types

Stateside, Puerto Rico, Guam, and the U.S. Virgin Islands	**Overseas** (All other locations)
Preferred Dentist Program (PDP) dentists (network dentists): ● Sign a contract with the TDP contractor and agree to follow TDP rules for care and payment ● Complete and file claims for enrollees **Non-network dentists:** ● Don't have a contract ● May make enrollees pay up front for services ● May or may not file claims	**TRICARE Outside the Continental United States (OCONUS) Preferred Dentists (TOPDs):** ● Won't make enrollees pay billed charges at the time of service ● Complete and file claims for enrollees **Non-TOPD dentists:** ● May make enrollees pay up front for services ● May or may not file claims

3.6 Claims

- Premium payment must be current for the TDP contractor to pay on dental claims.
- For claim forms and instructions go to http://www.tricare.mil/CoveredServices/Dental/TDP/Claims.aspx.
    - Overseas, claim submission documents are also available from the nearest TRICARE Area Office (TAO), overseas uniformed services dental care facility, or remote-area designated points of contact (POCs).
- Enrollees need to file or make sure their dentist files claims within 1 year from the date of service.

Stateside, Puerto Rico, Guam, and the U.S. Virgin Islands	**Overseas** (All other locations)
The TDP contractor accepts any standard American Dental Association® claim form ● The dentist or family must file separate claims for each enrollee (e.g., 3 children see 1 dentist on the same day, the dentist/family files 3 separate claims) ● If the dentist is a participating dentist, his or her office files claims ● If the dentist doesn't participate, enrollees may need to file their own claims **Note:** See Section 7.0 for mailing and fax information for TDP claims before and after May 1 2017	If the dentist's bill doesn't have the following information, enrollees must include it in their claim package: ● Date(s) of service ● Provider name, address, and phone number ● The specific treatment given and why ● Procedure code (If there's no procedure code, there has to be a complete written description of dental services including tooth number(s)) ● Which specific tooth/teeth the dentist treated ● Total charges **Note:** See Section 7.0 for mailing and fax information for TDP claims before and after May 1 2017

3.7 Costs

- Enrollees pay a cost share for dental care. The percentage varies based on the sponsor's pay grade, location, and the type of dental care. Cost share information is at http://www.tricare.mil/Costs/DentalCosts/TDP/CostShares.aspx
- Enrollees pay less out-of-pocket costs if they see a PDP dentist. Though they can see a non-network dentist, the enrollee pays his or her cost share and the difference between the TDP payment and billed charges.
- TDP enrollees can get dental care anywhere.
    - Overseas command-sponsored family members enrolled in TDP pay reduced cost-shares. Those not command sponsored pay more.
    - The lower overseas cost-share doesn't apply when command-sponsored enrollees don't get care stateside.

3.8 Annual and Lifetime Maximums

- **Maximum:** the most the TDP pays **in a benefit year** (May 1-April 30)
    - Annual maximum (non-orthodontic services): $1,300 per enrollee (will increase to $1,500 on May 1 2017)
        - Some diagnostic and most preventive services don't count against the annual maximum
    - Accidental annual maximum (dental treatment due to an accident): $1,200 per enrollee
- **Lifetime Maximum:** the most the TDP pays **in an enrollee's lifetime**
    - Orthodontic lifetime maximum: $1,750 per person (doesn't include orthodontic diagnostic services)
- In the overseas service area, TDP pays valid costs over the allowed amount, up to billed charges for command-sponsored enrollees only.

3.9 Disenrollment

- Enrollees may disenroll from the TDP after their 12-month commitment. They may disenroll:
    - By calling the TDP contractor
    - Online via the Beneficiary Web Enrollment (BWE) portal at http://dmdc.osd.mil/appj/bwe
    - By mailing a *TDP Enrollment/Change Authorization* to the TDP contractor.
- Coverage ends:
    - On the **1st day of the next month** if the contractor receives the disenrollment **by the 20th of the month**
    - On the **1st day of the second month** if the contractor receives it **after the 20th of the month**

Note: There are some exceptions to the 12-month commitment (see Appendix A for details)

4.0 TRICARE Retiree Dental Program

The TRICARE Retiree Dental Program (TRDP) is a voluntary, premium-based dental plan.

4.1 TRDP Coverage

- **Enhanced TRDP**: Worldwide
- **Basic TRDP**: Limited benefit available only in the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada. Basic TRDP is closed to new enrollments.

4.2 TRICARE Retiree Dental Program (TRDP) Eligibility

TRDP is available to:

- Retired service members and their eligible family members
- Retired National Guard and Reserve members, including those who aren't 60 years old and who aren't receiving retired pay, and their eligible family members
- Eligible surviving children of a sponsor who died on retired status (up to age 21 or 23)
- Unremarried surviving spouses of sponsors who died on retired status
- Surviving spouses of sponsors who died while on active service for more than 30 days (once they're no longer eligible for TDP)
- Medal of Honor recipients and their eligible family members

TRDP uses DEERS to check eligibility. Individuals must keep DEERS records up to date to show they are eligible.

4.3 Premiums

TRICARE bases TRDP premiums on the enrollee's home ZIP code and number of enrolled family members. Premium rates change January 1. Rates are at http://www.trdp.org/retirees/premiums.html.

Initial Payment:

The beneficiary makes the initial 2-month payment by credit card, debit card, or EFT.

- **Ongoing Payments:**
  - If the retiree's service retirement pay can cover the premiums, the TRDP contractor collects premiums through a retired pay allotment.
  - If not, then the retiree can set up ongoing payments with an EFT or credit card. Payment must be set up before the third payment is due to avoid a break in coverage.
- **Non-payment:** If enrollees don't pay their monthly premiums, their coverage ends. When this happens, they can't re-enroll for 12 months (enrollment lockout).

4.4 Enrollment

Individuals must enroll for a minimum of 12 months. After that, they can continue coverage on a month-to-month basis.

- Only the retiree (or surviving family member) can enroll or add family members.
- Most of the time, the retiree must enroll in TRDP to enroll his or her family members. There are some exceptions (see Appendix B for details).

4.4.1 Options:

- Single-person enrollment
- 2-person enrollment
- Family enrollment (3 or more persons)

Notes:

- ADSMs and their family members may enroll 30 days before the sponsor's retirement effective date. Coverage starts on the date of retirement (as listed on the enrollment request).
- Those who complete an enrollment request within 120 days of the sponsor's retirement are eligible for the full range of TRDP dental benefits. Enrolling 120 days or more after retirement requires 12 months of enrollment before enrollees can get certain dental services (referred to as the 12-month major services waiting period).
  - This also applies to surviving spouses who enroll within 120 days of losing TDP eligibility.
  - Those who enroll within the 120-day time frame have to let the contractor know by submitting an online inquiry. The online inquiry site is: http://www.trdp.org/customer-inquiry.html

- **Individuals can enroll:**
  - Online via the BWE website at http://dmdc.osd.mil/appj/bwe.
  - By mail

4.4.2 The TRDP contractor:

- Checks eligibility.
- Checks that the sponsor/family submitted the correct premium payment (2-month premium payment).
- Verifies receiving the premium payment from member's/family's allotment or financial institution.
- Processes the enrollment.

Coverage starts on the 1st day of the month after the TRDP contractor processes a complete enrollment.

- The TRDP ID card shows the coverage start date.
- Enrollees print out TRDP cards from the BWE website.

Note: A TRDP ID card isn't needed to receive dental care services. It helps the dentist file claims.

4.5 Provider Types

Participating TRDP Network Dentists	Out-of-Network Dentists
● Sign a contract with the TRDP contractor. Network providers agree to follow TRDP rules for care and payment ● Complete and file claims for enrollees ● Bill enrollees their cost shares for covered services **Note:** There are no participating network dentists in American Samoa, the Northern Mariana Islands, or Canada	● **Delta Dental dentists (who are not part of the TRDP network):** ○ File claims for enrollees ○ Will not bill enrollees for more than their cost share and deductible plus the difference up to their "Delta Dental approved amount" ● **Non-Delta Dental dentists:** ○ May make enrollees pay up front for services ○ Don't have to file claims for enrollees. They bill enrollees their cost share plus the difference between the TRDP payment and billed charges ● **TRDP Overseas:** Enrollees may see any civilian dentist.

4.6 Claims

- Enrollees' premium payments must be current for TRDP to pay on dental claims.
- Enrollees can view premium payment status, benefits, deductibles and cost shares, and check on claims through a Consumer Toolkit® account at https://www.ddfgptoolkits.com/ipWeb/appmanager/ct/desktop.
- Providers or enrollees must file clams within 1 year from the date of service. If they don't, TRDP denies payment.
- Go to http://tricare.mil/CoveredServices/Dental/TRDP/Claims.aspx for claims forms and instructions.

Enhanced TRDP (Stateside, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Northern Mariana Islands, and Canada)	**Overseas TRDP** (All other locations)
Filing claims: ● Participating TRDP network dentists and other Delta Dental dentists file claims for enrollees. ● If seeing a non-TRDP/Delta Dental dentist, enrollees have to file their own claims. **Mail to:** Delta Dental of California P.O. Box 537007 Sacramento, CA 95853-7007	**Filing claims:** ● Enrollees must file their own claims. ● The contractor converts the fees and pays the enrollee in U.S. dollars. The exchange rate on the date of service determines how much the contractor pays the enrollee. ● Enrollees may use the online TRDP Overseas Claim Submission form to submit claims electronically. ○ The overseas claim submission site is at https://secure.ddpdelta.org/forms/web/OSClaim.aspx **Mail to:** Delta Dental of California P.O. Box 537006 Sacramento, CA 95853-7006 United States of America

4.7 Costs

Along with monthly premiums, TRDP enrollees pay a deductible and cost shares for covered services.

4.7.1 Deductible

- The deductible applies to each benefit year (January 1-December 31)
- Enrollees have to pay the deductible first, then TRDP starts paying on claims
- The deductible is $50 per person, up to $150 per family
- Enrollees don't pay a deductible for diagnostic and preventive services

4.7.2 Cost shares

- Cost shares depend on the type of service and whether the dentist is a participating network dentist or an out-of-network dentist
  - **Participating TRDP network dentists:** Enrollees only pay their cost share amount and deductible.
  - **Delta Dental dentists:** Enrollees pay their deductible, cost share, and up to the Delta Dental approved amount, after TRDP pays.
  - **Non-Delta Dental dentists:** Enrollees pay their deductible, cost share and the difference between the TRDP payment and the dentist's billed charges.
- For an overview of cost shares, go to http://tricare.mil/CoveredServices/Dental/TRDP/Costs.aspx

- If a TRDP member has other dental coverage, they need to give the dental office the following:
  - The other plan's name and mailing address
  - Coverage effective date,
  - Primary enrollee's name, date of birth and plan identification number
  - Whichever plan the enrollee had first, is the first payer on dental claims. For example, if the family had dental coverage under OHI before they purchased TRDP, OHI pays first and TRDP pays second. If they had TRDP before OHI, TRDP pays first and OHI pays second.

4.8 Annual and Lifetime Maximums

Annual Maximums: the most TRDP pays **in a benefit year** (January 1-December 31)

- Enhanced enrollees' non-orthodontic services: $1,300 per person
  - Some diagnostic and preventive services payments don't apply to the annual maximum
- Enhanced enrollees' accidental care (dental care due to an accident): $1,200 per person

Lifetime Maximum: the most the government pays **in a person's lifetime**

- Enhanced enrollees' orthodontic lifetime maximum: $1,750 per person

?	CPO Gorman's father is soon to be a retired uniformed service member. To continue dental coverage for he and his wife, they send a TRDP enrollment form a month before his retirement effective date. Will the elder Mrs. Gorman's dental cost shares be the same as her cost shares under TDP? What is a known cost difference between these two programs?

4.9 Disenrollment

- TRDP allows enrollees to disenroll after their initial 12-month enrollment period ends. After that, individuals may disenroll at any time
  - By calling the dental contractor
  - Online via the BWE website at http://dmdc.osd.mil/appj/bwe
  - By mail
- Enrollees have a 30-day grace period to disenroll (30 days from the coverage start date) with no 12-month enrollment requirement as long as the contractor hasn't processed a claim for any enrollee (sponsor or family).
  - Only the sponsor or surviving family member can disenroll family members.
  - The sponsor has to request disenrollment at least a 30 days before he or she wants coverage to end.
  - Those who disenroll after the grace period, but before their 12-month commitment period ends, can't re-enroll for 12 months (enrollment lockout).

5.0 Anesthesia for Dental Treatment

- TDP and TRDP cover deep sedation and intravenous conscious sedation only when given for a covered procedure and by a dentist or other professional provider licensed and approved to provide anesthesia in the state where the enrollee gets the treatment under sedation. Enrollees have a cost-share.
- The **TRICARE medical benefit** covers general anesthesia services for dental treatment for beneficiaries with developmental, mental, or physical disabilities and children age 5 or under.
  - Beneficiaries must get prior authorization before getting anesthesia services under the medical benefit.
  - Cost shares depend on the beneficiary's TRICARE program option
  - Cost shares don't count against the TDP or the TRDP annual maximums

6.0 ADDP Resources

Active Duty Dental Program (ADDP)		
	U.S. & U.S. Territories	**Overseas**
Website	www.addp-ucci.com	http://www.tricare-overseas.com/
E-mail	addpdcf@ucci.com	**Eurasia-Africa:** tricarelon@internationalsos.com **Latin America and Canada:** tricarephl@internationalsos.com **Pacific:** **Singapore:** sin.tricare@internationalsos.com **Sydney:** sydtricare@internationalsos.com
Phone	1-866-984-ADDP (1-866-984-2337)	**Eurasia-Africa:** 1-877-678-1207 (stateside) +44-20-8762-8384 (overseas) **Latin America and Canada:** 1-877-451-8659 (stateside) 1-215-942-8393 (overseas) **Pacific**: **Singapore:** +65-6339-2676 (overseas) **Sydney:** 1-877-678-1209 (stateside) +61-2-9273-2710 (overseas) * For toll-free and country-specific contact information, go to www.tricare-overseas.com

Active Duty Dental Program (ADDP)		
	U.S. & U.S. Territories	**Overseas**
Mail	UCCI ADDP Unit P.O. Box 69430 Harrisburg, PA 17106-9430	TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968 www.tricare-overseas.com

7.0 TDP Resources

	TRICARE Dental Program (TDP) **Before May 1 2017**	**TRICARE Dental Program (TDP)** **Starting May 1 2017**
Website	http://mybenefits.metlife.com/tricare	
E-mail	**CONUS:** N/A **OCONUS:** OCONUSdentalclaims@metlife.com	
Phone	**CONUS:** 1-855-638-8371 1-855-638-8373 (TTY/DD) Sun 6:00 p.m.– Fri 10:00 p.m. (ET), except holidays **OCONUS:** 1-855-638-8372 1-855-638-8373 (TTY/TDD) Sun 6:00 p.m.– Fri 10:00 p.m. (ET), except holidays	**CONUS**: Toll: 717-888-7400 Toll free: 844-653-4061 **OCONUS:** Toll free: 844-653-4060
Enrollment Authorization Paperwork	https://eforms.metlife.com/wcm8/PDFFiles/41075.pdf	
Enrollment Authorization Mailing	MetLife TRICARE Dental Program Enrollment and Billing Services P.O. Box 14185 Lexington, KY 40512	
Claims Mailing Address	TRICARE Dental Program P.O. Box 14181 Lexington, KY 40512	United Concordia P.O. Box 69451 (**CONUS**) P.O. Box 69452 (**OCONUS**) Harrisburg, PA 17106
Claims Fax	**CONUS:** 1-855-763-1333 **OCONUS:** 1-855-763-1334	

8.0 TRDP Resources

	TRICARE Retiree Dental Program (TRDP)
Website	www.trdp.org
E-mail	**Online Inquiry:** http://www.trdp.org/customer-inquiry.html
Phone	1-888-838-8737 (24 hours automated) 1-866-847-1264 (TTY/TDD) +866-721-8737 (International, AT&T USA Direct Access) **Note:** Individuals must be enrolled to speak to a Delta Dental Customer Service Representative. **Benefit advisors:** http://www.trdp.org/benefits-advisors/local-support.html
Enrollment Authorization Paperwork	http://trdp.org/downloads/enrollment-application.pdf
Enrollment Authorization Mailing	Delta Dental of California Federal Government Programs P.O. Box 537008 Sacramento, CA 95853-7008

Module Objectives

- **Describe active duty dental coverage**
- **Explain the TRICARE Dental Program (TDP) and who is eligible**
- **Explain the TRICARE Retiree Dental Program (TRDP) and who is eligible**
- **State how TRICARE determines premiums for the TRICARE Retiree Dental Program (TRDP)**

Key Terms

- **Dental Treatment Facility (DTF)**
- **Active Duty Dental Program (ADDP)**
- **TRICARE Dental Program (TDP)**
- **TRICARE Retiree Dental Program (TRDP)**

Appendix A: Additional TRICARE Dental Program (TDP) Information

Enrollment

- Under the TDP family enrollment, if 1 family member enrolls, TDP enrolls all eligible family members. Exceptions:
  - The sponsor chooses not to enroll children under age 4. This only applies if there is only 1 enrolled family member age 4 or older.
  - Family members live in 2 or more locations (e.g., family remains behind for child to finish school). The sponsor may enroll only family members living in 1 location or in all locations. The sponsor has to let the TDP contractor know which family members live where. (DEERS should probably show this same information.)
  - An ADFM needs a hospital or special treatment environment (due to a medical condition, physical handicap, or behavioral health condition) when getting dental care. The sponsor doesn't have to enroll or may disenroll the family member.
    - The sponsor has to arrange for the family member to get care at a military hospital or clinic.
    - The sponsor must send the TDP contractor a written request to end the family member's enrollment.
    - The sponsor has to include a signed letter from the family member's provider or military hospital or clinic administrator confirming the need for special treatment.
  - National Guard and Reserve sponsors enroll separately from their family members.
    - The sponsor doesn't have to be enrolled for family members to enroll.
    - If a sponsor chooses to enroll both self and family, there is 1 premium payment for the sponsor and 1 for the family members.

Notes:

- If a family is a dual military couple (both active duty), they can't enroll the same family member(s). They have to decide which children to enroll under which sponsor.
- When both spouses are service members, neither can enroll in TDP as a family member. They each enroll as their own sponsor.

National Guard and Reserve Sponsors

- All members of the National Guard and Reserve must have an annual dental exam. They are responsible for giving an *Active Duty/Reserve Forces Dental Examination Form* (DD Form 2813) to the dentist and reporting the result to their service.
  - DD Form 2813 is available at https://employeedental.metlife.com/dental/public/EmpEntry.do
  - TDP-participating dentists complete the DD Form 2813 at no cost to the service member

TDP Survivor Benefit

- When a sponsor dies, the surviving spouse and children are eligible for the TDP Survivor Benefit.
  - They don't have to be in TDP at the time of the sponsor's death.
  - If enrolled, the TDP contractor automatically disenrolls surviving family members and enrolls them in the TDP Survivor Benefit. The TDP contractor notifies survivors of the disenrollment and the terms of the TDP Survivor Benefit.
- Spouses are eligible for up to 3 years beginning on the date of the sponsor's death.
  - Once the 3 years end, surviving spouses are eligible for TRDP.
- Children remain eligible until they lose TRICARE eligibility.
- The survivor benefit also applies to family members of the Selected Reserve of the Ready Reserve and IRR. There is no requirement for the sponsor to have been on active duty orders or enrolled in the TDP at the time of his or her death.
- The government pays 100% of the TDP premium.
- Family members are responsible for TDP cost-shares.

Note: The TRDP may be available to surviving family members who don't qualify for the TDP Survivor Benefit.

Disenrollment

Exceptions to the 12-month commitment period

Scenario	Description
Family member loses eligibility	Sponsor or family member loses eligibility due to death, divorce, marriage, age, or end of eligibility.
Sponsor and family move to the OCONUS service area	TDP enrollees may disenroll within 90 calendar days of the transfer. The date of the relocation must be on the disenrollment request. TDP bases the disenrollment date on the date the contractor gets the disenrollment request.
ADSM gets permanent change of station orders	If an ADSM transfers with TDP-enrolled family members to a duty station where they can get space-available dental care at the local DTF, the sponsor may disenroll his or her family within 90 calendar days of the transfer. TDP bases the disenrollment date on the date the contractor gets the disenrollment request.
National Guard or Reserve sponsor is deactivated (sponsor was on active duty for more than 30 days in a row)	Family members can disenroll if they enrolled within 30 days of their sponsor's activation (unless the sponsor requests re-enrollment).
National Guard or Reserve sponsor transfers to standby or retired reserve	A Guard or Reserve member can disenroll if his or her Service transfers the member to the Standby Reserve or Retired Reserve.

Appeals

There are 3 levels of appeal for denied claims:

- Level I: Reconsideration
- Level II: Formal Review
- Level III: Hearing

All denials explain how, where, and by when to file an appeal.

Appendix B: Appendix B: Additional TRICARE Retiree Dental Program (TRDP) Information

Eligibility

- Individuals who aren't eligible:
  - Former spouses of eligible members
  - Remarried surviving spouses of deceased members

Enrollment

- Usually, the retiree must enroll so his or her family members can enroll. Family members may enroll without the sponsor enrolling if they have documented proof one of the following applies to the retiree:
  - Is eligible to get ongoing comprehensive dental care from the Department of Veterans Affairs
  - Has a dental plan through employment, but the plan isn't available to family members
  - Can't get TRDP because of a current and enduring medical or dental condition

Appeals

There are 2 levels of appeal for denied claims:

- First-Level Appeal: Reconsideration
- Second-Level Appeal: Formal Review

All denials explain how, where, and by when to file an appeal.

TRICARE Fundamentals Course

National Guard and Reserve

7

Participant Guide

References

10 USC
32 CFR § 199.20
2008 TRICARE Policy Manual, Chapter 10
2008 TRICARE Operations Manual, Chapter 22, Chapter 24
www.tricare.mil/tma/greatlakes
www.dol.gov/elaws/userra.htm
DoD Instruction 1241.03

Brainteaser

Each of the eight items below is a separate puzzle.

How many can you figure out?

1. DOX DOX	2. ##### wait	3. polmomice	4. B BA BACK
5. STEP PETS PETS	6. k c u t s	7. DDDWESTDDD	8. b bow w

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

- **Define line of duty determinations and their use**
- **Explain TRICARE coverage for Guard/Reserve members on active service for more than 30 consecutive days**
- **Describe how delayed-effective-date active duty orders affect eligibility**
- **Describe TRICARE Reserve Select® (TRS) and TRICARE Retired Reserve® (TRR)**

Key Terms

- **Line of Duty (LOD)/Notice of Eligibility (NOE) Determination**
- **Early Eligibility**
- **TRICARE Reserve Select (TRS)**
- **TRICARE Retired Reserve (TRR)**
- **Purchase Suspension**

1.0 Introduction

The 7 U.S. Uniformed Services National Guard and Reserve components are:

- Army National Guard
- Army Reserve
- Marine Corps Reserve
- Naval Reserve
- Air Force Reserve
- Air National Guard
- Coast Guard Reserve

TRICARE options for Guard/Reserve members vary based on the sponsor's status.

- When on active service for more than 30 consecutive days and showing as eligible in the Defense Enrollment Eligibility Reporting System (DEERS), Guard/Reserve members have the same health care benefits as active duty service members (ADSMs).
- When on active service for 30 days or less, Guard/Reserve members may qualify for other TRICARE programs or benefits.

?	Throughout this module, you will answer scenario questions on Sergeant Wilson, a member of the Selected Reserve of the Ready Reserve.

2.0 Coverage While on Active Service for 30 Days or Less

Potential Coverage	Sponsor Coverage	Family Coverage
Line of Duty (LOD) Care/Notice of Eligibility (NOE)	LOD/NOE care covers treatment of an injury, illness, or disease that occurs in the line of duty. (See Section 2.1.)	Guard/Reserve family members aren't eligible for care under a sponsor's LOD/NOE.
TRICARE Reserve Select (TRS)	Qualified members may purchase TRS member-only or TRS member-and-family coverage. (See Section 7.0.)	TRS covers eligible family members when the sponsor purchases TRS member-and-family coverage.
TRICARE Dental Program (TDP)	Eligible sponsors may purchase TDP sponsor coverage. This is separate from TDP family coverage. (See the *Dental* module for more information.)	Sponsors may purchase TDP coverage for eligible family members.

2.1 Line of Duty/Notice of Eligibility Determination (LOD/NOE)

- The Services use an LOD/NOE determination to document, establish, manage, and request authorization for health care. LODs/NOEs are for Guard/Reserve members when an injury, illness, or disease occurs in the line of duty. Please note that the Coast Guard refers to an LOD as an NOE
    - Guard/Reserve members who work within 40 miles of a military hospital or clinic should seek LOD/NOE care from that military hospital or clinic. The Guard/Reserve member's command or medical unit should contact the military hospital or clinic patient administration office to coordinate care.
    - When Guard/Reserve members are on active service for 30 days or less (e.g., IDT, AT, or drill weekends), they don't show as eligible in DEERS. They can get care for a specific injury, illness, or disease that occurred in the line of duty only with a valid LOD/NOE determination. An LOD/NOE can also cover travel directly to or from (and while remaining overnight) their place of duty.

- The Defense Health Agency-Great Lakes (DHA-GL) authorizes civilian LOD/NOE care for Guard/Reserve members who **aren't** within 40 miles of a military hospital or clinic (they live and work in a remote location).
  - The unit medical representative submits the LOD/NOE determination, a copy of orders or a drill attendance sheet, and a *DHA-GL Medical Eligibility Verification Form* to DHA-GL. The form is found at http://www.health.mil/GreatLakes.
  - DHA-GL reviews the documentation and issues an authorization determination.
- The member doesn't need prior authorization for an initial emergency room visit. If admitted to a hospital/ inpatient facility, the member must get a DHA-GL or military hospital or clinic authorization before or as soon as possible after admission.
- After leaving the hospital/facility, the member must get a referral and prior-authorization before getting ongoing care.
- **Overseas:** Guard/Reserve members must use their service's procedures for LOD/NOE care. DHA-GL doesn't manage LOD/NOE care overseas other than in the U.S. Virgin Islands. For LOD/NOE care in the U.S. Virgin Islands, call DHA-GL at 1-888-647-6676
  - The TOP contractor will process initial and follow-on LOD claims for Guard/Reserve members on orders for 30 consecutive days or less, who are injured while traveling to or from annual training, or while performing their annual training and who receive civilian medical care overseas.
  - Members have to give copies of their LOD and eligibility status paperwork to the contractor.
  - The TOP contractor processes the claim upon verification of LOD status.

?	2 days after SGT Wilson's arrival, a canister falls on her foot while she's unloading a military transport vehicle. What needs to happen to get her care? Can she get care at a military hospital or clinic? Can she get civilian care?

2.2 LOD/NOE Coverage after Release from Active Service

- Guard/Reserve members may continue LOD/NOE care after release from active service for up to 1 year from date of diagnosis. If the member is still not fit for duty 1 year after the date they were injured or became ill and is not expected to be fit for duty within 6 months, he or she will be referred to the Integrated Disability Evaluation System (IDES).
- Members should make sure they and their command or medical unit have the official, signed LOD/NOE documents before releasing the member from active service. They may need it for ongoing care and claims processing.

Note: For more information on LOD/NOE care stateside, visit the DHA-GL website at http://www.health.mil/GreatLakes.

2.3 Guard or Reserve Members and LOD/NOE Retail Pharmacy Claims

- Guard/Reserve members with a confirmed LOD/NOE illness or injury must pay for their own prescription medications since they don't show as TRICARE eligible in DEERS.
- These members must complete a *TRICARE DoD/CHAMPUS Medical Claim–Patient's Request for Medical Payment* (DD Form 2642) and follow the steps below:

	Care Rendered Stateside and in the U.S. Virgin Islands	**Care Rendered in All Other Overseas Locations**
Step 1	Member submits the *DD Form 2642*, pharmacy receipts, and LOD/NOE documents to: Defense Health Agency-GL Attn: RC Retail Pharmacy Reimbursement Suite 304 2834 Green Bay Road North Chicago, IL 60064-3091 Fax: 1-847-688-6460	Member submits the *DD Form 2642*, pharmacy receipts, and LOD/NOE documents to: Overseas Active Duty Claims TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968
Step 2	DHA-GL reviews the documents and verifies eligibility. They send the *DD Form 2642* and the receipt or invoice to the pharmacy contractor. The contractor processes the claim.	The overseas claims processor receives and reviews the claim, verifies eligibility, and then processes the claim.
Step 3	The pharmacy contractor mails the check to the member.	The overseas contractor's claims processor mails the check to the member.

3.0 Coverage for Guard/Reserve Members With Early Eligibility

- When Guard/Reserve members get delayed-effective-date orders to active service for more than 30 consecutive days in support of a contingency operation, they and their eligible family members may be TRICARE eligible.
- Eligibility begins on the date the service issues the delayed-effective-date order or up to 180 days before the member reports for active service (whichever is later). This is known as "early eligibility."
  - The coding of "early eligibility" in DEERS is a service responsibility.
  - Members need to address eligibility issues with their unit. The personnel office notifies the member of his or her early eligibility status.
- Sponsors with early eligibility may either:
  - Seek care at a military hospital or clinic if living and working within 40 miles of that facility. (Must get a military hospital or clinic referral and authorization for non-routine care from a civilian provider.)
  - Seek covered primary care from a TRICARE-authorized provider (military, network, or non-network). Members in remote locations must get authorizations for non-routine care through the regional contractor and DHA-GL or the overseas contractor.
  - Sponsors don't enroll in TRICARE Prime until they reach their final duty station. They then follow command guidance.

- ADSMs may continue to buy other health insurance (OHI), but TRICARE becomes primary payer while they show as active duty.
- Family members:
  - Automatically have TRICARE Standard/Extra when first showing as eligible in DEERS. They may continue to buy their OHI. They may be Standard or enroll in a Prime option. TRICARE is second payer.
  - May be able to enroll in a TRICARE Prime option, including Prime, TRICARE Prime Remote for Active Duty Family Members (TPRADFM), TOP Prime, and TOP Prime Remote. Family members may also be able to enroll in the US Family Health Plan (USFHP).
- If a sponsor and family are enrolled in TRICARE Reserve Select (TRS) when early eligibility begins, TRS coverage automatically ends.

3.1 Guard/Reserve Early Eligibility Scenarios

Scenario 1: On March 1, a Guard/Reserve member gets delayed-effective-date orders to active service for 180 consecutive days, with a reporting date of September 1. On March 5, TRICARE coverage begins for the Guard/Reserve member and eligible family members.

Scenario 2: On March 1, a Guard/Reserve member gets delayed-effective-date orders to active service for 180 consecutive days, with a reporting date of September 1. On March 5, TRICARE coverage begins for the Guard/Reserve member and eligible family members. On April 1, the service amends the Guard/Reserve member's orders and cancels his or her active service. As a result, the member's and family's TRICARE coverage ends April 1.

?	On March 1, SGT Wilson receives orders to active service for 90 consecutive days in support of a contingency operation, starting September 1. Does SGT Wilson qualify for early eligibility? If so, when is she TRICARE- eligible? Can she enroll in TRICARE Prime?

4.0 Coverage While on Active Service for More Than 30 Days

Potential Coverage	Sponsor Coverage	Family Coverage
Medical Coverage (during active service)	● After arriving at their final duty location, members should follow command guidance on TRICARE Prime-option enrollment. ● They may continue to buy OHI, but TRICARE is primary payer	● Family members are automatically TRICARE Standard and Extra ● Family members may be able to enroll in a TRICARE Prime option. ● They may continue to buy their OHI. They may be Standard or enroll in a Prime option. TRICARE is second payer.
Dental Coverage	● If enrolled, TDP coverage automatically ends. ● ADSMs get dental care at military dental treatment facilities (DTFs) or through the Active Duty Dental Program (ADDP).	● If enrolled, TDP coverage continues at lower premiums. ● Eligible family members may purchase new TDP coverage at the lower rate.

5.0 Coverage After Separating from Active Service

Potential Coverage	Sponsor Coverage	Family Coverage
Transitional Assistance Management Program (TAMP)*	● TAMP provides 180 days of TRICARE coverage to eligible sponsors. (See the *Transitional Benefits* module for TAMP information.) ● Sponsors may enroll (or reenroll) in TRICARE Prime or TOP Prime, or use TRICARE Standard/Extra. (They can't be TRICARE Prime Remote and TOP Prime Remote during TAMP.) ● Certain sponsors have ADDP benefits during TAMP. Others may qualify to resume or purchase TDP coverage.	● TAMP provides 180 days of TRICARE coverage for eligible family members. ● Family members are automatically covered under TRICARE Standard and Extra. They may enroll or reenroll in TRICARE Prime if in a Prime Service Area (PSA). (They can't be TPRADFM and TOP Prime Remote during TAMP.) ● May qualify to resume or purchase TDP at the appropriate premium rate (based on sponsor's status).
TRICARE Reserve Select (TRS)	● Qualified Selected Reserve sponsors may purchase TRS to start when active duty benefits or TAMP coverage ends, whichever is later. (See Section 7.0) ● To avoid a break in TRICARE coverage, the sponsor must purchase TRS within 30 days of the last day of TRICARE eligibility (e.g., active duty, TAMP).	● The sponsor must purchase TRS coverage for eligible family members to get TRS member-and-family coverage. ● The family can't purchase family member coverage for only themselves.
Continued Health Care Benefit Program (CHCBP)	● CHCBP provides up to 18 months of health coverage. (See the *Transitional Benefits* module for more on CHCBP.) ● Eligible sponsors must purchase CHCBP within **60** days of the end of : ○ TRICARE eligibility ○ TAMP ○ TRS	● Qualifying dependent spouses, dependent children, unremarried former spouses, and unremarried surviving spouses may be eligible for up to 36 months of CHCBP coverage. ● Certain unremarried former spouses may qualify for CHCBP coverage beyond 36 months. ● Individuals must purchase CHCBP coverage within **60** days of the end of: ○ TRICARE eligibility ○ TAMP ○ TRS
TRICARE Dental Program (TDP)	● Sponsors who aren't TAMP eligible and had TDP before active service are automatically reenrolled. ● Sponsors who aren't TAMP eligible and didn't have TDP before active service may purchase TDP sponsor coverage.	● Family members may purchase or continue TDP family coverage. ● If already enrolled, premiums go back to the higher family-member rate.

* *To qualify for TAMP benefits, Guard/Reserve members must have been on active service for more than 30 consecutive days in support of a contingency operation. Service personnel determine and establish TAMP eligibility in DEERS.*

?	SGT Wilson has been on active duty for the past 8 months, but her orders are about to end. She doesn't want a break in health care coverage. As a National Guard/Reserve member separating from active service for more than 30 consecutive days in support of a contingency operation, what is available to her? How long will she have coverage?

6.0 Coverage When Retired

Potential Coverage	Sponsor Coverage	Family Coverage
TRICARE Retired Reserve (TRR)	● Members of the Retired Reserve may qualify to purchase TRR until they reach age 60, when they are entitled to premium-free TRICARE retiree benefits. (See Section 7.0)	● Sponsors must purchase TRR for family members to get coverage (TRR member-and-family coverage). ● If a qualified member of the Retired Reserve dies while he or she has TRR, surviving family members may purchase new or continue TRR coverage up to the date the deceased sponsor would have turned 60. On that date, they're entitled to premium-free TRICARE retired family member benefits.
TRICARE Retiree Dental Program (TRDP)	● Eligible sponsors may purchase coverage under the TRDP. (See the *Dental* module for more information.)	● Eligible family members may purchase TRDP. ● Former spouses and unremarried surviving spouses can't purchase TRDP.

7.0 TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR)

- TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) are premium-based health plans available stateside and overseas. They offer the TRICARE Standard and Extra or TRICARE Overseas Program (TOP) Standard benefit.
    - The regional and overseas contractors process applications, premium payments, billing, and offer customer support services.
    - TRICARE Area Offices (TAOs) provide information on getting health care overseas.

7.1 Eligibility

- Qualified members of the Selected Reserve may purchase TRS for themselves and their eligible family members.
- Qualified Retired Reserve members may purchase TRR for themselves and their eligible family members. These Guard/Reserve retirees are called "gray-area retirees"

7.2 Types of Coverage

TRS and TRR offer two types of coverage:

- Member-only coverage
- Member-and-family coverage

7.3 Qualifying for TRS/TRR Coverage

Guard/Reserve components' personnel offices determine if a member qualifies to purchase TRS or TRR.

- To qualify for TRS, Guard/Reserve members must be in the Selected Reserve of the Ready Reserve.
  - Certain members of the Selected Reserve whom the service separates ("involuntarily separated") under other than adverse conditions may qualify for an additional 180 days of TRS coverage for themselves and their family members upon the member's separation.
  - Additional TRS coverage requires the member to have been enrolled in TRS at the time of his or her involuntary separation and to continue making TRS premium payments.
  - DEERS automatically disenrolls members and families on the 180th day.
- To qualify for TRR, a retired Guard/Reserve member must be under 60 years old. He or she must be a member of the Retired Reserve of a reserve component who qualifies for non-regular retirement. If a retired Reservist receives retirement pay prior to age 60 (certain conditions apply), they aren't eligible for premium-free TRICARE until age 60.
- To purchase TRS or TRR, members can't be eligible to enroll or enrolled in the Federal Employees Health Benefits (FEHB) Program through their own employment. They can still purchase TRS/TRR if they're covered by FEHB through their spouse's employment.

?	A few years later, SGT Wilson retires and becomes a member of the Retired Reserve. She's 55 and isn't receiving retirement pay. She interviews for and is offered a civilian job with the Defense Health Agency (DHA) that makes her eligible for FEHB. Can she keep her TRS coverage? If not, is she eligible for TRR? Why or why not?

7.3.1 Verifying Qualification for TRS or TRR

- To see if they qualify for TRS or TRR, members must log on to the DMDC Reserve Component Purchased TRICARE Application (RCPTA) at www.dmdc.osd.mil/appj/trs.
  - To access the application, members need a DoD Self-Service Logon (DS Logon), DFAS myPay account, or DoD Common Access Card (CAC).
  - Members can get a DS Logon by visiting https://myaccess.dmdc.osd.mil/identitymanagement.
  - Members must contact their service personnel office with questions on qualifying/eligibility.

7.4 Purchasing TRS and TRR Coverage

- If members qualify, they must go into the RCPTA to access, print and sign the *Reserve Component Health Coverage Request Form (*DD Form 2896-1*)*. The completed form and initial 2-month premium payment must be sent to the regional or overseas contractor.

7.4.1 General Application Information

- Qualified members may purchase TRS or TRR coverage any time during the year.
- The form **must** be postmarked or received by the last day of the month for TRS or TRR coverage to start the next month.
- TRS or TRR starts on the first day of the first or second month, based on what the member notes on the form. Example: The contractor receives the form April 25. TRS/TRR starts May 1 or June 1.

7.4.2 Loss of Other TRICARE Coverage

- Qualifying members losing coverage under another TRICARE option may buy TRS or TRR to avoid a break in coverage. This **only** applies to a Selected Reserve member of a Reserve Component or a retired Reservist.
- The form **must** be postmarked or received no later than 30 days after the loss of other TRICARE coverage.
- TRS or TRR starts the day after the other plan ends.
- Members who qualify may apply for TRS or TRR up to 60 days before their other TRICARE plan ends.

7.4.3 Change in Family Status

- A sponsor's immediate family status may change through "qualifying life events" such as marriage, birth, adoption, divorce, or death.
- If a qualifying event happens, their TRS or TRR coverage (member-only or member-and-family) may need to change.
- Family members must show in DEERS.
- The member must send in a new TRS/TRR request form when adding/removing a family member, as well as when going from member-only to member-and-family coverage or vice versa.
- The new application **must** be postmarked or received no later than 60 days after the qualifying life event.
- Coverage then starts on the date of the qualifying life event, and the contractor adjusts premiums (if necessary) back to that date.

Note: If a new application adding a family member **isn't** postmarked or received within the 60 days, TRICARE denies claims until an application is received. Coverage starts on the date selected by the sponsor on the form.

7.4.4 Survivor Coverage

- If TRS or TRR coverage (member-only or member-and-family) is in place when a sponsor dies, qualified survivors may purchase or continue coverage:
  - TRS: Up to 6 months following the sponsor's date of death
  - TRR: Until the date the sponsor would have turned 60.
  - DEERS automatically changes coverage to TRS or TRR survivor coverage. (Advise beneficiaries to report and verify their survivor status in DEERS.)
- If family coverage was in effect at the time of the sponsor's death and survivors don't want TRS or TRR survivor coverage, they must submit a written letter or a *DD Form 2896-1* to their contractor within 60 days of the date of the sponsor's death.
  - Coverage ends the day after the sponsor's death.
  - Contractors refund premiums if there were no claims filed during those 60 days.
- If the sponsor had TRS or TRR **member-only** coverage at the time of death:
  - Eligible survivors may purchase TRS or TRR survivor coverage.
  - For coverage to start on the date of the sponsor's death (qualifying life event), a survivor must submit an application within 60 days of the sponsor's death.
  - Surviving family members who are eligible for or enrolled in the FEHB program may purchase TRS or TRR.
- If a sponsor wasn't in TRS or TRR at the time of death, surviving family members can't purchase either plan.

7.5 Receiving Care Under TRS and TRR

- TRS and TRR coverage is the same as TRICARE Standard and Extra or TOP Standard.
- Pharmacy benefits are the same as TRICARE Standard stateside and overseas.

7.6 TRS and TRR Costs

- TRS: TRICARE Standard and Extra cost-shares, deductibles, and catastrophic caps for **ADFMs** apply. This includes health care costs for the Guard/Reserve member.
- TRR: TRICARE Standard and Extra cost-shares, deductibles, and catastrophic caps for **regular retirees** apply.

Note: See the *TRICARE Options* Module for more on TRICARE Standard/Extra.

7.6.1 TRS and TRR Monthly Premiums

- TRS/TRR premiums may change on January 1 each year.
  - Visit www.tricare.mil/costs for current TRS and TRR premiums.
  - The first 2-month premium payment can be made with a personal check, cashier's check, money order, or credit/debit card (Visa or MasterCard).
  - After the first payment, all premiums must be paid by monthly electronic funds transfers (EFTs) or credit/debit card.
  - The payment method must be established with the contractor. Beneficiaries can do this when first purchasing TRS/TRR or by calling the contractor.
  - The contractor processes payments within the first 5 business days of each month.

7.7 Loss of TRS or TRR Coverage

7.7.1 Loss of TRS or TRR Eligibility

Members, families, and survivors lose eligibility/coverage when:

TRS	TRR
● The sponsor: ○ Separates from the Selected Reserve ○ Is called to active duty ○ Retires from the Selected Reserve ○ Becomes eligible to enroll or enrolls in FEHB coverage through his or her own employment	● The sponsor: ○ Turns 60 ○ Becomes eligible for premium-free TRICARE as a medical retiree per his or her service branch ○ Becomes eligible to enroll or enrolls in FEHB coverage through his or her own employment

Note: For those members who enroll in FEHB, coverage usually starts the first day of the second pay period. So, TRS and TRR members should keep TRS/TRR coverage up to 60 days from when they first become FEHB eligible. They should also keep this in mind when they fill out their TRS/TRR disenrollment request ending their TRS/TRR coverage to make sure they don't have a break in health care coverage.

7.7.2 Ending TRS or TRR Coverage Voluntarily

- To end TRS and TRR coverage, members and families must:
  - Log on to the DMDC *Reserve Component Purchased TRICARE Application* at www.dmdc.osd.mil/appj/reservetricare.
  - Print and sign the *DD Form 2896-1*.
  - Mail the form to the regional/overseas contractor.
- Coverage ends on the last day of the first or second month following the postmark of the *DD Form 2896-1*. For example, if mailed in March, coverage ends at the end of April or the end of May, as noted on the form.

7.7.3 Failure to Make Premium Payments

- Failure to pay monthly premiums ends in suspension or lock out of coverage.
  - For example, a member's credit/debit card expires. If the member doesn't give the contractor a new credit/debit card number, the contractor suspends the member/family's TRS coverage, or locks them out of TRR coverage, up to 12 months from the last day of the month the last premium was paid.

7.7.4 TRS Purchase Suspension

- The contractor suspends TRS coverage for 12 months for members who voluntarily disenroll, or fail to make their monthly premium payment. The suspension starts the last day of the month the last premium was paid.
- Members may request, within the first 3 months of their suspension, to have their TRS coverage reinstated ("request reinstatement") to avoid a break in coverage.
    - They send a written request to the regional or overseas contractor. Approved requests require payment of all overdue and current premiums, and information to set up electronic premium payments.
    - If approved, the contractor reinstates TRS coverage to the day after the last premium was paid.
    - Example: The contractor suspends TRS coverage January 1 – the credit card expired. In March, the member requests their TRS coverage be reinstated. He submits the required premium payment and payment information. It's approved. Coverage starts January 1.
- Members may also request to purchase TRS coverage after 3 and up to 12 months following their suspension.
    - Requests must include a 2-month initial premium payment, as well as information needed for electronic premium payments.
    - Coverage starts the first of the month as noted on the request form.
    - Example: The contractor suspends TRS coverage January 1 – the credit card company denied payment. In May, the member requests new TRS coverage. He submits the required premium payment and payment information. His request is approved. Coverage starts June 1 or July 1, as noted on the request form.
- These suspensions don't apply to Selected Reserve members and their family members if:
    - They lose TRS eligibility (See Section 7.7.1.)
    - They gain other TRICARE coverage
- For more on reinstatement, contact the TRICARE Regional Office (TRO) or TRICARE Area Office (TAO).

?	SGT Wilson turned down the civilian job because she and her fiancé decided to move. Soon after they marry, she decides to disenroll from TRS because she has coverage under her husband's employer-sponsored health plan. SGT Wilson stops making payments, but forgets to send in a TRS form to end her coverage. 1 month later, her husband loses his job and benefits. Can SGT Wilson still get TRS? If so, what does she need to do?

7.8 Coverage Options After TRS/TRR Ends

- TRS/TRR members and family members may be eligible to purchase CHCBP coverage or OHI through their employer, another family member, or their state's Health Insurance Marketplace when their TRS/TRR coverage ends. They should visit www.healthcare.gov for more information. (See the *Transitional Benefits* module for CHCBP information.)

7.9 TRS and TRR Features

The following table lists key features of each plan.

	TRICARE Reserve Select (TRS)	TRICARE Retired Reserve (TRR)
Qualifying	● Must be a member of the Selected Reserve of the Ready Reserve ● Can't be eligible to enroll or enrolled in the FEHB program under his or her own employment	● Must be a member of the Retired Reserve of a Reserve Component who hasn't reached age 60 ● Can't be eligible to enroll or enrolled in the FEHB program under his or her own employment
Cost-Shares	● ADFM rate	● Retiree rate
Premiums	● Monthly premium ● 2-month initial premium payment ● Premiums are set each calendar year on January 1 ○ Visit www.tricare.mil/costs for premium rates	● Monthly premium ● 2-month initial premium payment ● Premiums are set each calendar year on January 1 ○ Visit www.tricare.mil/costs for premium rates
Survivor Coverage	Surviving family member(s) may purchase or continue TRS coverage for up to 6 months after the date of the sponsor's death, as long as the sponsor had TRS coverage when he or she died.	Surviving family member(s) may purchase or continue TRR coverage until the date the deceased member would have turned 60, as long as the sponsor had TRR coverage on the date he or she died.

7.10 TRS/TRR Application Exercises

1. Captain Brown, a member in the Selected Reserve, is employed full-time at an auto parts store. His spouse works in the Department of Defense. She is enrolled in FEHB based on her own employment. Her family, to include Captain Brown, are covered under her plan. Does Captain Brown qualify to purchase TRS coverage?

2. A retired member of the Guard just celebrated her 60th birthday. True or False: She is now eligible for TRR.

3. True or False: A retired member who has FEHB is also eligible for TRR.

7.11 TRS/TRR Resources

<table>
<tr><th colspan="3">Stateside</th></tr>
<tr><th>North</th><th>South</th><th>West</th></tr>
<tr><td>TRS/TRR Enrollment Address:
Health Net Federal Services, LLC.
TRS/TRR Enrollment
P.O. Box 870162
Surfside Beach, SC 29587-9762
Phone: 1-800-555-2605
Website: www.hnfs.com</td><td>TRS/TRR Enrollment Address:
Humana Military Healthcare Services, Inc.
ATTN: PNC Bank
P.O. Box 105838
Atlanta, GA 30348-5388
Phone: 1-877-298-3408
Website:
www.humana-military.com</td><td>TRS/TRR Enrollment Address:
UnitedHealthcare Military & Veterans
TRICARE West Region Enrollment Department
P.O. Box 105492
Atlanta, GA 30348
Phone: 1-877-988-9378
Website: www.uhcmilitarywest.com</td></tr>
<tr><th colspan="3">Overseas</th></tr>
<tr><th>Eurasia-Africa</th><th>Latin America and Canada</th><th>Pacific</th></tr>
<tr><td rowspan="4">TRS/TRR Enrollment Address:
International SOS Assistance, Inc.
TOP TRS/TRR Enrollments
P.O. Box 11689
Philadelphia, PA 19116
Phone:
+44-20-8762-8384 (overseas)
1-877-678-1207 (stateside)
E-mail:
tricarelon@internationalsos.com</td><td rowspan="4">TRS/TRR Enrollment Address:
International SOS Assistance, Inc.
TOP TRS/TRR Enrollments
P.O. Box 11689
Philadelphia, PA 19116
Phone:
+1-215-942-8393 (overseas)
1-877-451-8659 (stateside)
E-mail:
tricarephl@internationalsos.com</td><td>TRS/TRR Enrollment Address:
International SOS Assistance, Inc.
TOP TRS/TRR Enrollments
P.O. Box 11689
Philadelphia, PA 19116</td></tr>
<tr><td>Singapore
Phone:
+65-6339-2676 (overseas)
1-877-678-1208 (stateside)
E-mail:
sin.tricare@internationalsos.com</td></tr>
<tr><td>Sydney
Phone:
+61-2-9273-2710 (overseas)
1-877-678-1209 (stateside)
E-mail:
sydtricare@internationalsos.com</td></tr>
<tr><td colspan="3">Website: www.tricare-overseas.com</td></tr>
</table>

Module Objectives

- **Define line of duty determinations and their use**
- **Explain TRICARE coverage for Guard/Reserve members on active service for more than 30 consecutive days**
- **Describe how delayed-effective-date active duty orders affect eligibility**
- **Describe TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR)**

Key Terms

- **Line of Duty (LOD)/Notice of Eligibility (NOE) Determination**
- **Early Eligibility**
- **TRICARE Reserve Select (TRS)**
- **TRICARE Retired Reserve (TRR)**
- **Purchase Suspension**

TRICARE Fundamentals Course

Other Benefits

8

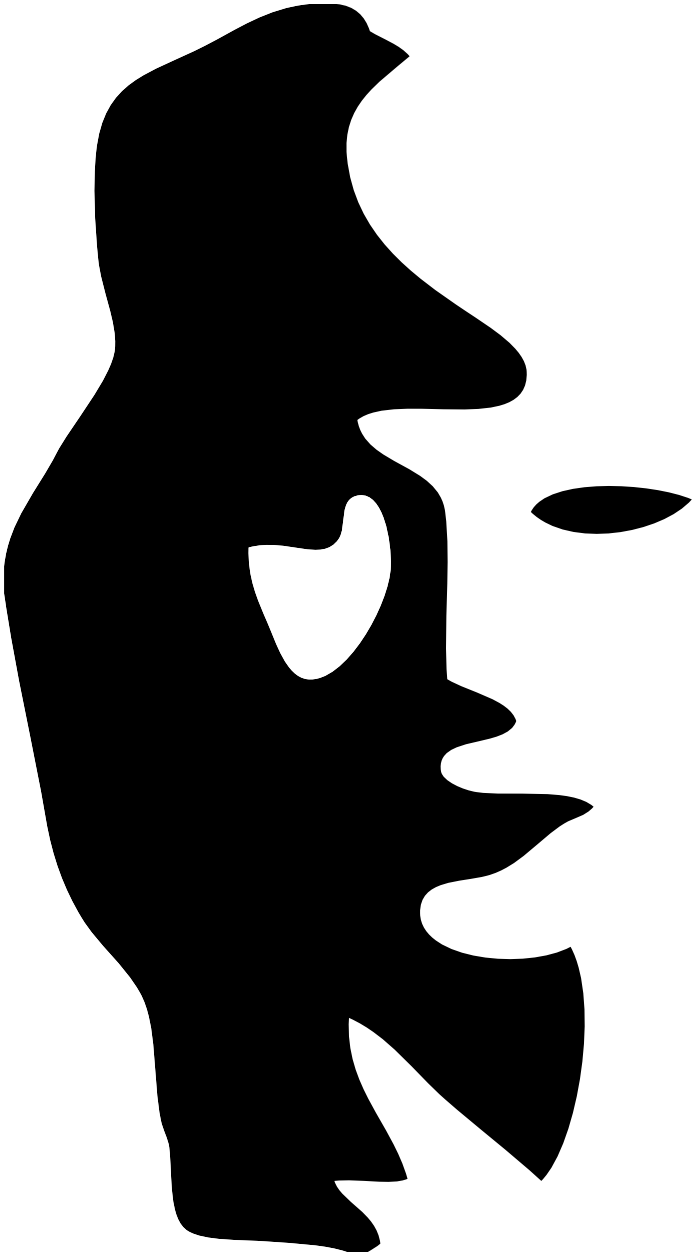
Participant Guide

References

10 USC § 1079 (d)–(f)
32 CFR §§ 199.5, 6, 8
2008 TRICARE Operations Manual, Chapter 6
2008 TRICARE Operations Manual, Chapter 17
2008 TRICARE Operations Manual, Chapter 24
2008 TRICARE Operations Manual, Chapter 25
2008 TRICARE Policy Manual, Chapter 9
www.militaryhomefront.dod.mil
www.usfhp.com
www.cap.mil/wsm
www.tricare.mil/tmaprivacy
www.tricare.mil/aca

Brainteaser

What do you see in the picture below?



Module Objectives

- **Identify who may be eligible for the TRICARE Young Adult (TYA) program**
- **State the purpose of TRICARE Plus**
- **Describe the Extended Care Health Option (ECHO)**

Key Terms

- **TRICARE Young Adult (TYA)**
- **TRICARE Plus**
- **Extended Care Health Option (ECHO)**
- **Exceptional Family Member Program (EFMP)**

1.0 TRICARE Young Adult Program (TYA)

TRICARE Young Adult (TYA) is a premium-based program. It offers TRICARE Standard or Prime coverage, stateside and overseas, to qualified young adults who lose eligibility due to age.

?	In this module, you'll answer scenario questions on Master Sergeant Cooper and his family.

1.1 TYA Eligibility

- Qualified young adults may buy TYA coverage if they show in the Defense Enrollment Eligibility Reporting System (DEERS) and:
  - Are a dependent of a TRICARE-eligible uniformed service sponsor
  - Are at least age 21 but under 26
  - Aren't married
  - Aren't a member of the uniformed services
  - Aren't eligible to enroll in an employer-sponsored health plan (based on their employment)
  - Aren't eligible for other TRICARE coverage
- The sponsor's status (e.g., active duty, retiree, etc.) and where the young adult lives affect TYA enrollment and coverage options.
  - **Overseas**: The young adult dependent must live overseas and be command-sponsored to buy TYA TOP Prime/Remote. If not, they can buy TYA Standard. (See the *TRICARE Options* and *Prime Remote Options* modules for more on command sponsorship.)
- Young adult dependents of TRICARE For Life (TFL) sponsors can buy TYA Standard. They may qualify to buy a TYA Prime option if they meet Prime option criteria.
- TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) eligible sponsors must be enrolled in TRS or TRR for the young adult to buy TYA Standard/Extra. (TYA Prime isn't an option since the sponsor can't be Prime.)
  - If the TRS/TRR-enrolled sponsor dies , the young adult dependent may buy or continue TYA coverage:
    - Eligibility to purchase TYA coverage ends 6 months after the Selected Reserve sponsor's death, or when the young adult turns 26, whichever comes first. The young adult pays survivor (retiree) cost shares.
    - Eligibility to purchase TYA coverage after the Retired Reserve sponsor's death continues until the young adult reaches age 26.
    - If a member of the Retired Reserve isn't covered by TRR on the date of his or her death, surviving dependents don't qualify for TYA until the date on which the deceased sponsor would have turned age 60. That's when surviving young adults may qualify to purchase TYA coverage until they turn 26.
- Young adult dependents of a Transitional Assistance Management Program (TAMP) eligible sponsor may qualify to purchase TYA coverage until TAMP ends or the young adult reaches age 26, whichever comes first.
  - If the sponsor dies while on TAMP, the young adult dependent may qualify to purchase TYA to the end of the TAMP coverage period or until he or she reaches age 26, whichever comes first.
  - These young adults pay active duty family member (ADFM) cost-shares.
- Upon the death of an active duty sponsor, former young adult dependents who already aged out of TRICARE are classified as survivors. They may qualify to purchase TYA coverage up to the age of 26 but pay survivor (retiree) cost-shares.

- TYA coverage ends when:
  - The young adult no longer qualifies for coverage (e.g., he or she gains health care through an employer). To disenroll, he or she has to submit a *TRICARE Young Adult Application* (DD Form 2947)
  - The sponsor loses TRICARE eligibility
  - The young adult turns 26
  - The young adult marries. He or she has to submit a *DD Form 2947*.
  - There is a failure to pay monthly premiums

1.2 Buying TYA

- Qualified young adult dependents can buy TYA on a month-to-month basis. They have to show as a former dependent in DEERS
- Qualified young adults can buy TYA through any of the 3 options below. They have to include a 2-month premium payment and verify that they aren't married or eligible for employer-sponsored health care.
- Young adults can get TYA coverage by:
  - Calling the regional contractor
  - Using the Beneficiary Web Enrollment (BWE) website at www.dmdc.osd.mil/appj/bwe
    - Only available to those who live or want to enroll in a PSA
    - BWE may be available overseas for those located near a military clinic or hospital in early 2017
  - Mailing *DD Form 2947* (available at www.tricare.mil/forms or www.tricare.mil/tya) to the regional contractor.
- Young adult dependents who lose TRICARE eligibility (e.g., age out of TRICARE at 21) can avoid a break in TRICARE coverage by making sure the postmark on their *DD Form 2947* is within 30 days of their loss of eligibility.
- Coverage starts:
  - TRICARE Standard: The first day of the month after the contractor receives the *DD Form 2947*. It may start up to 90 days in the future if requested on the application.
  - TRICARE Prime options: The "20th-of-the-month rule" applies. Continuous coverage requires an electronic payment from a checking or savings account or an automatic recurring credit/debit charge.
- Once the contractor completes the enrollment, it sends a notice to the young adult. The enrollee then logs on to milConnect to download his or her enrollment card and, if TYA Prime, get his or her PCM assignment.
- Once showing as TYA-enrolled in DEERS, enrollees need to get new ID cards to present when getting health care. This can be done through 1 of the following ways:
  - The sponsor taking the young adult to the ID-card facility
  - The sponsor sending the young adult a notarized *Application for Identification Card/DEERs Enrollment* (DD Form 1172-2). The young adult takes the form to a service ID-card facility.

- Qualified young adults can buy TYA coverage anytime, unless they are "locked out" for a year. Lockout applies if they don't pay their TYA premium or they voluntarily disenroll.
  - The young adult dependent can submit a new *DD Form 2947* up to 45 days before the lockout period ends. Coverage then starts as soon as the lockout ends.
  - Young adults can ask to continue TYA without lockout if they can show there was an administrative error with their enrollment or premium payment or if they show there is an extraordinary need to continue TYA coverage.
    - Young adults should send reinstatement requests to the contractor within 90 days of the last full premium payment.
    - The TRICARE Regional Office (TRO), TRICARE Area Office (TAO), or US Family Health Plan (USFHP) site decides if TYA coverage can resume.
    - The young adult has to send in appropriate premium payments within 30 days after he or she gets a notice of reinstatement. If they don't make the 30-day window, TYA coverage ends and the lockout remains in place.
- When a young adult no longer qualifies for TYA coverage, for example when a sponsor separates or isn't enrolled in TRS, DMDC sends a notice to the young adult.

?	Master Sergeant Cooper's daughter, Rachel, just graduated from college at age 23. She hasn't found a job yet, leading her parents to suggest she buy TYA coverage since the rest of the Cooper family is TRICARE Prime. What does Rachel have to do to get TYA coverage? How does she pay her premiums? Can she still use her old ID card?

1.3 TYA Coverage

- TYA benefits and rules mirror the option the young adult buys (i.e., TRICARE Standard/Extra, TRICARE Prime, TOP Standard, TOP Prime, USFHP).
- If a young adult wants to change coverage from TYA Standard to TYA Prime or vice versa, he or she must submit a new application. The regional contractor then changes the TYA premium amount.

Note: To be TYA Prime, the young adult has to live in a Prime Service Area (PSA), typically 40 miles or 30 minutes from a military hospital or clinic or Base Realignment and Closure (BRAC) site.

- TYA includes TRICARE pharmacy benefits. (See the *Pharmacy* module for more information.)
- TYA doesn't include dental coverage.
- The TYA status has to show in DEERS for TRICARE to process claims.

1.4 TYA Portability

- To transfer enrollment between regions, the young adult has to submit a new application.
- The contractor has 10 days to complete the transfer request.

1.5 TYA Costs

1.5.1 Monthly Premiums

- TRICARE bases TYA premiums on how much it costs to fully cover health care for all enrolled young adults.
- TYA premiums go to the contractor where the young adult lives.
- Premiums may change each January. For current premiums, visit www.tricare.mil/costs.
- Options and costs may change as the sponsor's status changes or the young adult moves (e.g., if a retiree moves overseas, TYA coverage has to shift from TRICARE Prime to TOP Standard).

1.5.2 Costs

- TYA costs are affected by the sponsor's status (active duty, Guard/Reserve, retiree, etc.)
- TRICARE Standard deductibles and cost-shares apply to TYA Standard. TRICARE Prime copays and cost-shares apply to TYA Prime.
- Deductibles, cost-shares, and copays apply to the individual/family's catastrophic cap; TYA premiums don't.
- TRICARE pharmacy copays and cost-shares apply.

1.6 Other Options for Young Adult Coverage

- TYA is not the only "up to age 26" option for military families to consider after a child ages out of TRICARE.
- Uniformed service families should study all health care options, including TRICARE's Continued Health Care Benefit (CHCBP), coverage through a state marketplace, other family members, employer or school sponsored, or other federal or state programs. Go to www.healthcare.gov for more information.

2.0 TRICARE Plus

- TRICARE Plus is a primary care program offered at select military hospitals or clinics, both stateside and overseas. The commander determines if the facility will offer TRICARE Plus.
  - TRICARE Plus isn't a TRICARE option. It covers primary care at a military hospital or clinic.
  - Military hospital or clinic commanders may limit the number of enrollees; ongoing enrollment is decided on a case-by-case basis.

2.1 TRICARE Plus Eligibility

Eligible	Not Eligible
● TRICARE Standard beneficiaries ● TFL beneficiaries ● Beneficiaries only eligible for care in a military hospital or clinic. For example, dependent parents and parents-in-law. ● ADFMs, whether or not they are command sponsored (only applies overseas)	● Beneficiaries enrolled in a: ○ Prime option (stateside or overseas) ○ Civilian or Medicare health maintenance organization (HMO) ● Active duty service members (ADSMs) ● Activated Guard/Reserve members

2.2 TRICARE Plus Enrollment

- There's no enrollment fees or cards with TRICARE Plus. Eligible beneficiaries must complete a *TRICARE Plus Enrollment Application* (DD Form 2853) and submit it to the military hospital or clinic.
- The military hospital or clinic validates eligibility in DEERS.
- If approved, the military hospital or clinic forwards the *DD Form 2853* to the contractor.
- Once the contractor enters the TRICARE Plus enrollment into the Defense Online Enrollment System (DOES) the beneficiary shows as TRICARE Plus in DEERS, with an assigned PCM.
- Once the TRICARE Plus enrollment shows in the military hospital or clinic's appointment system, enrollees can make appointments with their PCM.

2.3 TRICARE Plus Disenrollment

- TRICARE Plus enrollees may disenroll any time by giving the military hospital or clinic a *TRICARE Plus Disenrollment Request* (DD Form 2854).
- The military hospital or clinic sends the request to the contractor to record in DEERS.

2.4 TRICARE Plus—Not Portable

Unlike TRICARE Prime, TRICARE Plus isn't portable. TRICARE Plus at 1 military hospital or clinic doesn't carry over to another.

2.5 Specialty Care

- Military hospitals or clinics may see TRICARE Plus enrollees for specialty care on a "space-available basis."
- If the military hospital or clinic can't meet their needs, enrollees have to get specialty care from a civilian provider. They have to use a TRICARE-authorized provider if they're still TRICARE eligible (i.e., Standard/Extra, TFL) or use Medicare or other health insurance (OHI).
    - The military hospital or clinic isn't responsible for costs for care received elsewhere. The military hospital or clinic can't authorize civilian care or claims payment.
    - TRICARE Standard/Extra, TFL, Medicare, or OHI rules apply, as do cost-shares and deductibles, when enrollees get care outside of the military hospital or clinic.

3.0 Extended Care Health Option (ECHO) Program

- The Extended Care Health Option (ECHO) Program covers services and supplies beyond the basic TRICARE benefit. Only eligible active duty family members can get ECHO benefits, to include transitional survivors and those with TAMP.
- ECHO helps pay for services and supplies that reduce the disabling effects of a "qualifying condition." Qualifying conditions include:
    - A complex physical or psychological clinical condition so severe the family member is considered home bound
    - Multiple disabilities, which alone aren't ECHO-qualifying conditions, but together affect multiple body systems
    - Neuromuscular developmental conditions, or other conditions that come before a diagnosis of moderate or severe mental retardation, or a serious physical disability in infants or toddlers under the age of 3.
- ECHO may cover medical and rehabilitative services, equipment, institutional and respite care. (See Appendix A for a listing of covered services.)

3.1 ECHO Qualification Determination

- If a sponsor or provider thinks a family member may qualify for ECHO services, the sponsor and family need to get an eligibility determination.
    - The family member's assigned PCM or primary provider, USFHP provider, or a TRICARE-authorized or overseas civilian provider has to confirm and document the qualifying condition(s) and need for ECHO services. (See Appendix A for ECHO eligibility information.)
- To get ECHO benefits, the sponsor must enroll his or her family member in the Exceptional Family Member Program (EFMP).
    - The EFMP identifies ADFMs with special medical and/or educational needs.
    - Each service has its own EFMP and EFMP enrollment process.
    - TRICARE may not require EFMP enrollment if:
        - The sponsor's service doesn't have an EFMP (i.e., Guard/Reserve, Coast Guard, U.S. Public Health Service, National Oceanic and Atmospheric Administration)
        - The family member is a transitional survivor (i.e., the sponsor died while on active duty)
        - The family member lives with a custodial parent; he or she doesn't live with the sponsor
    - For more on EFMP, direct families to their Service EFMP Office or to www.militaryonesource.mil/EFMP. (See Appendix A for more information.)
- Regional contractors, TAOs, or USFHP determine if a family member is eligible for the ECHO program. Denying eligibility is a factual determination. It's not appealable.

3.2 ECHO Registration

- ECHO is not an enrollment program, but does require registration.
- To get a family member registered in ECHO, the sponsor or other authorized person acting for the family member must send the regional contractor, overseas contractor, or USFHP the following:
  - Proof the sponsor is on active service in one of the uniformed services
  - Medical records of qualifying conditions
  - Any additional forms the contractor or USFHP requires
- If there's a delay in EFMP enrollment, TRICARE may grant provisional ECHO status for 90 days. This way the family member can get ECHO services. If not enrolled in EFMP within 90 days, ECHO benefits end.
- ECHO eligibility is noted in DEERS. ECHO benefits start the date the family member is registered in ECHO.

?	The Cooper's son, Samuel, was recently diagnosed with cerebral palsy. The Coopers decide to register Samuel in ECHO to get some financial help. Before registering Samuel in ECHO, what do the Coopers need to do? What do they submit to register him? What office is responsible for accepting or denying ECHO eligibility?

3.3 ECHO Benefit Authorization

- Families must have authorizations before getting ECHO benefits.
  - The authorization specifies the type of service, scope, how often the service is needed, coverage, dates, amounts, requirements, limitations, provider name and address, and other information to clearly identify the approved benefits.
  - The authorization point of contact is the regional contractor, ECHO case manager, or USFHP.
- To change specialty providers, ECHO family members must get new referrals and authorizations.
- Beneficiaries may appeal denial of ECHO services and supplies.

3.4 ECHO Costs

- ECHO has no deductible or enrollment fee.
- There is a cost share for ECHO benefits, in addition to costs the family may have under a Standard or Prime option.
- The sponsor's pay grade determines the ECHO cost-share. Families only pay the ECHO cost-shares for the months registered family members get ECHO benefits. ECHO cost-shares don't count towards the family's catastrophic cap. (See Appendix A for cost-share amounts.)
- Families may have to pay Prime copays or Standard cost-shares for services that:
  - Establish qualifying conditions
  - Confirm the severity of the disabling effects of a qualifying condition
  - Measure functional loss
- For example, an active duty family uses TRICARE Standard. They get some diagnostic services for their child. The results show the child has an ECHO-qualifying condition. The family must pay the TRICARE Standard deductible and cost-shares for the diagnostic services. ECHO won't cover those costs.

3.4.1 Government's ECHO Cost-Share Limit

The government pays up to $36,000 for ECHO benefits per family member, each fiscal year (October 1–September 30). This doesn't include ECHO Home Health benefit costs.

3.4.2 ECHO Cost-Shares

- Cost-shares are based on the sponsor's pay grade:

Sponsor Pay Grade	Sponsor Cost-Share	Sponsor Pay Grade	Sponsor Cost-Share
E-1–E-5	$25	CWO-5, O-5	$65
E-6	$30	O-6	$75
E-7, O-1	$35	O-7	$100
E-8, O-2	$40	O-8	$150
E-9, CWO-1, CWO-2, O-3	$45	O-9	$200
CWO-3, CWO-4, O-4	$50	O-10	$250

3.5 Claims for Benefits with Prior Authorization

- When filing claims for ECHO-authorized care, the family or sponsor must submit:
  - A *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request For Medical Payment* (DD Form 2642)
  - A copy of the family member's prior authorization
- Families send claims to the TRICARE or USFHP claims processor. The claims mailing address is based on where the family member lives (Standard) or is enrolled (Prime option).

3.6 ECHO Resources

More information on the ECHO program is at www.tricare.mil/ECHO.

4.0 Travel Benefit for Those with a Combat-Related Special Compensation Determination

- Certain retirees awarded Combat-Related Special Compensation (CRSC) may be entitled to the CRSC travel benefit. They can't be enrolled in TRICARE Prime or USFHP. To get the benefit:
  - Travel must be more than 100 miles from the referring provider's location;
  - Travel must be for medically necessary, non-emergency specialty care for a documented combat-related condition; and
  - The primary care provider has to write a referral for the care.
- The CRSC travel benefit isn't available overseas.
- TRICARE reimburses retirees with CRSC costs for actual travel expenses such as lodging, fuel (rather than mileage), meals, parking, tolls, or other costs associated with getting the specialty care.
- These retirees must use the least costly mode of transportation.
- Government rates are used to estimate the reasonable costs for allowed expenses and are found at http://www.defensetravel.dod.mil/site/perdiem.cfm

Note: The TROs manage the CRSC travel benefit
(See http://www.tricare.mil/Plans/SpecialPrograms/CRSCTravelBenefit?sc_database=web)

5.0 TRICARE Benefits and the Affordable Care Act (ACA)

- The Affordable Care Act (ACA) of 2010 requires individuals to have and keep basic health care coverage. This is known as "minimum essential coverage" (MEC).
- The following TRICARE health care plans are considered MEC:
  - TRICARE Prime
  - TRICARE Prime Remote
  - TRICARE Prime Overseas
  - TRICARE Prime Remote Overseas
  - TRICARE Standard and Extra
  - TRICARE Standard Overseas
  - TRICARE For Life
  - TRICARE Reserve Select (if bought)
  - TRICARE Retired Reserve (if bought)
  - TRICARE Young Adult (if bought)
  - US Family Health Plan
- The following transitional health plans are considered MEC:
  - Transitional Assistance Management Program (premium-free, 180 days)
  - Continued Health Care Benefit Program (if bought, 18-36 months)
- Individuals who are **only** direct-care eligible and those with line of duty care don't have MEC.

6.0 Computer/Electronic Accommodations Program (CAP)

The Computer/Electronic Accommodations Program (CAP) is a centrally funded federal government reasonable accommodations program. It's for disabled Department of Defense (DoD) and federal government employees. (See Appendix B for more information.)

Module Objectives

- **Identify who may be eligible for the TRICARE Young Adult program (TYA)**
- **State the purpose of TRICARE Plus**
- **Describe the Extended Care Health Option (ECHO)**

Key Terms

- **TRICARE Young Adult Program (TYA)**
- **TRICARE Plus**
- **Extended Care Health Option (ECHO)**
- **Exceptional Family Member Program (EFMP)**

Appendix A: Additional ECHO Information

Exceptional Family Member Program (EFMP)

- EFMP identifies ADFMs with special medical and/or educational needs. The intent is to make sure needed services are available to families at assigned duty stations. EFMP involves the Services' personnel, medical, and DoD education systems.
    - An exceptional family member is a child, spouse, or adult dependent living with the sponsor who requires special medical or educational services. The ADFM has to have a diagnosed physical, intellectual, or emotional condition. An authorized family member may be a spouse, child, stepchild, adopted child, or foster child.
    - Special medical or educational needs may include medical, mental health, developmental or educational resources, wheelchair accessibility, adaptive equipment, assistive technology devices, and associated services.
- Services mandate enrollment in EFMP when an ADFM has special needs.
- To enroll, the sponsor or an authorized person acting on the sponsor's behalf must complete a *Family Member Medical Summary* (DD Form 2792) and a *Special Education/Early Intervention Summary* (DD Form 2792-1). The Services' may waive enrollment for activated Guard/Reserve members.
- Enrollment in EFMP is especially important when going overseas on permanent change of station orders.
- For more information on the EFMP, visit http://www.militaryonesource.mil/efmp.

ECHO Eligibility

- The following family members, with a qualifying condition(s), are eligible for the ECHO program:
    - A spouse, dependent child, or an unmarried person whose sponsor is an active duty member of a uniformed service (this includes Guard/Reserve members on active service orders for more than 30 consecutive days)
    - A spouse, dependent child, or an unmarried person whose sponsor is a former member of a uniformed service and who is a victim of physical or emotional abuse (Benefits are limited to the amount of time the abused dependent receives transitional compensation.)
    - A transitional survivor (This is a surviving spouse, for up to 3 years from the sponsor's death, and surviving dependent children until they lose eligibility. See the *Key TRICARE Concepts and Terms* module for more on transitional survivors.)
    - A spouse, dependent child, or unmarried person who is receiving ECHO benefits when the sponsor dies, and the sponsor was eligible at the time of death for hostile-fire pay or died from a disease or injury incurred while eligible for hostile-fire pay. The spouse, dependent child, or unmarried person can receive ECHO during the time they qualify as a transitional survivor or until they age out at 21.
    - A family member who is eligible for TRICARE benefits through TAMP.

ECHO Benefits

ECHO Covered Services

- Medical and rehabilitative services
- Durable equipment and assistive technology devices, to include reasonable maintenance and repair
- Training to use assistive technology devices or to learn certain skills to reduce the effects of the disabling condition; training of parents and guardians; vocational training
- Assistive services, such as those from a qualified interpreter or translator
- Institutional care when the family member has to live in a controlled setting
- Travel costs for institutionalized family members receiving authorized ECHO benefits (to and from the institution)
- In-home medical services
- ECHO respite care: ECHO family members may get 16 hours of respite care per month in any month the family member receives other authorized ECHO benefits
- Special education (as defined by the Americans with Disabilities Act)
- Applied Behavior Analysis (ABA) associated services for family members with Autism Spectrum Disorders
- Personal incontinence supplies
- Hippotherapy is covered under the ECHO program only for those family members with a primary or secondary diagnosis of Multiple Sclerosis (MS) or Cerebral Palsy (CP)

Note: All ECHO benefits require prior-authorization.

ECHO Non-covered Services

- Inpatient care for treatment of an acute illness or an acute worsening of the qualifying condition
- Structural changes to living space and permanent fixtures
- Dental care and orthodontic treatment (covered under adjunctive dental care or purchase of dental program coverage)
- Certain durable medical equipment and maintenance of beneficiary-owned equipment
- Homemaker services for help with household chores, except services under the ECHO Home Health Care benefit
- Purchase and maintenance of service animals including but not limited to seeing eye dogs, hearing/handicap assistance dogs, seizure and other detection animals, and service monkeys.

ECHO Home Health Care (EHHC)

- The ECHO Home Health Care (EHHC) benefit provides medically necessary skilled services to eligible homebound beneficiaries whose needs are greater than what's allowed under the basic Home Health Agency payment system.
- The following are covered when provided in the beneficiary's home by participating TRICARE-authorized Home Health Agencies (HHAs):
    - Medically necessary services:
        - Skilled nursing care provided by a Registered Nurse (RN)
        - Skilled nursing care provided by a Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) under the direct supervision of a RN
        - Services provided by a home health aide under the direct supervision of a RN
        - Physical therapy, occupational therapy, and speech-language pathology services
        - Medical social services under the direction of a physician

    - Teaching and training activities
    - Medical supplies
  - Respite care services:
    - EHHC-eligible beneficiaries who require frequent interventions (as defined in Section 6.1.4.) may receive 8 hours of respite care services on 5 days per calendar week
    - The respite care services are to relieve the primary caregiver(s) to allow them to rest or sleep

Appendix B: Computer/Electronic Accommodations Program

- CAP's mission is to provide assistive technologies and accommodations to certain people with disabilities and wounded, ill, and injured service members.
  - This includes those that are blind, have low vision, dear, hard of hearing or have a dexterity, communication, cognitive, or learning disability.
- This allows equal access to information and opportunities throughout DoD and the federal government. CAP helps people with disabilities by covering the technology and accommodation costs.
- Any employee with a disability employed by a component of the DoD or by any federal agency can request CAP assistive technology and services.
- CAP also provides assistance and guidance on the aging workforce with disabling conditions that keep them from accessing information, gaining employment, or slowing workplace productivity to ensure successful employment for people with disabilities.
- The National Defense Authorization Act of 2000 granted CAP the authority to expand its services to agencies outside the DoD. CAP has formal agreements with 66 federal agencies.
- In 2004, CAP launched its Wounded Service Member (WSM) Initiative. CAP supports WSMs in their recovery and rehabilitation by giving them assistive technology for possible employment opportunities.
- On October 17, 2006, Public Law 109-364 authorized WSMs to keep assistive technology and get CAP services when they separate from active duty service.
- The Computer/Electronic Accommodations Program Service Member Initiative Handbook is at http://www.cap.mil/Documents/OUTR_SM_Initiative_Handbook_V8_20150630.pdf

CAP Eligibility

- Disabled employees who work for the DoD or one of 66 federal agency partners.
- ADSMs with limitations from an injury or illness that occurred while on active duty.

CAP Services

- Conducting needs assessments to identify appropriate assistive technology
- Purchasing assistive technology and services
- Assisting in technology integration
- Providing training on how to use assistive technology
- Advising agencies about creating accessible electronic environments
- Assisting in accommodating work-related injuries
- Supporting telework participants
- Conducting presentations about CAP services and other accessibility issues
- Disability education and awareness

CAP for Wounded Service Members

The Department of Defense Instruction, Assistive Technology (AT) for Wounded, Ill and Injured Service Members (DoDI 6025.22) was signed in January of 2015, establishing policy for AT programs in the Military Health System and the Recovery Coordination Program

In support of DoDI 6025.22 establishing policy for assistive technology programs in the Military Health System, CAP works closely with wounded service members to ensure they receive appropriate AT for their needs. CAP supports WSM in the following ways:

- Support
  - CAP supports wounded service members, working closely with medical providers, therapists, case managers, and military liaisons at military hospitals or clinics to increase awareness and availability of assistive technology.
- Equip
  - CAP equips service members with assistive technology devices, accommodations and training to help individuals with dexterity impairments, cognitive difficulties, vision loss, and hearing loss recover and transition to employment.
- Empower
  - It is CAP's mission to empower our nation's heroes by providing them with the assistive technology and accommodations they need to increase access and employment opportunities in the federal government.

Note: Visit http://www.cap.mil/WSM/DoDInstruction/DoDInstruction.aspx to view a CAP webinar on services available to wounded service members.

CAP Websites

For more information on CAP, please visit:

- www.cap.mil (support for federal civilian employees with disabilities)
- www.cap.mil/wsm (support for wounded service members)

TRICARE Fundamentals Course

TRICARE and Medicare

9

Participant Guide

References

32 CFR § 199
National Defense Authorization Act, FY 2001, Section 712
2008 TRICARE Operations Manual, Chapter 20
2008 TRICARE Operations Manual, Chapter 24, Section 20
2008 TRICARE Reimbursement Manuals, Chapter 4
www.medicare.gov

Brainteasers

Each of the eight items below is a separate puzzle.

How many can you figure out?

1. BRIDGE w t r a e	2. issue issue issue issue issue issue issue issue issue issue	3. p o o r	4. T T T T R R R R R R R R
5. Answer Answer Answer Answer ⟵	6. P----------P L---L A N---N E----------E	7. CITY	8. injury + insult

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

- **State what TRICARE For Life (TFL) is and who is eligible**
- **Identify how active duty status affects Medicare Part B enrollment**
- **Discuss the relationship between TFL and other health insurance (OHI)**

Key Terms

- **TRICARE For Life (TFL)**
- **Medicare Part A**
- **Medicare Part B**
- **Other Health Insurance (OHI)**

1.0 Introduction

Becoming Medicare-eligible may affect an individual's TRICARE eligibility and how he or she gets care. This module gives a brief explanation of Medicare, outlines actions beneficiaries may need to take to keep their TRICARE coverage, and how TRICARE works with Medicare.

?	Throughout this module, you will answer scenario questions on retired Sergeant Major Gill and his wife, Noelle.

2.0 Medicare Basics

- Medicare is a federal health insurance program for people:
  - Age 65 or older
  - Under age 65 with certain disabilities
  - Of any age with end-stage renal disease (ESRD), amyotrophic lateral sclerosis (Lou Gehrig's disease), or mesothelioma

2.1 Medicare Coverage and Costs

	Medicare Part A	Medicare Part B	Medicare Part D
Helps Cover	● Inpatient hospital care ● Hospice care ● Inpatient skilled nursing facility care ● Home health care	● Provider services ● Outpatient care ● Home health care ● Durable medical equipment ● Some preventive services	● Cost of prescription drugs
Premiums	Individuals usually don't pay a monthly premium for Part A as long as they (or their spouse) paid Medicare taxes while working.	Individuals pay a monthly premium based on their income. If they don't sign up when they're first eligible, they may have to pay a late enrollment penalty. Their premium may go up 10% for each full 12-month period they could have had Part B, but didn't sign up.	Individuals pay a monthly premium.
Individuals may call Medicare at 1-800-633-4227 or visit www.medicare.gov for more information about Medicare.			

2.2 Signing Up for Medicare Part A and B

Scenario	Action to Take
Individual is about to turn 65, and hasn't applied for Social Security or Railroad Retirement Board (RRB) benefits	**He or she needs to sign up for Part A and Part B.** The individual should contact Social Security or the RRB no later than 2 months before turning 65. Those not eligible for premium-free Part A based on their own work history should contact Social Security to find out if they qualify under their spouse's* Social Security number (SSN). (See Appendix B for more information.) * Includes former or deceased spouses
Individual is already getting benefits from Social Security or the Railroad Retirement Board (RRB) (example: retired early)	Individual doesn't need to do anything. He or she **automatically gets Part A and Part B starting the first day of the month he or she turns 65**. (If his or her birthday is on the first day of the month, Part A and Part B start the first day of the month before.) Medicare mails the individual a Medicare card 3 months before his or her 65th birthday. **Those who live in Puerto Rico** automatically get Part A, but they **must sign up for Part B**. They should contact Social Security or the RRB no later than 2 months before they turn 65 to sign up.
Individual is under 65 and disabled	Individual doesn't need to do anything. He or she **automatically gets Part A and Part B on the 25th month of getting Social Security disability payments**. Medicare mails the individual a Medicare card 3 months before his or her 25th month of disability benefits. **Those who live in Puerto Rico** automatically get Part A, but they **must sign up for Part B**. They should contact Social Security or the RRB no later than 2 months before their 24th month of disability to sign up. **Note**: If disability payments end because the individual goes back to work, Medicare eligibility may continue for up to 8 years and 6 months. The Social Security Administration (SSA) bills for the Part B premium every 3 months.
Individual has Lou Gehrig's disease (ALS)	Individual doesn't need to do anything. He or she **automatically gets Part A and Part B** 5 months after signing up for Social Security disability benefits.
Individual has an asbestos-related disease and lived in Lincoln County, Montana.	Individual **needs to sign up**. He or she **gets Part A and Part B** the month after signing up for benefits.
Individual has ESRD, is on dialysis, or had a kidney transplant.	Individual **needs to sign up** for Medicare. He or she should contact Social Security to find out when and how to sign up.
Individuals may call Social Security at 1-800-772-1213 for more information about their Medicare eligibility and to sign up for Part A and Part B.	

3.0 How to Keep TRICARE When Eligible for Medicare

A beneficiary's record in the Defense Enrollment Eligibility Reporting System (DEERS) automatically updates to show his or her Medicare coverage. 4 months before their 65th birthday or 3 months before their 25th month of disability benefits, DMDC either mails a postcard or sends an e-mail to beneficiaries advising them to go to milConnect find out about their Medicare-TRICARE status. The table below explains what action beneficiaries need to take to keep TRICARE benefits.

Scenario	Action to Take
Active duty service members (ADSMs)	**Don't need to sign up for Part B.** If they have Medicare based on age or disability, they can wait to enroll in Part B and sign up during a Special Enrollment Period (SEP). They can sign up: ● While the sponsor is on active duty ● During the 8-month period that starts the month after the sponsor's active duty status ends (including death of sponsor) or TRICARE coverage ends, whichever happens first They don't pay a late enrollment penalty if they sign up during a SEP. This SEP doesn't apply if they have ESRD. If they have ESRD, they must sign up when they're first eligible so they don't pay a late enrollment penalty.
Active duty family members (ADFMs)	If the sponsor is retiring, the person with Part A (the sponsor or family member) must sign up for Part B before the sponsor's retirement date. This prevents a break in TRICARE coverage.
Survivor of a deceased active duty sponsor (Transitional Survivor)	**Spouses: Don't need to sign up for Part B for the first 3 years** after their active duty sponsor dies. Even though they don't need Part B, strongly encourage them to sign up within 8 months of their sponsor's death. If they don't sign up during this 8-month SEP, they may have to pay a late enrollment penalty. **Children: Don't need to sign up for Part B**. Even though they don't need Part B, strongly encourage them to sign up within 8 months of their sponsor's death. If they don't sign up during this 8-month SEP, they may have to pay a late enrollment penalty.

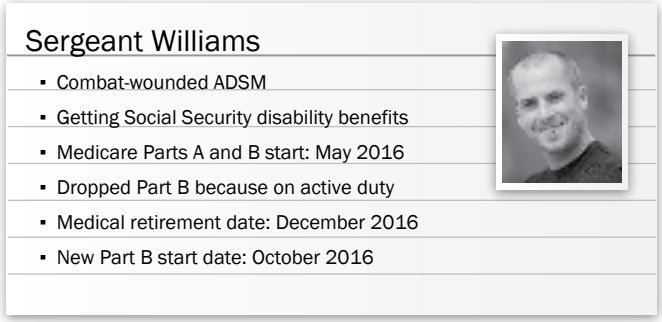
<table>
<tr><th>Scenario</th><th>Action to Take</th></tr>
<tr><td>Retirees (including retired National Guard and Reserve members getting retirement pay)</td><td rowspan="5">Must sign up for Part B.
If they have group health plan coverage (based on their or their spouse’s current employment), Medicare lets them wait to enroll in Part B. They can sign up for Part B:
● Anytime they’re still covered by the group health plan
● During the 8-month period that starts the month after the employment ends or the coverage ends, whichever happens first.
Even though they can sign up later, they won’t have TRICARE coverage if they don’t have Part B.</td></tr>
<tr><td>Family members of a retiree</td></tr>
<tr><td>Medal of Honor recipients or eligible family members</td></tr>
<tr><td>Survivors of a deceased retired sponsor</td></tr>
<tr><td>Eligible former spouse</td></tr>
<tr><td>TRICARE Reserve Select enrollees</td><td rowspan="3">Don’t need to sign up for Part B. Even though they don’t need Part B, strongly encourage them to sign up as soon as they’re eligible. They don’t get an SEP, so they may have to pay Medicare a late enrollment penalty if they don’t sign up when they’re first eligible.</td></tr>
<tr><td>TRICARE Retired Reserve enrollees</td></tr>
<tr><td>TRICARE Young Adult enrollees</td></tr>
<tr><td>US Family Health Plan (USFHP) enrollees</td><td>Don’t need to sign up for Part B. Even though they don’t need Part B, strongly encourage them to sign up as soon as they’re eligible. They don’t get an SEP, so they may have to pay a late enrollment penalty if they don’t sign up when they’re first eligible. If they disenroll from USFHP or move to a non-USFHP area, they won’t be TRICARE eligible if they don’t have Part B.
Once they’re Medicare-eligible at age 65, they can’t enroll or stay enrolled in USFHP. (If they enrolled in USFHP before October 1, 2012, they can stay enrolled in USFHP when they’re Medicare-eligible at age 65, as long as they stay enrolled with no break in coverage)</td></tr>
</table>

?	Retired Sergeant Major Gill turns 65 in 2 months and will have Medicare Part A. What happens to SgtMaj Gill’s TRICARE eligibility if he doesn’t sign up for Medicare Part B? What happens to his wife, who is 63, when SgtMaj Gill starts on Medicare? Are there situations in which SgtMaj Gill wouldn’t sign up for Part B, but still be TRICARE-eligible?

4.0 Scenarios

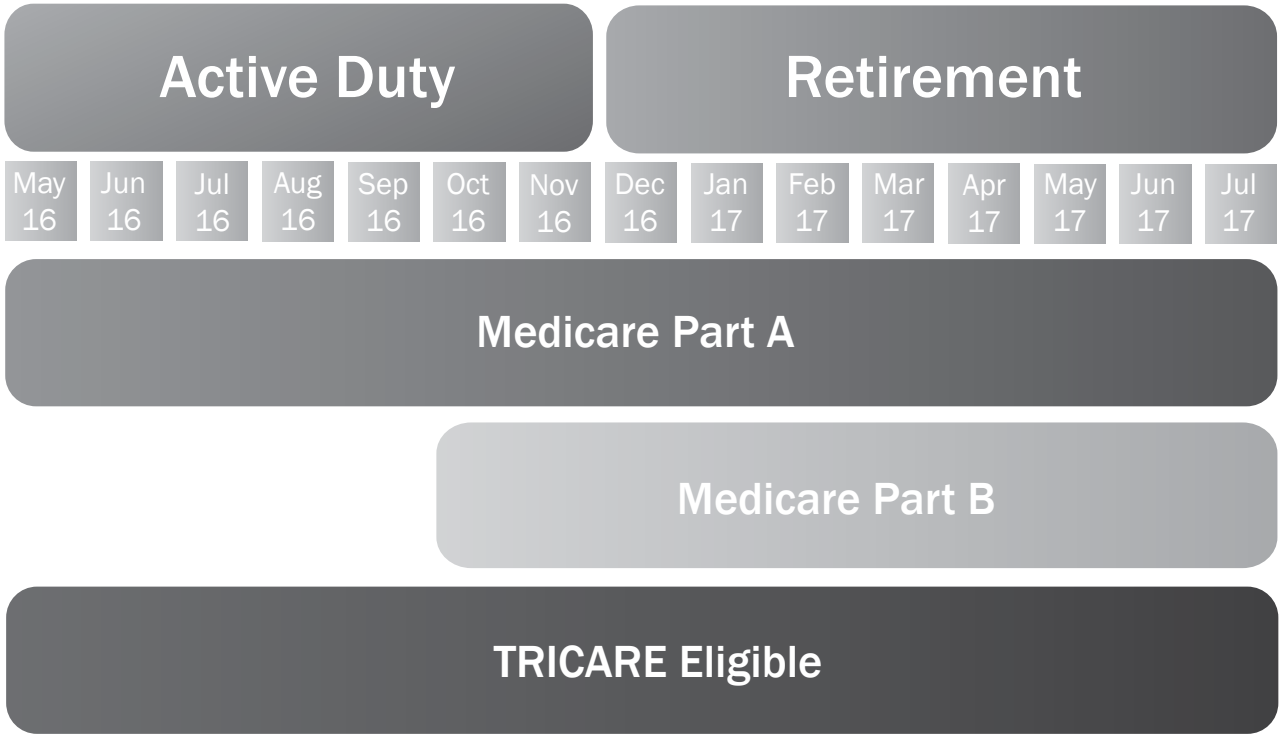
4.1 Scenario 1

Sergeant Williams is a combat-wounded ADSM getting Social Security disability benefits. He gets notice that his Medicare Part A and Part B start May 2016. He drops Part B because he's on active duty. His medical retirement date is December 1, 2016. He decides to sign up for Part B while on active duty. His Part B starts October 1, 2016. Does he have a break in coverage? When does his TRICARE eligibility start?



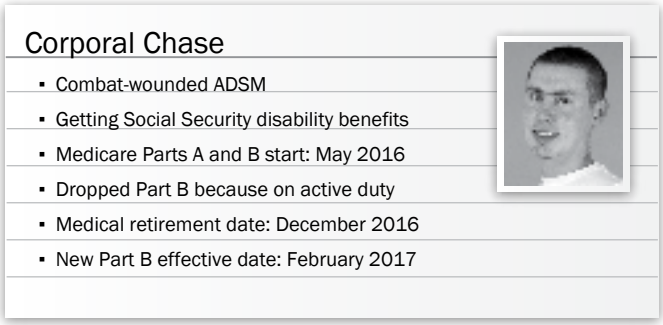
Scenario 1

No break in TRICARE eligibility because he signed up for Medicare Part B before he retired.



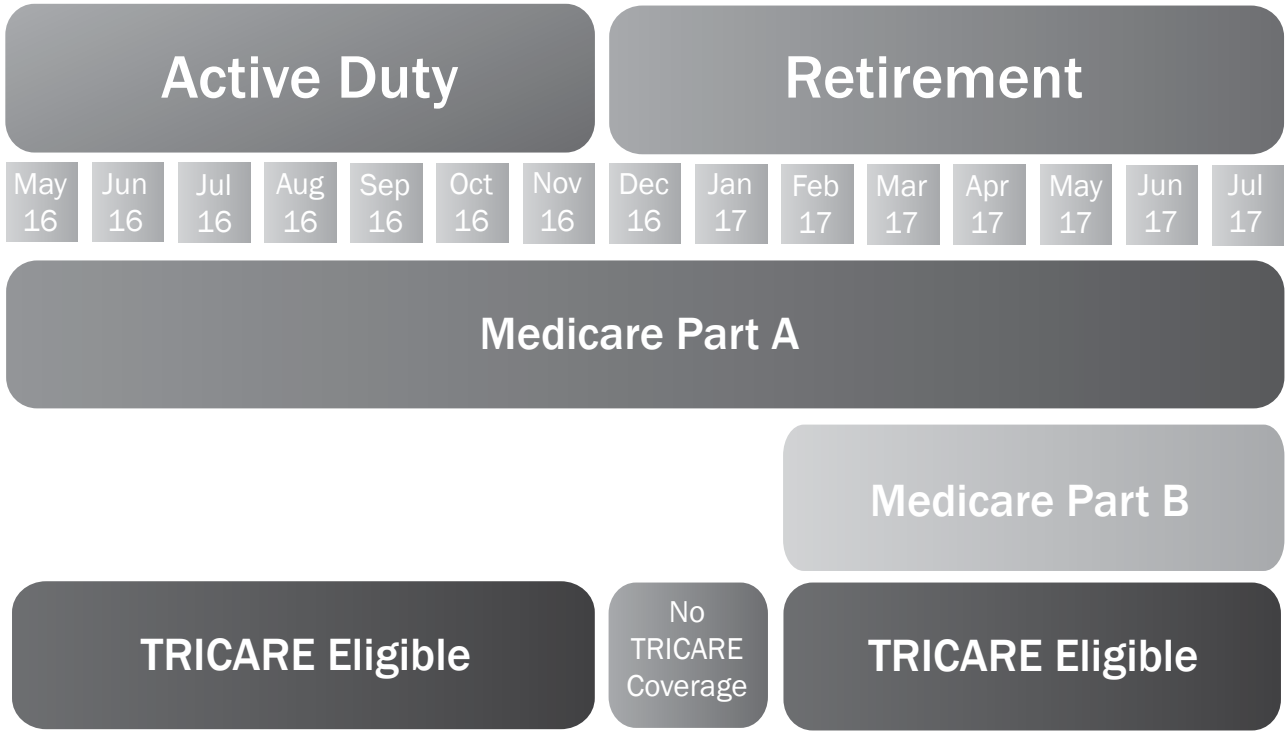
4.2 Scenario 2

Corporal Chase is a combat-wounded ADSM getting Social Security disability benefits. He gets notice that his Medicare Part A and Part B start May 2016. He drops Part B because he's on active duty. His medical retirement date is December 1, 2016. Corporal Chase signs up for Part B after he retires. His Part B starts February 1, 2017. Does he have a break in coverage? When does his TRICARE eligibility start?



Scenario 2

Break in TRICARE eligibility because he signed up for Medicare Part B after he retired.



5.0 Medicare and TRICARE Prime

Beneficiaries who have Medicare and are under age 65 can enroll in TRICARE Prime if they live in a Prime Service Area (PSA). They don't have to pay the TRICARE Prime enrollment fee as long as they have Part B. If they're ADFMs, they can enroll in Prime, even if they're 65 or older.

6.0 TRICARE For Life

TRICARE For Life (TFL) is coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B, no matter how old they are. TFL coverage starts the first day Medicare Part A and Part B start.

6.1 How TFL Works with Medicare Stateside and in U.S. Territories

With TFL, beneficiaries can:

- See any Medicare provider
- Go to military hospitals and clinics (space-available care only)

If their provider (doctor, therapist, medical equipment supplier, etc.) participates with Medicare:

- The provider file claims with Medicare, not the beneficiary.
- Medicare processes the claim and sends the claim to the TFL contractor for processing (as long as there's no other health insurance [OHI]).
- Medicare participating providers accept the Medicare-approved amount as full payment for covered services.

Whether a beneficiary has out-of-pocket expenses depends on whether Medicare, TRICARE, both, or neither covers his or her care.

Scenario	Medicare	TRICARE	Beneficiary Pays
Medicare and TRICARE* cover the care	Processes the claim and pays part of the Medicare-approved amount	Processes the claim and pays what's left of the Medicare-approved amount	Nothing
Only Medicare covers the care (example: chiropractic care)	Processes the claim and pays part of the Medicare-approved amount	Processes the claim and pays nothing	Medicare deductible and cost-share
Only TRICARE covers the care (example: overseas care and compression stockings)	Pays nothing	Processes the claim and pays part of the TRICARE-allowable amount	TRICARE deductible and cost-share
Medicare and TRICARE don't cover the care (example: cosmetic surgery)	Pays nothing	Pays nothing	All billed charges

* *When Medicare process the claim first and decides the care isn't medically necessary, Medicare and TRICARE don't pay. The beneficiary can appeal the decision with Medicare. If Medicare decides to pay, TRICARE also pays if it's a TRICARE-covered service. (See the Appeals module for more information).*

6.2 How TFL Works Overseas

Even though Medicare doesn't pay for care overseas (except in U.S. territories and U.S. territorial waters), beneficiaries must still have Medicare Part A and Part B to keep TRICARE. When getting care, whether living or traveling overseas, TRICARE is their only payer, unless they have OHI. Beneficiaries have to pay TRICARE Overseas Program (TOP) Standard's annual deductible and cost shares. They may need to get prior authorization for some services. They can see any overseas provider, except in the Philippines. If they live in or travel to the Philippines, they must see a TRICARE-certified provider for care.

6.3 Private Contracts and Care at Veterans Affairs (VA) Facilities

A "private contract" is a written signed agreement between a beneficiary and a doctor or other provider who chooses not to get paid by Medicare. The private contract only applies to services from the provider who signed the contract. If a beneficiary signs a private contract:

- Medicare won't pay, even if it's a Medicare-covered service.
- TRICARE only pays what it would have if Medicare paid on the claim (up to 20% of the TRICARE-allowable amount).
- Beneficiary must pay the rest of the TRICARE-allowable amount.

The same applies when a TRICARE beneficiary goes to a VA facility for care not related to a service-connected injury or illness. By law, VA providers can't bill Medicare and Medicare can't pay for VA services.

For more information on what Medicare or TRICARE covers, go to www.medicare.gov or www.tricare.mil/coveredservices or call the TFL contractor.

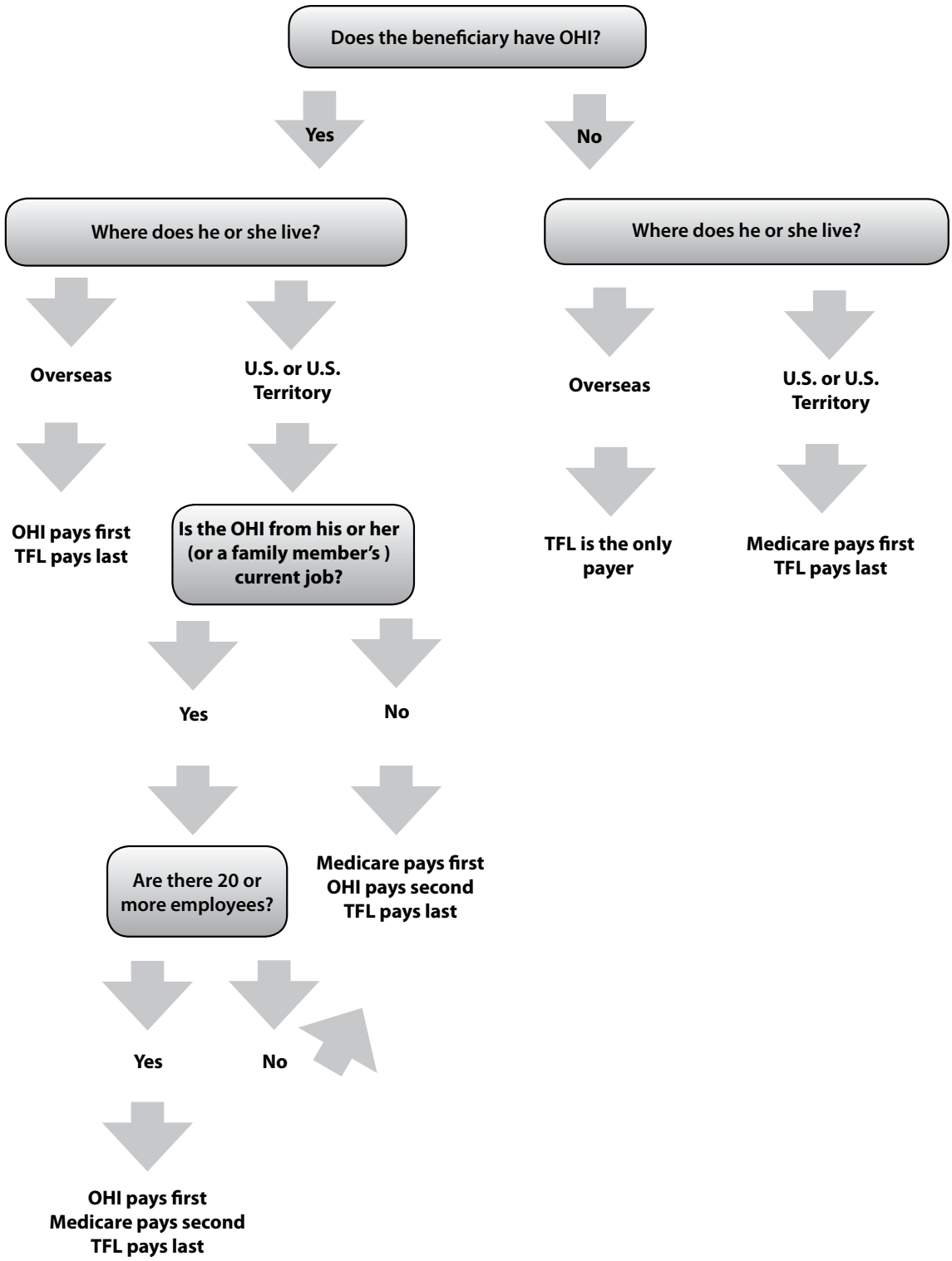
6.4 TFL Claims

The TFL claims processor handles all claims for TFL beneficiaries, except for those who live or get care overseas. The TOP claims processor handles overseas claims. The TFL claims processor also handles claims for Prime enrollees with Medicare Part A and Part B, Part A only, or Part B only.

Scenario	Action to Take
Beneficiaries get care in the United States or in a U.S. territory (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands)	Beneficiaries don't need to do anything (unless they have OHI). Medicare processes their claim first and then automatically sends the claim to the TFL contractor, unless they have OHI. If they have OHI, beneficiaries need to file claims with the TFL contractor after Medicare and the OHI process the claim. When Medicare doesn't cover care, their provider may file the claim directly with the TFL contractor. Beneficiaries get a Medicare Summary Notice (MSN) in the mail every 3 months. The MSN shows all the services or supplies billed to Medicare during the 3-month period. It shows what Medicare paid and what the beneficiary may owe the provider. The MSN isn't a bill. Beneficiaries also get a monthly summary TFL explanation of benefits (EOB). The EOB shows all the services or supplies billed to TFL during a 1-month period. It shows what TFL paid, and what the beneficiary may owe the provider. The EOB isn't a bill. Instead of getting monthly EOBs, beneficiaries may register at www.TRICARE4U.com to get an e-mail notification when their claims process. Once registered, they can log in to see their EOBs.
Beneficiaries get care in any other overseas location	Unless they have OHI, they should be ready to pay at the time of service and file claims with the TOP claims processor. They must include proof of payment with their claim. They use the claims address for the overseas area where they got care.
For more information, go to www.tricare.mil/Resources/Claims.aspx.	

6.5 How TFL Works with Other Health Insurance

When a beneficiary has Medicare, TRICARE, and OHI, TRICARE is the last payer for TRICARE-covered services. Exceptions include Medicaid, TRICARE supplements, the Indian Health Service, and other programs and plans identified by the Defense Health Agency.



?	SgtMaj Gill's wife, Noelle, who is also Medicare-eligible, works full-time as a kindergarten teacher. She has group health insurance through her employer, along with TFL and Medicare. After several weeks of foot pain, her podiatrist recommends she wear an ankle brace. Which of her 3 coverage plans should get this claim first? What should she do if her primary health care plan denies the claim?

7.0 Pharmacy and TFL

- The TRICARE pharmacy benefit doesn't change when a beneficiary has Medicare. Beneficiaries don't need to sign up for Medicare Part D (prescription drug coverage) to keep TRICARE pharmacy coverage. (See the *Pharmacy* module for more information.)
- Medicare sees the TRICARE Pharmacy Program as creditable drug coverage.
- If a beneficiary loses TRICARE coverage and signs up for Medicare Part D within 62 days of losing TRICARE, he or she won't pay a PART D late enrollment penalty.

8.0 Application Exercises

Scenario 1

Mrs. White is a uniformed service retiree who also retired from her civilian job. She has Medicare Part A and Part B, OHI through her former civilian employer, and TFL. TFL is the primary payer. True or False? Why?

Scenario 2

Mr. Smythe is a uniformed service retiree, who is still working full time at age 69. Mr. Smythe has Medicare Part A but doesn't have Part B. He is eligible for TFL. True or False? Why?

Scenario 3

Sergeant Jones was an ADSM getting Social Security disability benefits. She's now retired. Before her retirement, she signed up for Part B. She is eligible for TFL. True or False? Why?

Scenario 4

Mr. Green is a retired uniformed service member who lives outside of the United States. He has Medicare Part A and Part B. He is eligible for TFL. True or False? Why?

Module Objectives

- **State what TRICARE For Life (TFL) is and who is eligible**
- **Identify how active duty status affects Medicare Part B enrollment**
- **Discuss the relationship between TFL and other health insurance (OHI)**

Key Terms

- **TRICARE For Life (TFL)**
- **Medicare Part A**
- **Medicare Part B**
- **Other Health Insurance (OHI)**

Appendix A: Medicare Overview

- **Medicare Part A (Hospital insurance)**
  - Helps cover inpatient care in hospitals, skilled nursing facilities, hospice care, and home health care.
  - The SSA determines eligibility for premium-free Part A based on an individual's or his or her spouse's payment of Medicare taxes while working.
- **Medicare Part B (Medical insurance**)
  - Helps cover doctor's services, outpatient care, home health services, some preventive services, durable medical equipment, and other outpatient medical services.
  - Individuals sign up for Part B and pay a monthly premium; premiums may change on an annual basis.
    - Premiums depend on an individual's income. Most people pay the standard premium amount.
- **Medicare Part C (Medicare Advantage Plans)**—includes Medicare HMOs, Medicare PPOs, Medicare special needs plans, and Medicare private fee-for-service plans.
  - Provides Part A and Part B coverage, and may offer vision, hearing, dental, and health and wellness coverage.
  - Most plans include a prescription benefit.
  - To learn more about Medicare Advantage plans, go to: https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html

Note: TRICARE doesn't pay for Part C premiums. TRICARE covers copayments for covered services.

- **Medicare Part D (Medicare Prescription Drug Coverage)**
  - Helps cover the cost of prescription drugs.
  - Medicare-approved private insurance companies run Part D plans.
  - Individuals who don't sign up for Part D when first eligible, don't have other creditable prescription drug coverage, and don't get Extra Help, may pay a late enrollment penalty if they sign up later.
  - Medicare considers the TRICARE Pharmacy Program creditable prescription drug coverage.
  - Beneficiaries who lose TRICARE coverage won't have to pay a Part D late enrollment penalty as long as they sign up for Part D within 62 days of losing TRICARE.

Medicare Part B Enrollment Periods

Initial Enrollment Period

- A 7-month period that starts 3 months before the month the beneficiary turns 65, (includes the birthday month) and ends 3 months after the month the beneficiary turns 65.
    - Individuals with a birthday on the first day of the month are eligible for Medicare the month before their 65th birthday.
    - Individuals with a birthday other than on the first day of the month are eligible for Medicare the first day of the month they turn 65.

General Enrollment Period

The General Enrollment Period is from January 1 through March 31 of every year. Part B coverage starts July 1 of that year. Individuals may have to pay a late enrollment penalty.

Special Enrollment Period

The Special Enrollment Period (SEP) is for individuals who didn't sign up for Part B when they were first eligible because they are covered under a group health plan based on current employment (their own or a spouse's). This includes ADSMs and ADFMs.

They can sign up:

- Anytime they're still covered by the group health plan
- During the 8-month period that starts the month after the employment ends or the coverage ends, whichever happens first
    - Beneficiaries usually don't pay a late enrollment penalty if they sign up during an SEP.
    - Part B coverage starts the month after enrolling.
    - The SEP doesn't apply to people with ESRD.

Medicare Part B Premium Penalty

Individuals who don't sign up for Part B when first eligible may have to pay a late enrollment penalty for as long as they have Part B. The monthly premium for Part B may go up 10% for each full 12-month period they could have had Part B, but didn't sign up.

Appendix B: "I just turned 65 and I'm not eligible for premium-free Medicare Part A; what do I need to do to keep my TRICARE coverage?"

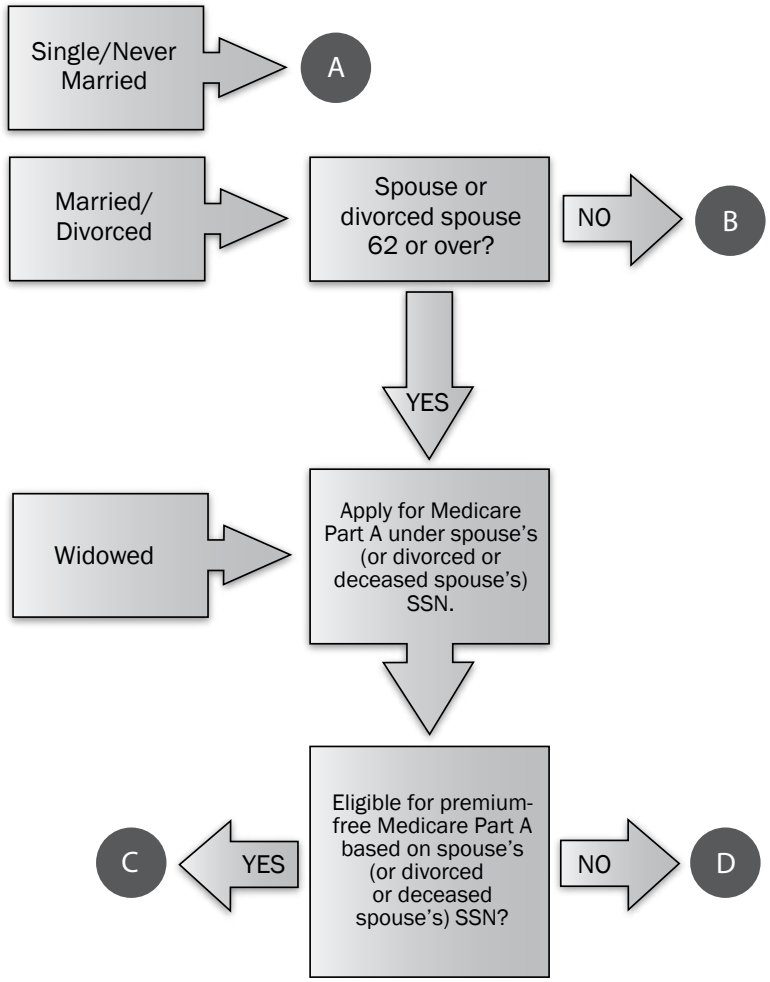
Share the following with the beneficiary in response to the question above:

The Social Security Administration sends you a Notice of Award, a Disapproved Claim, or both, after you apply for Medicare.

- A Notice of Award is an official letter that states you're eligible for premium-free Part A and enrolled in Part B, eligible for premium-free Part A and not enrolled in Part B, or only enrolled in Part B.
- A Notice of Disapproved Claim is an official letter that states you're not eligible for premium-free Medicare Part A.

If you don't sign up for Medicare Part B when you're first eligible, you may have to pay a late enrollment penalty if you decide to or have to sign up later.

Use the diagram below to find out what you need to do to keep your TRICARE coverage. Even if you're not eligible for premium-free Medicare Part A at age 65, you can still sign up for Part B.



To Keep TRICARE Coverage

A. Take your Notice of Award, Disapproved Claim, or both, to your local ID card office to update your DEERS record and to get a new ID card. You continue to be eligible for TRICARE Prime and TRICARE Standard past your 65th birthday.

B. Follow instructions for A and sign up for Part B. Then, 3 months before your spouse (or divorced spouse) turns 62, sign up for Part A under his or her SSN. If you don't enroll in Part B when first eligible, you must wait until the Medicare General Enrollment Period (GEP) to enroll. If you wait to enroll during the GEP, you may have a break in TRICARE coverage.

C. You'll get a Notice of Award from the Social Security Administration. Sign up for Part B. Your record in DEERS automatically updates to show your Part A and Part B coverage. Your TRICARE For Life coverage begins on the date you have both Part A and Part B.

D. You'll get a Notice of Award, Disapproved Claim, or both, from the Social Security Administration. This notice is based on your spouse's (or divorced or deceased spouse's) SSN. Take the Notice of Award, Disapproved Claim, or both, received based on your and your spouse's (or divorced or deceased spouse's) record to your local ID card office to update your DEERS record and to get a new ID card. You continue to be eligible for TRICARE Prime and TRICARE Standard past your 65th birthday.

TRICARE Fundamentals Course

Claims

10

Participant Guide

References

32 CFR § 199.7, 199.10
2008 TRICARE Operations Manual, Chapters 8–10
2008 TRICARE Reimbursement Manual, Chapter 1
2008 TRICARE Policy Manual, Chapter 12

Brainteasers

Each of the 8 items below is a separate puzzle.

How many can you figure out?

<table>
<tr>
<td>1.

R | E | A | D | I | N | G</td>
<td>2.

Go stand</td>
<td>3.

LANG4UAGE</td>
<td>4.

N
I
A
T
C P
A</td>
</tr>
<tr>
<td>5.

dice
dice</td>
<td>6.

Dribble
Dribble</td>
<td>7.

GROUND
  </td>
<td>8.

FRIENDS STANDING FRIENDS
miss</td>
</tr>
</table>

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Module Objectives

- **Explain who can file claims and where to submit them**
- **Describe how other health insurance (OHI) works with TRICARE**
- **Describe how to resolve claims issues**
- **Give 3 reasons for a delay in claims processing or getting an Explanation of Benefits (EOB)**

Key Terms

- **Claims**
- **Other Health Insurance (OHI)**
- **Explanation of Benefits (EOB)**
- **Fraud**

This and the next module (Appeals) apply to health care services, not to pharmacy or dental. See the Pharmacy and Dental modules for claims and appeals information. This module's fraud information applies to all contractors.

?	Throughout this module, you will answer scenario questions on active duty service member Major Stewart and his family.

1.0 Introduction to Claims

- A claim is a request for payment for benefits or services given to a beneficiary. TRICARE only pays for covered services or supplies beneficiaries get from authorized or overseas civilian providers.
- Stateside, most beneficiaries won't have to file claims, but there may be times when they will need to pay and file a claim for payment ("reimbursement").
- Overseas, most Standard beneficiaries have to file claims. This isn't the case for most Prime-option enrollees, as long as they get prior authorization from the overseas contractor for their civilian care.

2.0 Who Can File Claims

- Beneficiaries and authorized and/or overseas providers (professionals or institutions) may file claims.
  - If a beneficiary is under age 18 or over 18 but mentally incapacitated or physically dependent on others, the parent, spouse, or legal guardian may file claims for that person.
- **Network providers** must file claims.
- **Non-network providers** don't have to file claims for beneficiaries, but may choose to do so. If they don't, the beneficiary files the claim.

2.1 Filing Deadlines

United States and U.S. Territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands)	All Other Overseas Locations
Within **1 year** of the date of service or date of discharge for inpatient care	Within **3 years** of the date of service or date of discharge for inpatient care

Note: Filing deadlines don't apply to active duty service members' (ADSMs') claims.

- **Network providers**
  - If a network provider doesn't meet the claims filing deadline, the network provider can't bill the beneficiary for services.
- **Non-network providers**
  - If a non-network provider doesn't meet the claims filing deadline, the beneficiary pays all costs
- **Beneficiaries are responsible for making sure claims are filed on time, no matter who submits them.**

3.0 Where to Send Claims

- There are 2 major TRICARE claims processors:

North, South, and West Regions	Overseas Regions and TRICARE For Life (TFL)
PGBA	Wisconsin Physicians Service (WPS)

- **Care in the U.S. or U.S. Territories under TFL:**
  - Under TFL, providers must send claims to Medicare first.

  - Medicare processes and pays their portion of the claim and electronically forwards the claim to the TFL claims processor
  - If the beneficiary has other health insurance (OHI), Medicare pays their portion and forwards the claim to the OHI for processing. The beneficiary is then responsible for forwarding the claim and the OHI paperwork to the TFL claims processor.
- The TFL claims processor handles claims for TRICARE beneficiaries entitled to Part A and Part B, Part A only, or Part B only.
  - Medicare doesn't pay for overseas care. Beneficiaries mail their claims to the overseas claims processor.
- **Care in all other overseas areas:**
  - Beneficiaries must send their claims to the overseas claims processor
  - Beneficiaries can also file their claims online
- If a claim goes to the:
  - Regional contractor instead of the claims processor, the contractor sends it to the claims processor.
  - Wrong claims processor, they send it to the right claims processor or return it to the sender.

Note: For US Family Health Plan (USFHP) claims information, see the *TRICARE Options* module. For Continued Health Care Benefit Program (CHCBP) claims information, see the *Transitional Benefits* module.

?	Major Stewart's family has TRICARE Prime. Recently, his daughter's doctor referred her to a civilian ear, nose, and throat specialist for a chronic sinus condition. If the Stewarts live in Atlanta, GA, who processes the claim for Emily's office visit? When is the filing deadline? Who's responsible for making sure the claim is timely filed?

4.0 Claim Forms

4.1 Beneficiaries

Beneficiaries use the *TRICARE DoD/CHAMPUS Medical Claim Form* (DD Form 2642) to file claims for civilian health care. If a provider uses this form, the claims processor returns the claim.

- *DD Form 2642* can be downloaded from:
  - TRICARE website: www.tricare.mil/forms
  - PGBA website: www.myTRICARE.com
  - WPS website: www.TRICARE4u.com
  - TRICARE Overseas: www.tricare-overseas.com
- Beneficiaries may call the regional contractor to get a *DD Form 2642*.
- Beneficiaries must submit a separate claim for:
  - Each episode of care (e.g. several bills for 1 surgery—claims from the hospital, surgeon(s), anesthetist, durable medical equipment)
  - Services from different providers
  - Each family member, even if family members visit the same provider on the same day

4.2 Providers

- U.S. and U.S. Territories:
  - Professional providers use the CMS 1500 02-12, *Health Insurance Claim Form*.
  - Institutional providers use the CMS 1450 UB-04, *Health Insurance Claim Form*.
- Overseas providers should go to www.tricare-overseas.com/providers/claims for claim forms

4.3 Items to Include With a Claim

Beneficiaries need to include:

- **A copy of the provider's itemized bill**. The bill must be on the provider's letterhead or on a standard form with the provider's tax ID number and must include the following:
  - Beneficiary's full name (as noted in DEERS)
  - Sponsor's Social Security (SSN) number or the beneficiary's own Department of Defense Benefits Number (DBN). The DBN is on the back of the sponsor's Common Access Card (CAC).
    - Eligible unremarried former spouses are to use their own SSN or DBN, not the former sponsor's.
  - Provider's name and address (If there's more than 1 provider's name on the bill, the beneficiary should circle the name of the provider seen).
  - Date, place, description, and charge for each service
  - Diagnosis (If the diagnosis isn't on the bill, beneficiaries should complete block 8a on the form)
  - The provider's invoice/receipt
- **OHI paperwork** (required if the beneficiary has OHI). This may be a payment determination, denial statement, or Explanation of Benefits (EOB) (See Section 8.0)
- **Proof of payment—only applies overseas**. TRICARE accepts the following as proof of payment:
  - A canceled check, credit card receipt, or electronic funds transfer (EFT) record showing the beneficiary paid the provider
  - Proof of cash withdrawal if the beneficiary pays in cash
- ***Statement of Personal Injury—Possible Third-Party Liability, TRICARE Management Activity*** **(DD Form 2527)**
  - When it appears a beneficiary's care may be due to an accident, work injury, or both, or when certain procedure or diagnostic codes show a third-party may be responsible for payment, the claims processor sends the beneficiary the *DD Form 2527* and a letter asking him or her to complete and return the form.
  - Beneficiaries must return the form within 35 days of the date on the letter. If they don't, the claims processor won't process the claim.

?	Emily's PCM referred her to a non-network specialist. The non-network specialist told the Stewarts that his office doesn't file claims. This means the Stewarts have to file the claim. What must the Stewarts send to the claims processor?

5.0 Processing Criteria

Claims processors review claims using the criteria (in the order given) below:

1. The beneficiary is eligible.
2. The claim meets the filing deadline.
3. The provider is TRICARE-authorized.
4. The service or supply is a TRICARE benefit.
5. The service or supply is medically necessary and appropriate or is an approved clinical preventive service.
6. The beneficiary paid his or her portion for the service or supply (when appropriate).
7. The claim has enough information to determine the TRICARE-allowable charge for each service or supply.

Note: As soon as 1 criteria isn't met, the claims process stops. The processor sends a letter or EOB to the sender with the reason for the return or non-payment.

5.1 Newborn Claims

- The claims processor can process claims for newborns not registered in DEERS as long as:
  - The newborn's date of birth is within 365 days of when the contractor checks for eligibility; ***and***
  - The sponsor is or was TRICARE-eligible on the date(s) of service on the newborn's claim
- 366 days after the date of birth, the claims processor denies all claims until the sponsor registers the newborn in DEERS.
  - **Exception**: If the sponsor (and family) has TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) coverage, the sponsor must send in a new *Reserve Component Health Coverage Request* (DD Form 2896-1). The contractor must receive the form or it must be postmarked within 60 days of the newborn's birth date for coverage to start on the date of the newborn's birth. The claims processor can process claims from that date forward.
  - Example: The child is born April 1. The contractor gets the *DD Form 2896-1* on May 15. The newborn's coverage starts April 1.
  - If the family submits the form on day 61 or later, TRS or TRR coverage starts the first or second month after the contractor receives the application. This means the claims processor would deny claims for the dates the child wasn't covered by TRS or TRR. (See Appendix A of the *Key TRICARE Concepts and Terms* module for more on newborn eligibility.)

6.0 TRICARE Overseas Program (TOP) Prime and Prime Remote Claims

The following table describes some unique processes for TOP claims.

TOP Prime Option Claims
● The overseas contractor's call centers serve as primary care managers (PCMs) for TOP Prime Remote enrollees. They arrange and authorize care with qualified overseas providers. ● TOP Prime enrollees have the military hospital or clinic send a referral to the overseas contractor, who authorizes the care with the overseas provider. ● When authorized, the provider sends the claim to the overseas claims processor. It processes as "cashless-claimless", meaning the TOP Prime option enrollee doesn't have to pay the provider or file a claim. ○ When TOP Prime option-enrolled ADSMs get care without an authorization, the claims processor denies their claims. In these cases, reimbursement should come through the ADSM's service-specific fund. ○ When enrollees get authorized care from other than the contractor-identified provider, enrollees pay the provider. They have to file their own claims. TRICARE then reimburses the enrollee. ● The TOP Prime Remote procedure for overseas claims worked through a TOP Prime option Point of Contact (POC) is as follows: ○ The POC helps complete and submit claims, but they can't sign forms for enrollees. ○ The overseas contractor sets up a dedicated P.O. Box, fax number, and e-mail address for POC-submitted claims and correspondence. ○ The overseas contractor returns payment (foreign currency/U.S. dollars) and EOBs to the POC, who then gives the payment and EOBs to the providers and beneficiaries (when requested). **Note 1:** Box 13 on the *DD Form 2642* asks if beneficiaries would like payment issued in local currency. The term "local" refers to the country where the beneficiary received services. ● If marked "yes," the claims processor issues payment in that country's currency. ● If marked "no" or neither box is checked, the claims processor pays in U.S. dollars. **Note 2:** TRICARE doesn't pay for care in U.S. Embassy clinics

7.0 TRICARE and Other Health Insurance (OHI)

- TRICARE refers to any other health insurance a beneficiary may carry as "other health insurance (OHI)". It may be through an employer or a private insurance program. By law, TRICARE pays after all OHI, except for:
  - Medicaid
  - TRICARE supplements
  - State Victims of Crime Compensation Programs
  - Other Federal Government Programs identified by the Director, Defense Health Agency (DHA) (i.e. Indian Health Service)
- If a beneficiary has OHI, the beneficiary or the provider must file a claim with the OHI before filing with TRICARE.
- After the OHI processes the claim, the beneficiary or provider (if willing) files a claim with TRICARE, attaching a copy of the OHI's EOB and the itemized bill to the claim form.
- Beneficiaries must tell TRICARE contractors and providers when they have OHI and if their OHI changes. The claims processor may delay processing or later demand repayment ("recoup") if the beneficiary had but didn't file with or reveal his or her OHI.
- The claim has to include a copy of the OHI's EOB.
  - If TRICARE covers the procedure or treatment and approves the claim for payment, TRICARE's deductibles, cost-shares, and copays still apply.

7.1 Overseas Insurance

- Family members who are native to the host country may have insurance coverage specific to that nation.
- TRICARE considers this insurance as OHI including, but not limited to, German Statutory Health Insurance, Japanese National Insurance, and Australian Medicare. It can't be waived.
  - The overseas insurance is primary payer; TRICARE pays last.
  - Beneficiaries send the overseas claims processor the claim form, receipts, proof of payment, and a copy of the paperwork showing the overseas insurer's payment.

8.0 Explanation of Benefits (EOB)

- After a claim processes, the beneficiary and provider each get a TRICARE EOB showing what action the claims processor took on the claim.
- Beneficiaries get 1 monthly summary EOB by mail instead of a separate EOB each time a claim processes. Example Summary EOBs can be found in Appendix B
- Instead of getting monthly EOBs by mail, beneficiaries may register to get their EOBs online. They get e-mails telling them when an EOB is posted. Beneficiaries can access the website 24/7. They also have the option to download a copy. Beneficiaries may sign-up at:
  - North: www.mytricare.com
  - South: www.mytricare.com
  - West: www.mytricare.com
  - Overseas: www.tricare-overseas.com
  - TRICARE For Life: www.tricare4u.com
- Beneficiaries should carefully review their EOBs to make sure the information is correct. If beneficiaries see charges on the EOB for service(s) they didn't get, they should contact the claims processor. Incorrect charges may be due to a provider or claims system error, or may be fraud.
- If a beneficiary doesn't get a summary EOB or can't find a claim on the claims processor's website within 6 weeks of the date of service, tell the beneficiary to contact his or her provider to make sure the provider filed the claim. This also helps make sure the provider files the claim on time.

    - If the provider filed the claim, the beneficiary and provider should follow-up with the claims processor.
- Remind beneficiaries to follow-up with ambulance companies separately to make sure the company files the claim on time. (Hospitals and ambulance companies don't share insurance information.)

8.1 Reasons for Delays in Claims Processing or Receiving an EOB

- Wrong address
- Provider didn't document or prove medical necessity
- Claims processor didn't receive a third-party liability form
- Provider submitted the claim after the filing deadline
- Diagnosis is missing or doesn't match the type of services received
- There is a government-directed delay (possibly because the provider is being investigated)
- Claim is incomplete
- OHI forms are missing
- Claim is complex and requires in-depth review
- No authorization on file
- Provider's unique Provider Identification Number or National Provider Identification is missing
- Eligibility is questioned or information on the claim doesn't match DEERS

8.2 Parts of a Stateside EOB

The information below gives details for the stateside regional claims processor's EOBs. See the next page for a sample EOB for the South region. Since all the stateside regional contractors use PGBA as their claims processor, this sample is representative for all regions.

1. **Claims Processor Name and Address**: Self-explanatory. PGBA, LLC processes all claims for the North, South, and West regions. WPS processes overseas and TFL claims.
2. **Regional Contractor Name**: Self-explanatory.
3. **Mail-to Name and Address**: Name and address of patient (parent or guardian for minors) based on the provider's claim form.
4. **Date of Notice**: The date the claims processor prepared the EOB.
5. **Sponsor SSN:** The last 4 digits of the sponsor's SSN.
6. **Beneficiary Name**: The person the provider saw or treated.
7. **Sponsor Name:** Self-explanatory.
8. **Partial Benefits Were Payable To**: The provider who received payment.
9. **Claim Number:** A unique number for tracking purposes.
10. **Services Provided By**: Self-explanatory.
11. **Date of Services**: The date range for claims on the EOB.
12. **Services Provided:** Describes the service received. It also lists specific procedure codes doctors, hospitals, laboratories, and other providers use to identify those services
13. **Amount Billed:** Amount the provider charged for the services provided.
14. **TRICARE Approved:** The amount TRICARE can pay on the claim.
15. **APC #:** Ambulatory Payment Classification Number. A number Medicare or TRICARE assigns with grouped procedure codes.
16. **See Remarks:** Codes for a claim action or important message. The code is explained later in the "Remarks" section at the bottom of the EOB (some remarks appear on a separate page).
17. **Claim Summary:** Summary of totals on the entire EOB. This includes:
    - Amount Billed: See above
    - TRICARE Approved: See above
    - Non-covered: The amount TRICARE didn't pay
    - Paid by Beneficiary: The amount paid by the beneficiary
    - Other Insurance: The amount paid by the beneficiary's OHI (if applicable)
    - Paid to the Provider: Amount TRICARE paid the provider
    - Paid to Beneficiary: Amount TRICARE paid the beneficiary
    - Check Number: Identifies the check through which the payment was issued
    - Previous Payments: Previous amounts paid by TRICARE
18. **Beneficiary Liability Summary**: The amount the beneficiary is responsible for. This includes deductibles, copayments, cost-shares, and patient responsibility.
19. **Benefit Period Summary**: Shows how much the claims processor applied to the beneficiary's/family's deductibles and maximum out-of-pocket expense (catastrophic cap). The deductible and catastrophic cap is reset every fiscal year (October 1–September 30).

(1) PGBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29021-7032

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
Humana-Military.com

(4) **Date of Notice:** July 19, 2016
(5) **Sponsor SSN:** ***-**-1234
(6) **Sponsor Name:** JOHN DOE
(7) **Beneficiary Name:** JANE DOE

(3) JOHN S DOE
123 SE MAIN
PORT ST LUCIE FL 34983

Partial benefits were payable to:

(8) **SMITH & ASSOCIATES LLC**
STE 100
1234 N WASHINGTON BLVD
IRVING TX 75063

(9) Claim Number: 9999X0F6V-00-01

Services Provided By/ Date of Services	(12) Services Provided	(13) Amount Billed	(14) TRICARE Approved	APC# (15)	See Remarks (16)
(10) SMITH & ASSOCIATES LLC					
06/14/2016	001 Office or other outpatient v (99203)	150.00	102.43		1, 2, 3, 4, 5, 6, 7
(11) 06/14/2016	002 Injection, ceftriaxone sodiu (J0696)	30.00	0.00		6, 7, 8
06/14/2016	001 Therapeutic, prophylactic, o (96372)	25.00	24.06		1, 6, 7
06/14/2016	001 Noninvasive ear/pulse oximet (94760)	20.00	0.00		6, 7, 8
06/14/2016	001 Service(s) provided in the o (99051)	50.00	0.00		6, 7, 9
Totals:		**275.00**	**126.49**		

Claim Summary (17)

Amount Billed:	275.00
TRICARE Approved:	126.49
Non-covered:	148.51
Paid by Beneficiary:	125.00
Other Insurance:	0.00
Paid to Provider:	1.49
Paid to Beneficiary:	22.57
Check Number:	0000009999
Previous Payments:	102.43

Beneficiary Liability Summary (18)

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

Benefit Period Summary (19)

Fiscal Year Beginning:
October 01, 2015

	Individual	Family
Deductible:	0.00	300.00
Catastrophic Cap:		1,000.00

Remarks:

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

1-800-403-3950

THIS IS NOT A BILL

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

8.3 Parts of an Overseas EOB

The information below gives details for the overseas claims processor's EOB.

1. **Administered By:** Shows the name of the claims processor. WPS processes overseas claims.
2. **Regional Contractor Name and Logo**: Self-explanatory.
3. **Mail-to Name and Address**: Name and address of patient (parent or guardian for minors) based on the provider's claim form.
4. **Date of Notice**: The date the claims processor prepared the EOB.
5. **Sponsor SSN:** Self explanatory
6. **Sponsor Name:** Self explanatory
7. **Patient Name**: The person the provider saw or treated.
8. **Claim Number:** Self explanatory
9. **Provider Number:** The provider's ID number
10. **Provider Name:** Self explanatory
11. **Services Provided By:** Who provided the services
12. **Date of Service:** Self-explanatory
13. **Amount Billed:** The amount the provider charged for the service
14. **TRICARE Allowed:** The amount TRICARE can pay on the claim
15. **Remarks:** Codes for a claim action or important message. The code is explained later in the "Remarks" section of the EOB.
16. **Claim Summary:** Summary of totals on the entire EOB. This includes:
    - TRICARE Amount Billed: See above
    - TRICARE Allowed: See above
    - TRICARE Paid: The amount TRICARE paid on the claim
    - Medicare/Other Insurance Paid: Amount paid by the beneficiary's OHI/Medicare (if applicable)
17. **Beneficiary Share:** The amount the beneficiary is responsible for. This includes:
    - Cost Share/Copay
    - Deductible
18. **Catastrophic Cap:** How much the claims processor applied to the beneficiary's/family's deductibles and maximum out-of-pocket expense. The deductible and catastrophic cap is reset every fiscal year (October 1–September 30)

Overseas Region Sample EOB

TRICARE EXPLANATION OF BENEFITS

(1) Administered by: WPS TRICARE Administration
This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

(2) INTERNATIONAL SOS

(3) PATIENT NAME
STREET ADDRESS
CITY STATE ZIP

(4)	Date of Notice	03/16/2016
(5)	Sponsor SSN	XXX-XX-1234
(6)	Sponsor Name	Sponsor Name
(7)	Patient Name	Patient Name
(8)	Claim Number	2015001 1234567
(9)	Provider #	Provider Number
(10)	Provider Name	Provider Name

If you have questions about this notice, please call 1-877-451-8659 or visit us online at www.TRICARE-overseas.com

Explanation of Benefits (EOB) **THIS IS NOT A BILL** Explanation of Benefits (EOB)

(11) SERVICES PROVIDED BY	(12) DATE OF SERVICE	(13) AMOUNT BILLED	(14) TRICARE ALLOWED	(15) REMARKS
Provider Name	02/02/16 – 02/19/16	$89292.44	$89292.44	003
Total		$89292.44	$89292.44	

(16) CLAIM SUMMARY		(17) BENEFICIARY SHARE	
TRICARE Amount Billed	$89292.44	Cost Share/Copay	$0.00
TRICARE Allowed	$89292.44	Deductible	$0.00
TRICARE Paid	$89292.44		
Medicare/Other Ins. Paid	$0.00		

OUT OF POCKET EXPENSE:

	Beginning October 1, 2015		Beginning October 1, 2014		Beginning October 1, 2015	
	Limit	Met to Date	Limit	Met to Date	Limit	Met to Date
(18) Catastrophic Cap	$3,000.00	$0.00	$3,000.00	$3000.00	$3,000.00	$3000.00

Remark Codes:

Payment has been made to the beneficiary.

003: If you are not satisfied with our determination, you have the right to request a review within 90 days of the date of this notice. Please send your request and a copy of this notice to the following address: TRICARE Overseas P.O. Box 7992, Madison, WI 53708. You can also submit your request for review on our website, www.TRICARE-overseas.com.

PAID TO	AMOUNT PAID	AMOUNT YOU OWE
Payee Name	$89292.44	$0.00

T R I C A R E®

TRICARE EXPLANATION OF BENEFITS

Administered by: The TFC

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

Jane Smith
123 S. Christmas Lane
Nice, SC 20315

Date of Notice	January 15, 2016
Sponsor SSN	XXX-XXX-XXXX
Sponsor Name	John Smith
Beneficiary Name	Jane Smith
Claim Number	345678901
Provider Number	XX-XX648
Check Number	512340

If you have any questions about this notice, please call 1-800-123-4569 or visit us online at www.tricare.mil/tricareu

Explanation of Benefits **THIS IS NOT A BILL** Explanation of Benefits

SERVICES PROVIDED BY	DATE OF SERVICE	SERVICES PROVIDED	AMOUNT BILLED	TRICARE ALLOWED	SEE REMARKS
Pierce, Hunnicutt, & Winchester, P.C.	11/29/2015	Outpatient Visit (99214)	$200.00	$80.00	01, 02, 03
Totals:			$200.00	$80.00	

CLAIMS SUMMARY		BENEFICIARY SHARE	
TRICARE Amount Billed	$200.00	Copay	$0.00
TRICARE Allowed	$80.00	Cost-Share	$20.00
TRICARE Paid	$60.00	Deductible	$0.00
Other Ins. Allowed	$0.00	Patient Responsibility	$20.00
Other Ins. Paid			
Other Ins. Patient Resp.			

OUT OF POCKET EXPENSES

Beginning October 1, 2015	Met To Date	Limit	Beginning October 1, 2015	Met To Date	Limit
Deductible	$150.00	$300.00	Catastrophic Cap	$170.00	$3,000.00

REMARKS

01—Billed amount exceeds allowance.

02—You receive maximum benefits when you use a network provider. By law, a non-network non-participating provider may balance bill an additional 15% above the TRICARE-allowable charge.

03—$20.00 has been applied toward the catastrophic cap of $3,000.00.

PAID TO	AMOUNT PAID	CHECK NUMBER
Jane Smith	$60.00	512340

8.4 Application Exercises

8.4.1 Group Activity: Reading an EOB

Answer the questions below based on the fictional EOB on the previous page.

1. What's the EOB date?

2. Who's the sponsor?

3. Who got care?

4. Who did the beneficiary see? What service did he or she get?

5. How much did the provider bill?

6. How much did TRICARE allow? What's the term for this amount?

7. What do the remark codes mean?

8. What's the deductible?

9. What's the cost-share/copay?

10. How much does the beneficiary owe?

11. Who was paid—the provider or the beneficiary?

12. What type of provider is this?

13. Which TRICARE option did the beneficiary use? How do you know?

14. By law, how much can the provider bill Jane Smith?

8.4.2 Practice Scenario

Mrs. Jane Smith just walked into your office, very upset. She recently saw Pierce, Hunnicutt, & Winchester, P.C. She paid the doctor's office $200 at the time of service and the provider told her she could file with TRICARE for reimbursement. Mrs. Smith filed her claim and got her EOB, along with a check for $60. She's upset because she didn't get back the full $200. Mrs. Smith wants this taken care of now!

Based on her EOB and your knowledge, help Mrs. Smith understand why she didn't get back the full $200.

Note: It's important for beneficiaries to read their **entire** EOB. If TRICARE doesn't pay for a non-covered service or item, the EOB may show a patient liability of $0 because the claims processor denied the service or item. This doesn't mean the beneficiary doesn't owe anything. The beneficiary may be responsible for the full amount of the service the claims processor denied.

9.0 Solving Claims Issues

- To solve claims issues, beneficiaries should first call the claims processor.
- If the claims processor can't solve the issue, beneficiaries may contact a Beneficiary Counseling and Assistance Coordinator (BCAC) at his or her military hospital or clinic, the TRICARE Regional Office (TRO), or the TRICARE Area Office (TAO) for help.
- If a provider sends a beneficiary to collection for an unpaid claim, the beneficiary should first contact the claims processor to find out why he or she owes the provider. If the claims processor can't solve the issue, beneficiaries may contact a Debt Collection Assistance Officer (DCAO) at his or her military hospital or clinic, the TRO, or TAO for help

9.1 Helping Beneficiary with Claims Issues

- BCACs and DCAOs must register to access to the regional claims processor's online systems (www.myTRICARE.com or www.TRICARE4u.com) to see claims for their region.
    - If the beneficiary doesn't have an EOB, look up claims information online (if you have access) or call the claims processor.
    - If the beneficiary has an EOB, study the amounts, codes, and remarks to see how and why the claim processed as it did.
- To help, you may need to look for or get answers to the following questions:
    - Did the provider or beneficiary file the claim?
    - Was the beneficiary eligible on the date of service?
    - What type of coverage (e.g. Prime, Standard) did the beneficiary have on the date of service?
        - If Prime, did the beneficiary not follow the rules of Prime (remarks may show "no authorization on file" or "processed as point of service")?
    - Did the beneficiary have OHI? If so, does the EOB show that other insurance processed the claim?
    - What care did the beneficiary get (e.g., office visit, hospitalization, medications given in a provider's office, supplies)?
    - Was the care inpatient or outpatient?
    - Did the beneficiary contact the claims processor to get answers to questions? If so, what did he or she learn?

Note: BCACs and DCAOs should try to work consistently with 1 key claims processor staff member when researching and solving beneficiary claim issues.

?	About 6 weeks after filing the claim for Emily's office visit, the Stewarts get an EOB in the mail. They're surprised the EOB shows they're responsible for the full cost of the visit. Since Emily had a referral, they think something is wrong. What's the first step the Stewarts should take to fix this issue? Under what circumstances would they be responsible for the entire cost of the visit?

10.0 Program Integrity

- Program Integrity is responsible for stopping fraud, waste, and abuse through prevention, detection, coordination, and enforcement.
- The DHA Program Integrity Office:
  - Investigates certain cases for the DHA
  - Manages the DHA anti-fraud program
  - Coordinates and controls national cases, works with contractors, the Department of Justice, and investigative agencies
  - Oversees all contractor program integrity units to make sure they comply with anti-fraud activities

10.1 What is Fraud?

- Fraud is when a person or organization purposely deceives others to gain some sort of unauthorized benefit.
- Fraud may be:
  - Submitting claims for services not delivered or used
  - Filing false claims or medical records
  - Showing incorrect dates, frequency, duration, or description of services
  - Billing at a higher rate than typical for a less costly service
  - Getting services beyond what is necessary
  - Breaking a provider participation agreement
- Fraud can lead to a criminal conviction, civil settlement, termination, or exclusion from the TRICARE program.

10.2 Who Commits Fraud?

- Health care providers and other health care professionals commit most fraud (e.g., physicians, dentists, labs, hospitals, psychiatrists, ambulance companies, and clinics)
- Contractors and contract employees
- Beneficiaries

10.3 Fraud Indicators

- Excessive charges by a provider
- Unwillingness of provider to submit records
- Written request for rapid claims processing
- Conflicting dates of service
- Diagnosis or treatment isn't usually associated with a beneficiary's age or sex
- Excessive billing by the provider for low cost items or services
- Provider bills the same procedures for every patient, no matter what their diagnosis
- Provider uses P.O. boxes to receive payment
- Claims with too much or unclear documentation
- Overlapping services on the same date
- Unusual places of service
- Too many providers for same date of service
- High volume of treatment for a particular condition or diagnosis
- Claims handwritten in the same ink for both the beneficiary and provider portion of claim
- Provider isn't in the same geographic area as the beneficiary
- Claims with misused or misspelled medical terms

10.4 Where to Report Potential Fraud Cases

<table>
<tr><th colspan="3">Defense Health Agency</th></tr>
<tr><td colspan="3">Defense Health Agency
Attn: Program Integrity
1604 E. Centretech Parkway
Aurora, CO 80011-9066
Fax: (303)-676-3981
Submit a fraud report online at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity/Fraud-and-Abuse-Report-Submission-Form</td></tr>
<tr><th>TRICARE North Region:</th><th>TRICARE South Region:</th><th>TRICARE West Region:</th></tr>
<tr><td>Health Net Federal Services
P.O. Box 105310
Atlanta, GA 30348-5310
1-800-977-6761
E-mail: program.integrity@healthnet.com</td><td>Humana Military Healthcare Services
500 West Main St.
Louisville, KY 40202
1-800-333-1620</td><td>UnitedHealthcare Military & Veterans
Attn: Program Integrity
888-899-5071
P.O. Box 740826 Atlanta, GA 30348-5493</td></tr>
<tr><th>TRICARE Overseas:</th><th>TRICARE For Life (TFL):</th><th>TRICARE Pharmacy Program:</th></tr>
<tr><td>International SOS
1717 W. Broadway
P.O. Box 7635
Madison, WI 53707
1-877-342-2503
E-mail: TOPProgramIntegrity@internationalsos.com</td><td>Wisconsin Physician Services
1-866-773-0404
E-mail: reportit@wpsic.com</td><td>Express Scripts, Inc.
13900 Riverport Dr.
Maryland Heights, MO 63403
1-866-216-7096
E-mail: fraudtip@express-scripts.com</td></tr>
<tr><th>Active Duty Dental Program:</th><th>TRICARE Dental Program:</th><th>TRICARE Retiree Dental Program:</th></tr>
<tr><td>United Concordia Companies, Inc.
Special Investigations Unit
4401 Deer Path Road, DP-4F
Harrisburg, PA 17110
1-877-968-7455
Online Fraud Complaint Form: https://secure.addp-ucci.com/dwaddw/privacy.xhtml?privacyTarget=https://secure.ucci.com/non-ldap/forms/form.html</td><td>Metlife Special Investigations Unit-TRICARE
5950 Airport Rd
Oriskany, NY 13424
1-800-462-6565
E-mail: SIULINE@metlife.com</td><td>Delta Dental
Stateside: 1-888-838-8737
Overseas: (AT&T USADirect Access Number) + 866-721-8737</td></tr>
</table>

Module Objectives

- **Explain who can file claims and where to submit them**
- **Describe how other health insurance (OHI) works with TRICARE**
- **Describe how to resolve claims issues**
- **Give 3 reasons for a delay in claims processing or getting an Explanation of Benefits (EOB)**

Key Terms

- **Claims**
- **Other Health Insurance (OHI)**
- **Explanation of Benefits (EOB)**
- **Fraud**

Appendix A: Claims Resources

North Region Claims Processor

North Region Locations
Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P. O. Box 870140 Surfside Beach, SC 29587-9740 1-877-874-2273 www.myTRICARE.com

South Region Claims Processor

South Region Locations
TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 www.myTRICARE.com

West Region Claims Processor

West Region Locations
TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 1-877-988-9378 www.myTRICARE.com

Eurasia-Africa Claims Processor

Eurasia-Africa Locations	
Africa, Europe, and the Middle East	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976
1-877-678-1207 (Stateside) +44-20-8762-8384 (Overseas) www.TRICARE4u.com	

Latin America and Canada Claims Processor

Latin America and Canada Locations	
Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
1-877-451-8659 (Stateside) +1-215-942-8393 (Overseas) www.TRICARE4u.com	

Pacific Claims Processor

Pacific Locations	
Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries	
Active Duty Service Members: TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968	**All Other Beneficiaries:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
Singapore: 1-877-678-1208 (Stateside) +65-6339-2676 (Overseas) Sydney: 1-877-678-1209 (Stateside) +61-2-9273-2710 (Overseas) www.TRICARE4u.com	

TRICARE For Life Claims

United States and U.S. Territories	Overseas
WPS TRICARE For Life (TFL) P.O. Box 7890 Madison, WI 53707-7890 1-866-773-0404 www.TRICARE4u.com	Use the appropriate overseas region address listed above

Appendix B: Parts of a Summary EOB

The information below gives details for the regional claims processor's summary EOBs. See the following pages for a sample summary EOB for each region.

1. **Claims Processor Name and Address**: Self-explanatory. PGBA, LLC processes all claims for the North, South, and West regions. WPS processes overseas and TFL claims.
2. **Regional Contractor Name and Logo**: Self-explanatory.
3. **Mail-to Name and Address**: Name and address of patient (parent or guardian for minors) based on the provider's claim form.
4. **Date of Notice**: The date the claims processor prepared the EOB.
5. **Sponsor ID:** The ID is either the sponsor's (active duty, retired, or deceased) SSN or the individual's DBN. For security, only the last four digits of the SSN are on the EOB.
6. **Patient Name**: The person the provider saw or treated.
7. **Claims Processed From**: The date range for claims on the EOB.
8. **Provider of Service**: Self-explanatory.
9. **Total Paid This Reporting Period:** The amount TRICARE paid the provider.
10. **Total Patient Responsibility**: The amount the beneficiary owes the provider.
11. **Benefit Period Summary**: Shows how much the claims processor applied to the beneficiary's/family's deductibles and maximum out-of-pocket expense (catastrophic cap). The deductible and catastrophic cap is reset every fiscal year (October 1–September 30).
12. **Sponsor Name:** Self-explanatory.
13. **Patient Name:** The person the provider saw or treated.
14. **Sponsor SSN:** The last four digits of the sponsor's SSN.
15. **Provider:** Provider (person, practice, facility) name.
16. **Amount Other Insurance Paid:** The amount the beneficiary's OHI paid (if applicable).
    - **Amount You Paid:** The amount the beneficiary paid the provider, as noted on the claim.
17. **Amount Your Provider May Bill You:** The amount the beneficiary owes (deductible, co-pay, cost share).
    - **Amount Paid To Your Provider:** The amount TRICARE paid the provider.
    - **Amount Paid To You:** The amount TRICARE paid the beneficiary.
18. **Claim Number:** A unique number for tracking purposes.
19. **Date(s) of Service**: Self-explanatory.
20. **Service Provided:** Describes the service received. It also lists specific procedure codes doctors, hospitals, laboratories, and other providers use to identify those services.
21. **APC #:** Ambulatory Payment Classification Number. A number Medicare or TRICARE assigns with grouped procedure codes.
22. **Remarks:** Code for a claim action or important message. The code is explained later in the "Remarks" section of the EOB.
23. **Your Provider Charged:** The amount the provider billed TRICARE for a particular service(s).
    - **Allowed Amount:** The amount TRICARE allows based on date and location of service and provider status (network, non-network, or non-authorized).
    - **Amount Not Covered:** The amount TRICARE doesn't cover.
24. **Deductible:** The amount the claims processor applied to the deductible.
    - **Copayment and Cost-Share:** Self-explanatory.

North Region Sample EOB—Page 1

(1)

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

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

Health Net® FEDERAL SERVICES | TRICARE®

(2)

(3)

PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

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

(4)

June 10, 2015

SUMMARY EXPLANATION OF BENEFITS (5)

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

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

(6) **Patient Name: PATIENT**

(7) **Claims Processed from 05/12/15 to 06/10/15**

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

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2014.

As of June 7, 2015, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

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

CN: 100524N0000002

North Region Sample EOB—Page 2

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

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

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

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

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

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

(19) Date(s) of Service Begin	End	(20) Service Provided	(21) APC #	(22) Remarks	Your Provider Charged	(23) Allowed Amount	Amount Not Covered	Deductible	(24) Copayment	Cost Share
05/22/15	05/22/15	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

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

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

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

Date(s) of Service Begin	End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/15	05/23/15	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

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

CN: 100524N0000002

South Region Sample EOB—Page 1

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

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

(2) Humana. Military

TRICARE

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

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

(4) June 10, 2015

SUMMARY EXPLANATION OF BENEFITS (5)

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

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

(6) **Patient Name: PATIENT**

(7) **Claims Processed from 05/12/15 to 06/10/15**

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

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2014.

As of June 7, 2015, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

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

South Region Sample EOB—Page 2

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

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

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

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

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

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

(19) Date(s) of Service Begin	End	(20) Service Provided	(21) APC #	(22) Remarks	Your Provider Charged	(23) Allowed Amount	Amount Not Covered	Deductible	(24) Copayment	Cost Share
05/22/15	05/22/15	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

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

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

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

Date(s) of Service Begin	End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/15	05/23/15	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

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

CN: 100524S0000002

West Region Sample EOB—Page 1

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

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

(2) UnitedHealthcare® | TRICARE®

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

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

(4) June 10, 2015

SUMMARY EXPLANATION OF BENEFITS (5)

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

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

(6) **Patient Name: PATIENT**

(7) **Claims Processed from 05/12/15 to 06/10/15**

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

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2014.

As of June 7, 2015, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

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

West Region Sample EOB—Page 2

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

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

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

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

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

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

(19) Date(s) of Service Begin	End	(20) Service Provided	(21) APC #	(22) Remarks	Your Provider Charged	(23) Allowed Amount	Amount Not Covered	Deductible	(24) Copayment	Cost Share
05/22/15	05/22/15	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

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

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

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

Date(s) of Service Begin	End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/15	05/23/15	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

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

CN: 100524S0000002

TRICARE Fundamentals Course

Appeals

11

Participant Guide

References

2008 TRICARE Operations Manual, Chapters 12–13, 16, 20, 24

Module Objectives

- **Explain who can file an appeal**
- **Understand what can and can't be appealed**
- **Describe the types of appeals**

Key Terms

- **Appeal**
- **Provider Sanction**
- **Appeal of Medical Necessity Determinations**
- **Appeal of Factual Determinations**
- **Appeal of a Dual Eligible (Medicare-TRICARE) Determinations**
- **Mixed Cases**

1.0 Introduction to Appeals

- An appeal is an action a beneficiary, provider, or representative takes when he or she doesn't agree with a certain decision made by a TRICARE contractor or the Defense Health Agency (DHA).
- There are 5 types of appeals. The appeals process depends on the type of appeal:
  - Medical necessity determinations
  - Factual determinations
  - Mixed cases (medical necessity and factual)
  - Dual-eligible (Medicare and TRICARE) determinations
  - Provider sanction
- Information on how, where, and by when to file an appeal is in the Explanation of Benefit (EOB) or denial letter
- Appeal requirements (for all levels of appeal—except for provider status appeals)
  - Must be timely filed
  - Must be an appealable issue
  - Must have a monetary amount in dispute (estimated costs if prior authorization is denied)
  - Must be filed by a proper appealing party
  - Must be in writing

1.1 Who Can Appeal?

- A TRICARE beneficiary, including:
  - A parent or guardian representing a child under age 18
  - The parent or guardian of a family member who can't act on his or her own behalf
- A provider who was:
  - Denied approval as an authorized TRICARE provider
  - Suspended, excluded, or terminated
- A non-network participating provider
- An attorney
- An estate's legal representative, if there's no next of kin
- A member of Congress
- A representative appointed in writing by a beneficiary or provider
  - The beneficiary has to write a letter identifying who he or she is appointing to act as a representative. (See the *TRICARE Operations Manual* Chapter 12, Addendum A for a sample letter. The contractor may send a copy of this to the beneficiary/provider as an example).
    - The letter has to state what information the beneficiary wants TRICARE to share with the representative. The beneficiary could also attach a copy of the *Authorization for Disclosure of Medical or Dental Information* (DD Form 2870) with this same information.
    - *DD Form 2870* is at http://tricare.mil/Resources/Forms/Privacy.aspx or from the TRICARE contractor.
  - Once a beneficiary reaches age 18, he or she must file his or her appeals or appoint a representative to do so. (This applies even if a parent started the appeal process before the child turned 18.)
  - A provider can't file an appeal for a beneficiary but a beneficiary can chose a provider as a representative.
  - To avoid a conflict of interest, an officer or employee of the United States, including an employee or staff member of a Uniformed Service legal office, Beneficiary Counseling and Assistance Coordinators (BCACs), Debt Collection Assistance Officers (DCAOs), or a Health Benefits Advisor, can't be a representative.

- An exception can be made if the appeal is for an immediate family member.
- The letter must be postmarked or received by the contractor, TRICARE Quality Monitoring Contractor (TQMC), or the DHA before the appeal filing deadline.
- The letter from the beneficiary filing the appeal must meet the requirements of a request for a reconsideration

Note: Throughout the rest of this module, the term "beneficiary" is used to describe any appealing party to reduce extra wording. This means "beneficiary" can refer to anyone listed above.

1.2 What Can Be Appealed?

- A decision denying:
  - Prior authorization for requested services or supplies
  - TRICARE payment for services or supplies
  - A continuation of TRICARE payments for services, treatments, or supplies the contractor authorized in the past
  - A provider's request for approval as a TRICARE-authorized provider or a provider sanction

1.3 What Can't Be Appealed?

- The TRICARE-allowable charge for a service
  - The beneficiary may ask the contractor for an allowable charge review
- The contractor's or DHA's decision to ask for more information before taking action on a claim or appeal
- Decision on a provider's status
  - A beneficiary can't appeal the decision, but the provider may appeal on his or her own behalf
  - Not appealable if another federal or federally-funded program (e.g. Medicare) made the decision on the provider's status
  - Network provider and regional contractor contract disputes
  - Services from non-authorized providers
- TRICARE eligibility
  - Since the services determine eligibility, beneficiaries must appeal eligibility denials with the sponsor's branch of service
- Denial of a treatment plan, denial of services from a primary care manager (PCM), point-of-service (POS) charges (with some exceptions)

2.0 Non-Expedited Appeals Process

- The beneficiary making the appeal sends a package with copies of the following to the contractor:
  - A cover letter that states the specific issue in dispute
  - A copy of the contractor's decision letter or EOB
  - Any supporting documents the beneficiary thinks will help his or her case
  - Documents of previous decisions made by the contractor or TQMC.
- Not including a copy of the decision letter, EOB, or previous decisions may delay the review or the contractor or DHA may return the package to the beneficiary.

- The beneficiary should:
  - File the appeal before the expiration of the appeal filing deadline stated on the EOB or decision letter
  - State in the cover letter his or her intent to send more information if not all of the supporting documents are available
  - Keep originals of all appeal paperwork
- See the chart on the next page for more on the appeals process.

2.1 Expedited Appeals Process

- Expedited appeals are for preadmission/preprocedure appeals
- The beneficiary has to file the appeal within 3 calendar days after receiving the contractor's first denial decision.
- Appeals going to the TQMC have to be sent within 5 calendar days after the date the beneficiary receives the contractor's second denial.
- A request for reconsideration filed with the TQMC by the beneficiary more than 3 calendar days after the date of receipt but within 90 calendar days from the date of the initial reconsideration determination will be handled as a non-expedited reconsideration.

2.2 Medical Necessity Determinations

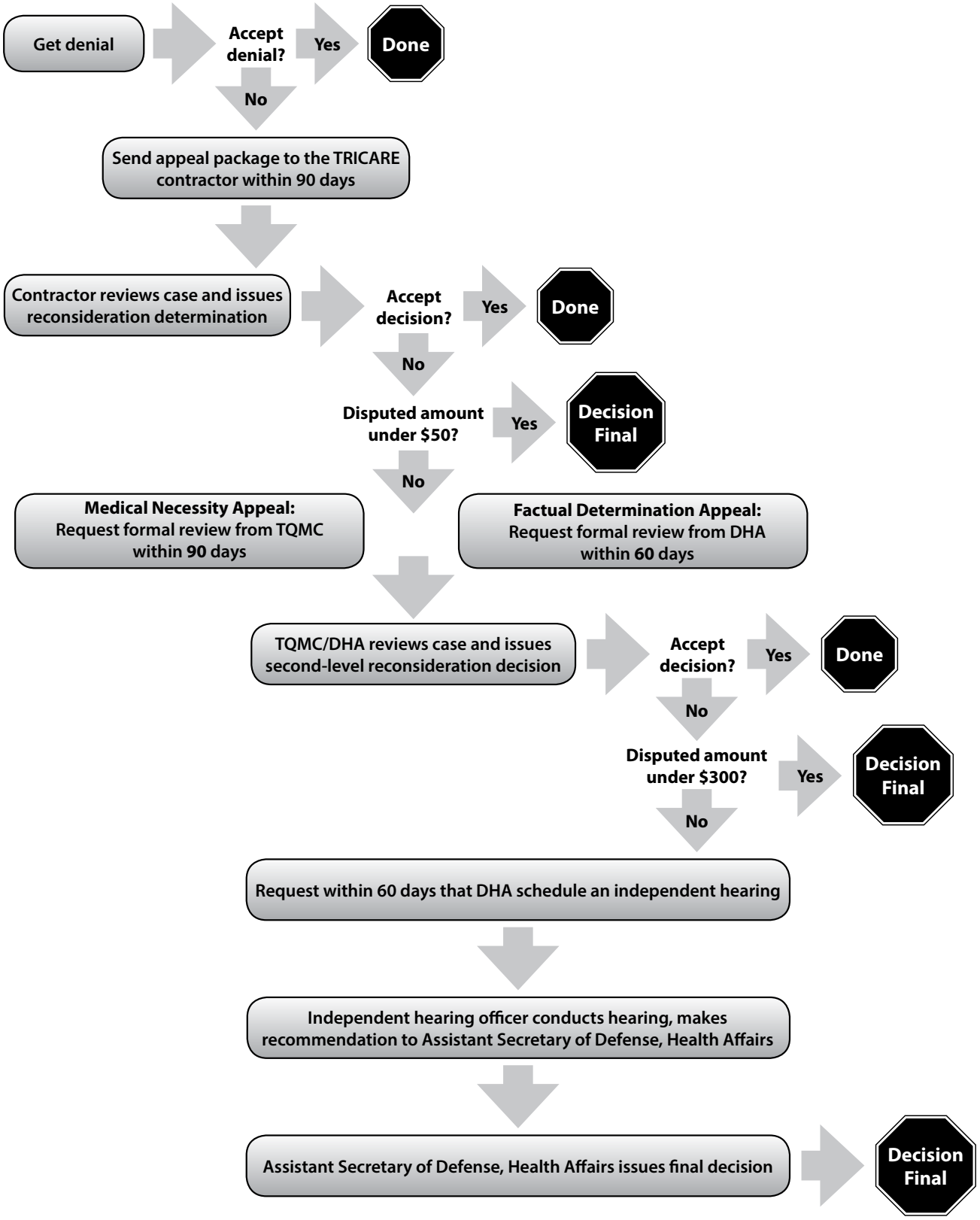
- A beneficiary files a medical necessity appeal when TRICARE denies coverage because a service isn't medically necessary, meaning the care isn't appropriate, reasonable, and adequate for the beneficiary's condition. This includes
  - Inpatient care
  - Outpatient care
  - Specialty care
  - Custodial care
  - Mental health services
- Beneficiaries can file an expedited or non-expedited appeal.
- The contractor reviews the request (referred to as "reconsideration") and issues a decision.
- If the beneficiary doesn't agree with the decision, the next level of appeal is with the TQMC.

2.3 Factual Determinations

- A beneficiary files a factual determination appeal or mixed case when TRICARE denies coverage for a reason other than medical necessity. Some examples include:
  - Whether or not TRICARE covers a service
  - Hospice care
  - Denial of a provider's request for approval as a TRICARE-authorized provider
- There isn't an expedited factual determination appeal.
- The contractor reviews the reconsideration request and issues a decision.
- If the beneficiary doesn't agree with the decision, the next level of appeal is with the DHA.

Note: Medical peer review may be needed for factual determinations.

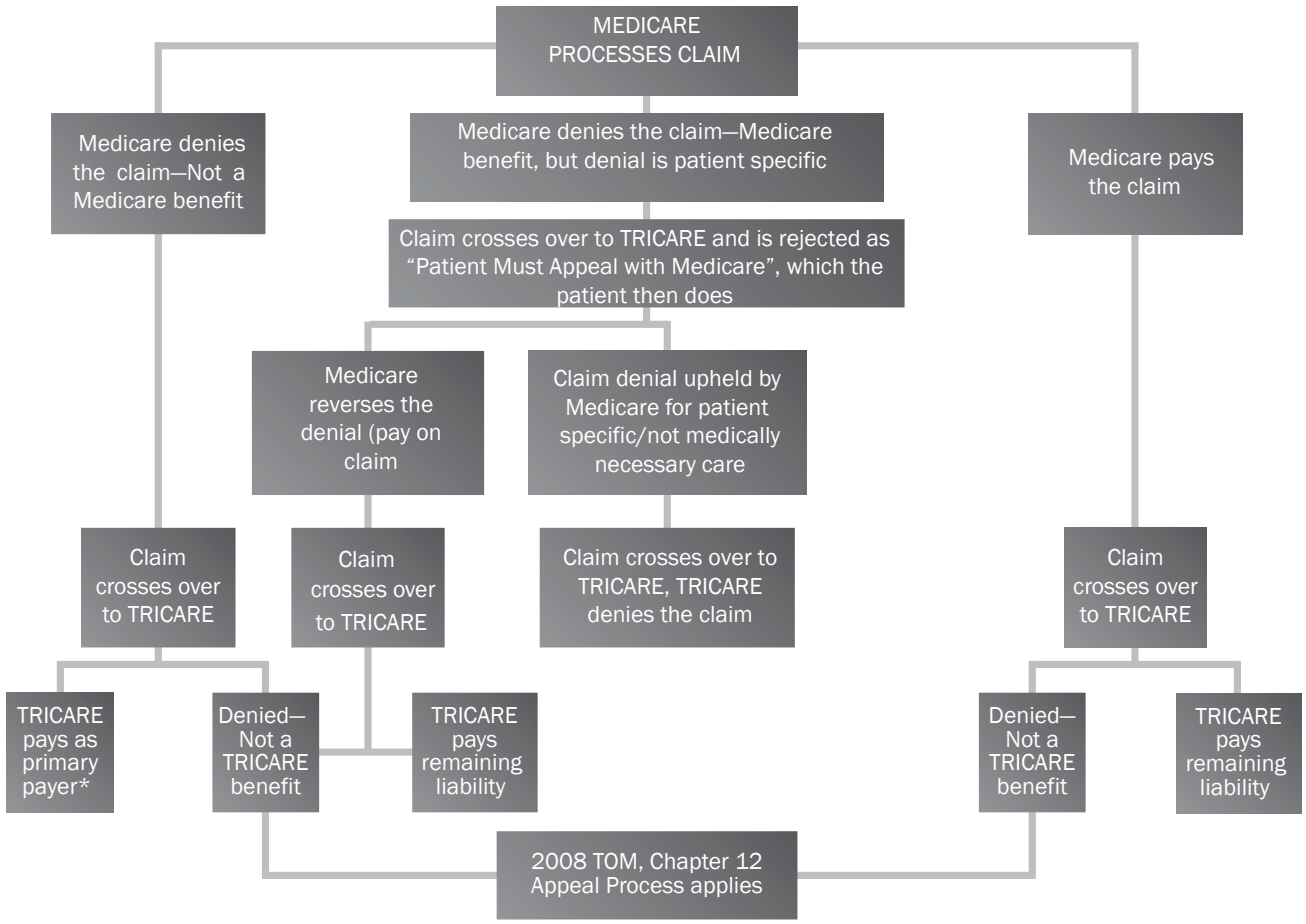
TRICARE Non-expedited Appeals Process*



* *Process does not apply to TRICARE Prime Remote appeals. See Section 5.0 of this module for more information.*

3.0 Appeals of Dual Medicare-TRICARE Claims

- Dual-eligible beneficiary appeals apply to beneficiaries who are eligible for Medicare and TRICARE.
- If Medicare denies coverage, the beneficiary:
  - **Can appeal** the decision to Medicare. TRICARE won't cover the service or supply. If the beneficiary appeals to Medicare and Medicare makes a payment, TRICARE reviews the claim for payment.
  - **Can't appeal** the decision to Medicare, TRICARE reviews the claim for payment.



*If a TRICARE-covered benefit

4.0 Provider Sanction

- TRICARE may sanction a provider for:
  - Not maintaining his or her credentials
  - Fraud
  - Abuse
  - Conflict of interest
  - Other reasons
- Only the provider or his or her representative can appeal the sanction.
- If the provider appeals, an independent hearing officer conducts a hearing. The DHA Appeals, Hearings, and Claims Collection Division oversees the process.

5.0 The Appeal Process for Active Duty Service Members

- If the stateside regional contractor, at the direction of the Defense Health Agency – Great Lakes (DHA-GL) (formerly known as the Military Medical Support Office [MMSO]), denies authorization for an active duty service member's (ADSM's) health care services, the ADSM can file an appeal with DHA-GL or their service.
  - Army, Air Force, Navy, Marine Corps, Reserve, and National Guard (except Coast Guard Reserve) send appeals to:

    Defense Health Agency Great Lakes

    Attn: Appeals

    Bldg. 3400 Suite 304

    2834 Green Bay Road

    Great Lakes, IL 60088
  - U.S. Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA) send appeals to:

    Medical Affairs Branch

    Attn: Beneficiary Medical Programs

    5600 Fishers Lane, Room 4C-06

    Rockville, MD 20857
- If the TRICARE Overseas Program (TOP) contractor denies payment or authorization for an ADSM's health care services, the ADSM may file an appeal with the TOP contractor. Appeals should be sent to:

  International SOS Government Services, Inc.

  Reconsideration/Grievances Department

  P.O. Box 11570

  Philadelphia, PA 19116 USA
- If the appeal is denied, the ADSM may appeal the denial with the designated Service Point of Contact (SPOC) (See the *TRICARE Operations Manual*, Chapter 16, Addendum A for SPOC contact information.)
- If the SPOC uphold the denial, the ADSM may file an appeal with the appropriate Surgeon General's office.

6.0 Examples of Appeals

Example 1: The contractor receives claims for hospitalization, testing, physician services, and the purchase of a cerebellar stimulator implant device for a TRICARE beneficiary. These claims involve the surgical implant of the cerebellar stimulator in the patient's brain. The claims for the hospital care, physician's services, and the stimulator device are denied by the contractor on the basis that the procedure is unproven. The claims for testing are paid. Upon appeal, the contractor retrieves all the claims for the episode of care (EOC). The contractor finds that the charges for the testing were paid in error because they relate to the denied unproven procedure.

Example 2: A beneficiary with out-of-control diabetes is hospitalized, during which she receives nutrition counseling, an eye examination, and insulin therapy. On the last day of the hospitalization, a doctor performs an abortion. The initial determination denies cost-sharing for all services and the hospital requests a reconsideration. All services must be reviewed to determine which are related to the covered hospitalization for diabetes and which are related to the non-covered abortion.

Example 3: Outpatient psychotherapy sessions are provided to a beneficiary and cost-shared by the contractor for 12 months. All claims for the 13th month are denied due to lack of an adequate treatment plan. Upon appeal of the denial of the claim, the contractor retrieves and examines all previously paid claims to determine whether all the claims should be paid, all denied, or whether denial is proper for some of the claims.

Example 4: The contractor denies a claim for physical therapy on the basis that the services weren't medically necessary. At reconsideration, the contractor discovers that previous claims for the same services and condition were paid in error. Because the erroneously paid claims involve the same issue - medical necessity of the physical therapy - the contractor shall add the erroneously paid claims to the reconsideration and review all claims together.

Module Objectives

- **Explain who can file an appeal**
- **Understand what can and can't be appealed**
- **Describe the types of appeals**

Key Terms

- **Appeals**
- **Provider Sanction**
- **Appeals of Medical Necessity Determinations**
- **Appeals of Factual Determinations**
- **Appeals of Dual Eligible (Medicare and TRICARE) Determinations**
- **Mixed Cases**

TRICARE Fundamentals Course

Resources and Tools

12

Participant Guide

References

1.0 Important TRICARE Resources

1.1 Important Websites for Customer Service Staff

TRICARE Website	www.tricare.mil
DHA and MHS Website	http://www.health.mil/
Customer Service Community Website	https://info.health.mil/agency/mhs/CSC
Customer Service Community Directory	www.tricare.mil/bcacdcao
General Inquiry for DEERS (GIQD)	www.dmdc.osd.mil/appj/giqd
Assistance Reporting Tool (ART)	https://art.tma.osd.mil/

1.2 Important Websites for Beneficiaries

Formulary Search Tool	https://www.express-scripts.com/static/formularySearch/2.0/#/formularySearch/drugSearch
Frequently Asked Questions (FAQs)	www.tricare.mil/faqs
milConnect	http://milconnect.dmdc.mil
TRICARE Forms	www.tricare.mil/forms
TRICARE Authorized Providers	www.tricare.mil/findaprovider
Beneficiary Web Enrollment	www.dmdc.osd.mil/appj/bwe
RAPIDS Site Locator	www.dmdc.osd.mil/rsl
TRICARE Costs	www.tricare.mil/costs
TPR Look-Up Tool	http://www.tricare.mil/tpr/default_zip.aspx
PSA Look-Up Tool	www.tricare.mil/PSAZIP
TRICARE Resources	http://www.tricare.mil/Resources.aspx

1.3 Stateside TRICARE Regional Contractors and TRICARE Regional Offices (TROs)

North Regional Contractor	**Health Net Federal Services** 1-877-TRICARE (1-877-874-2273) www.hnfs.com
South Regional Contractor	**Humana Military Healthcare Services, Inc.** 1-800-444-5445 www.HumanaMilitary.com
West Regional Contractor (for dates of service on or after April 1, 2013)	**UnitedHealthcare Military & Veterans** 1-877-988-WEST (1-877-988-9378) www.uhcmilitarywest.com
TRO North	www.tricare.mil/tronorth tronorth@tma.osd.mil
TRO South	www.tricare.mil/trosouth trosouthcs@tros.tma.osd.mil
TRO West	www.tricare.mil/trowest trow-southwest@trow.tma.osd.mil

1.4 TRICARE Overseas Program Contractor and TRICARE Area Offices (TAOs)

	TRICARE Overseas Program Contractor	TRICARE Area Office
Eurasia-Africa **(Africa, Europe, and the Middle East)**	**International SOS** www.tricare-overseas.com TOP Regional Call Center Overseas: +44-20-8762-8384 Stateside: 1-877-678-1207 tricarelon@internationalsos.com Medical Assistance +44-20-8762-8133	www.tricare.mil/eurasiaafrica Toll-Free: 1-888-777-8343 Commercial: 0049-6371-9464-2999 Commercial Fax: +49-(0)6302-67-6378 DSN: 1-314-590-2999 DSN Fax: 1-314-496-6378 tma.sembach.medcom-ermc.mbx.teoweb-tao-ea@mail.mil
Latin America and Canada **(Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands)**	**International SOS** www.tricare-overseas.com TOP Regional Call Center Overseas: +1-215-942-8393 Stateside: 1-877-451-8659 tricarephl@internationalsos.com Medical Assistance +1-215-942-8320	www.tricare.mil/tlac Toll-Free: 1-888-777-8343 DSN: 94-554-8520 Commercial: +1-210-292-8520 Commercial Fax: +1-210-292-3224 taolac@tma.osd.mil
Pacific **(Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries)**	**International SOS** www.tricare-overseas.com TOP Regional Call Center (Singapore) Overseas: +65-6339-2676 Stateside: 1-877-678-1208, opt. 4 TOP Regional Call Center (Sydney) Overseas: +61-2-9273-2710 Stateside: 1-877-678-1209, opt. 4 Singapore: sin.tricare@internationalsos.com Sydney: sydtricare@internationalsos.com Medical Assistance Singapore: +65-6338-9277 Sydney: +61-2-9273-2760	www.tricare.mil/pacific Toll-free: 1-888-777-8343 Commercial: +81-98-970-9155 Commercial Fax: +81-6117-43-2037 DSN: 315-643-2036 DSN Fax: 315-643-2037 tpao.csc@med.navy.mil

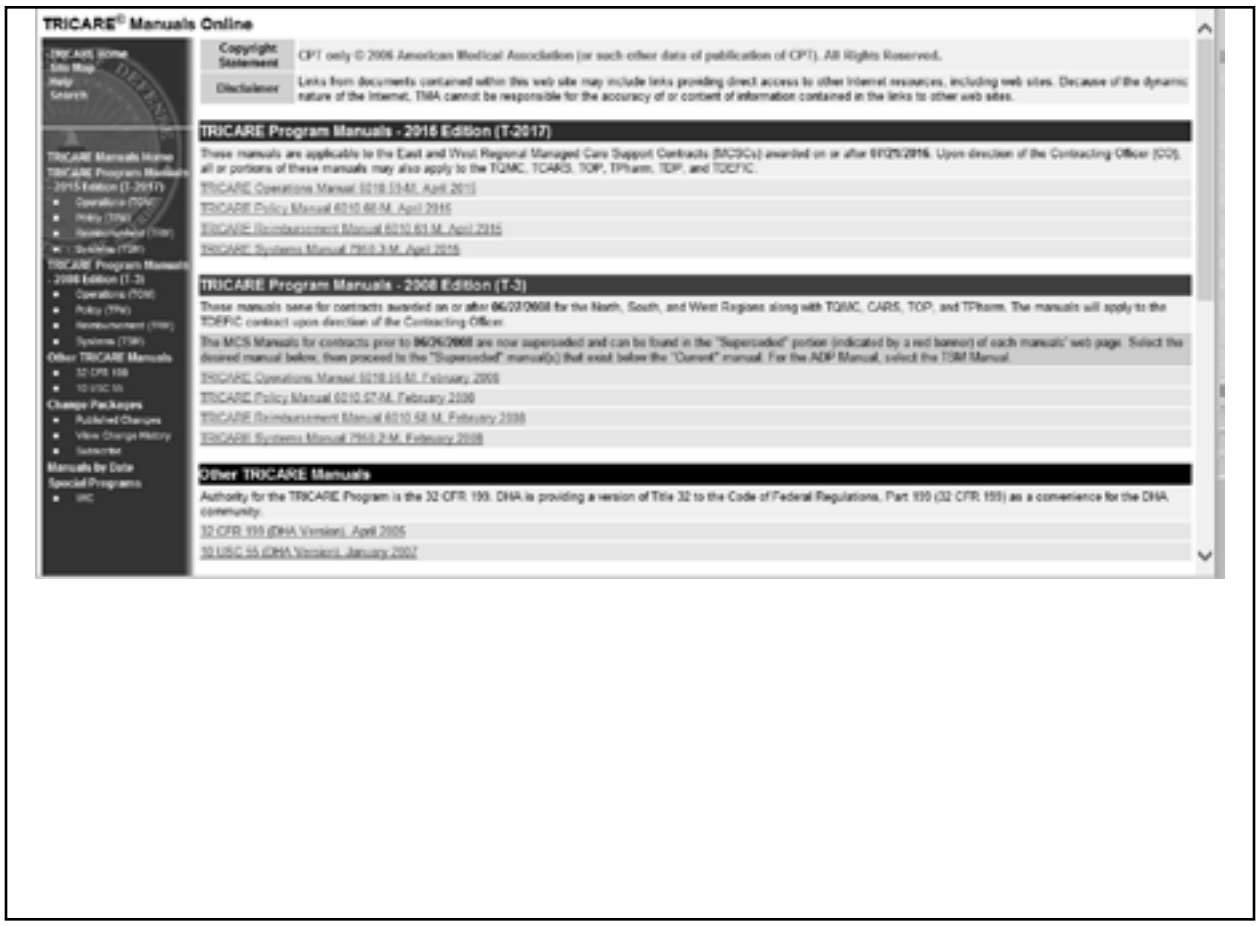
1.5 TRICARE For Life

TRICARE For Life	www.tricare.mil/tfl (for program description) www.TRICARE4u.com (for TFL contractor) 1-866-773-0404, TDD 1-866-773-0405 See the TFL contractor's website for overseas contact information.

2.0 The TRICARE Manuals (http://manuals.tricare.osd.mil)

The TRICARE Manuals are the primary resource for TRICARE benefit information. Manuals are found at http://manuals.tricare.osd.mil. They're kept up to date through published changes Contractors can't carry out changes until directed by the Defense Health Agency Contracting Officer.

Authority for the TRICARE program is Title 32 of the Code of Federal Regulations, Part 199 (32 CFR 199) and U.S. Code, Title 10, Chapter 55.



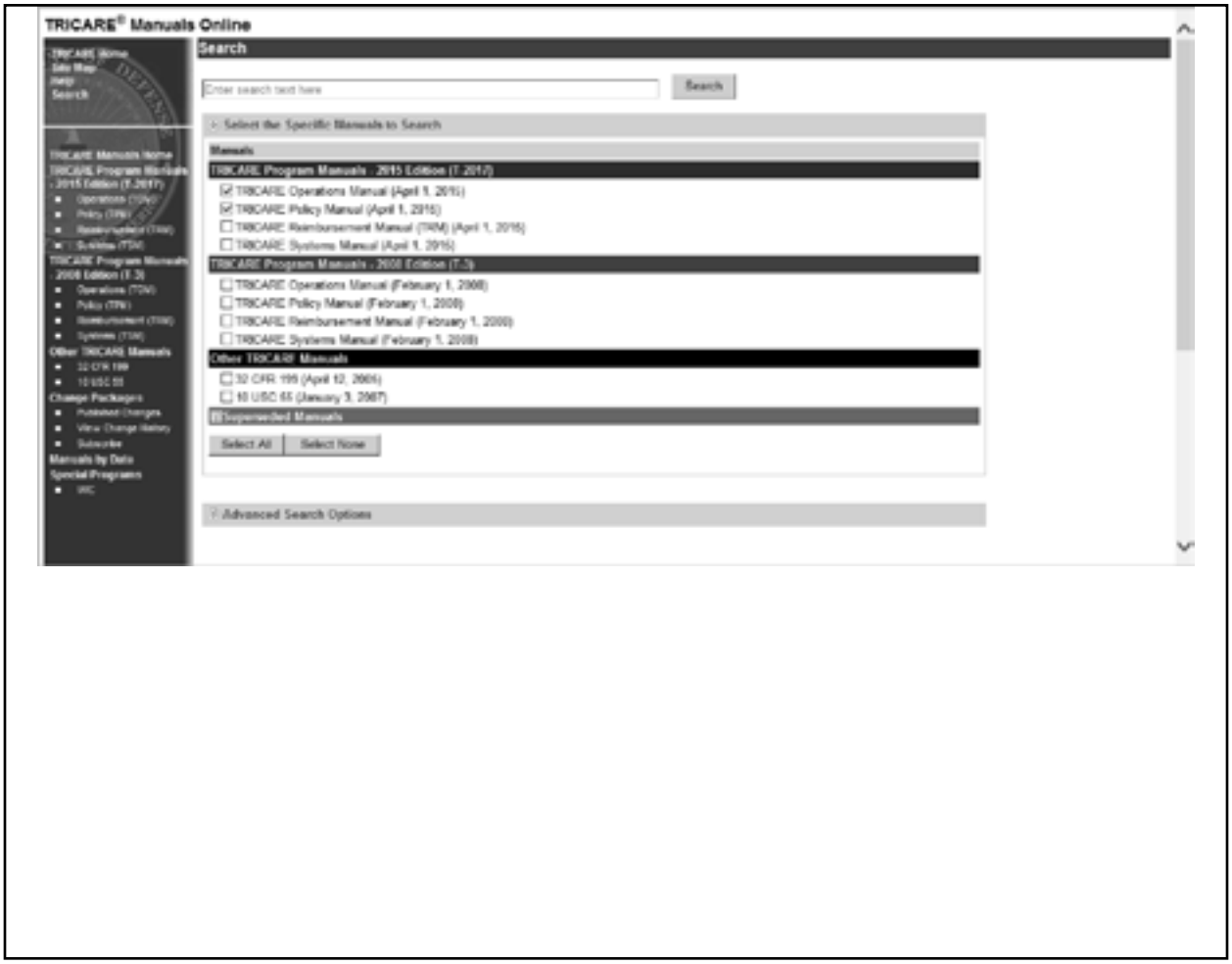
2.1 Basic Search

The TRICARE Manuals website lets you search for benefit information.

- There are now 2 posted versions:
  - TRICARE Program Manuals—2008 Edition: Contracts awarded on or after 06/27/2008 through 2016-2017 (pending award date)
  - TRICARE Program Manuals—2015 Edition: Contracts awarded in and after 2016

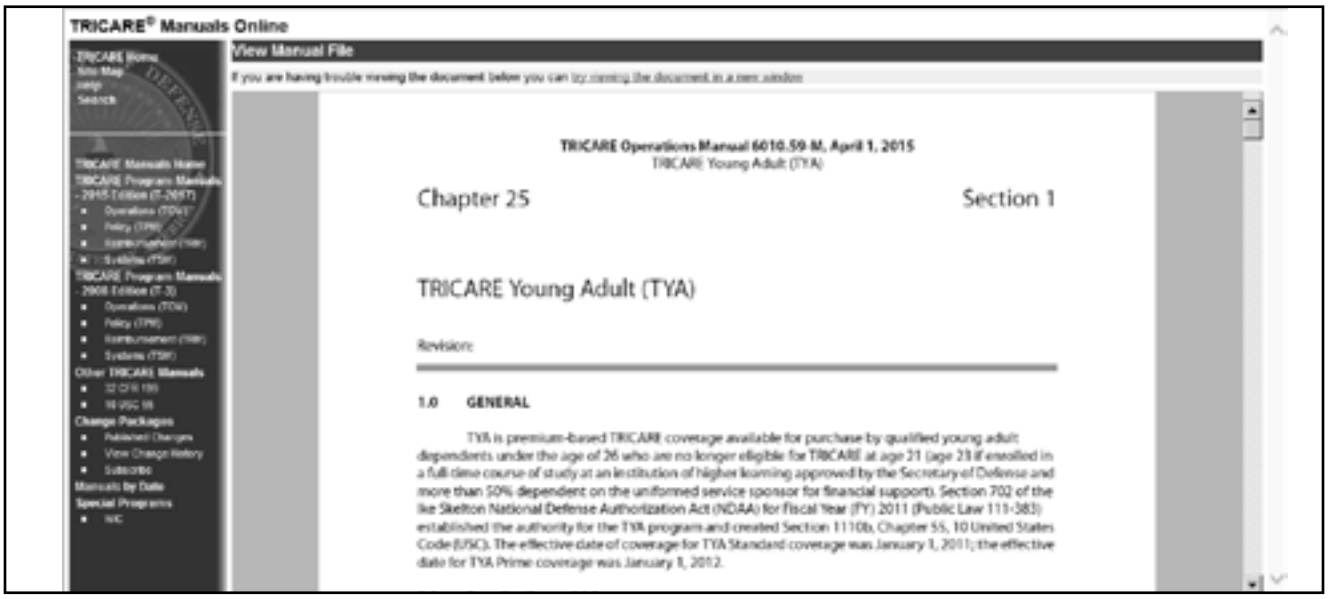
2.1.1 Enter a search string (e.g., TYA) and select the manual(s) you want to search

- To find current benefit information, select the version of the manual based on the contract award date. For example, if your checking on what the benefit was in 2010, use the 2008 version. If you're checking for benefit information in December 2017, use the 2015 version.
- Try to make the search word(s) as specific, unique, and simple as possible. If you use a lot of words, you're less likely to find what you're looking for (the search engine looks for the entire string of words you entered).



2.1.2 The website displays a list of manual content containing terms from the search string

2.1.3 The website displays the selected manual section



2.2 Register for Manual Updates

To get manual updates, visit http://manuals.tricare.osd.mil/mailingListRegistration.aspx.

3.0 Additional Resources

3.1 TRICARE Websites

Basic Websites	
TRICARE Online Website	www.tricareonline.com
Military Health System (MHS) Website	www.health.mil
Defense Health Agency Website	www.health.mil https://info.health.mil/SitePages/Home.aspx

Educational Sites and Tools	
TRICARE Smart Site (print/download products—briefings, fact sheets, brochures, handbooks, etc.)	www.tricare.mil/tricaresmart
TRICARE Fundamentals Course Online	https://jkodirect.jten.mil/html/COI.xhtml?course_prefix=DHA&course_number=-US051
ART Basics (Online Training)	https://jkodirect.jten.mil/html/COI.xhtml?course_prefix=DHA&course_number=-US074
Custom Reporting in ART (Online Training)	https://jkodirect.jten.mil/html/COI.xhtml?course_prefix=DHA&course_number=-US073
Customer Service Training	https://jkodirect.jten.mil/html/COI.xhtml?course_prefix=DHA&course_number=-US067

Links for Providers	
TRICARE Provider Site	www.tricare.mil/providers
Becoming a TRICARE Provider	www.tricare.mil/providers/becomeaprovider.aspx

Social Media	
Media Center	http://www.tricare.mil/About/News http://health.mil/media
Facebook	www.facebook.com/tricare
Twitter	www.twitter.com/tricare
YouTube	www.youtube.com/tricarehealth
Podcasts	http://www.tricare.mil/Resources/MediaCenter/Podcasts
TRICARE TV	http://www.tricare.mil/Resources/MediaCenter/TRICARETV
Sign up for e-mail updates	www.tricare.mil/subscriptions

3.2 Mobile Applications

Some mobile applications (may not be available on all devices):

- milConnect Mobile, provided by DMDC
- Express Scripts

3.3 Defense Health Agency (DHA) – Great Lakes (DHA-GL) (formerly known as MMSO)

Army, Air Force, Navy, Marine Corps, and Coast Guard	1-888-647-6676 http://www.health.mil/About-MHS/Defense-Health-Agency/Healthcare-Operations/TRICARE-Health-Plan-Division/Defense-Health-Agency-Great-Lakes [Insert branch of Service] Point of Contact Defense Health Agency-GL Suite 304 2834 Green Bay Road North Chicago, IL 60064-3091
United States Public Health Service (USPHS)	1-800-368-2777, opt. 2

DHA-GL Medical Eligibility Verification Reserve Component Form
http://www.health.mil/About-MHS/Defense-Health-Agency/Healthcare-Operations/TRICARE-Health-Plan-Division/Defense-Health-Agency-Great-Lakes

3.4 Dental Resources

Active Duty Dental Program (ADDP) Contractor United Concordia Inc.		
www.addp-ucci.com	1-866-984-ADDP (1-866-984-2337)	E-mail: addpdcf@ucci.com
General Mailing Address United Concordia Companies, Inc. ADDP Unit P.O. Box 69430 Harrisburg, PA 17106-9430		Claims Mailing Address United Concordia Companies, Inc. ADDP Claims P.O. Box 69429 Harrisburg, PA 17106-9429

TRICARE Dental Program (TDP) Contractor MetLife	
http://mybenefits.metlife.com/tricare	
Stateside: 1-855-MET-TDP1 (1-855-638-8371)	Overseas: 1-855-MET-TDP2 (1-855-638-8372)
TDD/TYY: 1-855-MET-TDP3 (1-855-638-8373)	
Stateside Claims Mailing Address MetLife TRICARE Dental Program (TDP) P.O. Box 14181 Lexington, KY 40512	Overseas Claims Mailing Address MetLife TRICARE Dental Program (TDP) P.O. Box 14182 Lexington, KY 40512 E-mail: OCONUSdentalclaims@metlife.com
General Mailing Address MetLife TRICARE Dental Program (TDP) P.O. Box 14185 Lexington, KY 40512	
Note: See www.tricare.mil/tdp for updates on the new TDP Contract starting May 1 2017	

TRICARE Retiree Dental Program (TRDP) Contractor Delta Dental of California	
www.trdp.org	Stateside: 1-888-838-8737 International Toll-Free: +866-721-8737
General Mailing Address Delta Dental of California Federal Government Programs P.O. Box 537008 Sacramento, CA 95853-7008	Claims Mailing Address Delta Dental of California Federal Government Programs P.O. Box 537007 Sacramento, CA 95853-7007

3.5 Pharmacy Resources

TRICARE Pharmacy Program Contractor Express-Scripts Inc. (United States and U.S. Territories)	
www.express-scripts.com/TRICARE	1-877-363-1303
General Mailing Address Express Scripts, Inc. P.O. Box 60903 Phoenix, AZ 85082-0903	Claims Mailing Address Express Scripts, Inc. P.O. Box 52132 Phoenix, AZ 85072

Other Pharmacy Resources	
Formulary Search Tool	https://www.express-scripts.com/static/formularySearch/2.0/#/formularySearch/drugSearch
Pharmacy Operations Division	http://www.health.mil/pod 1-210-295-1271 (DSN: 421-1271)

3.6 Stateside Claims

North Region: **Palmetto Government Benefits Administration (PGBA)**	Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P. O. Box 870140 Surfside Beach, SC 29587-9740 www.myTRICARE.com
South Region: **Palmetto Government Benefits Administration (PGBA)**	TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 www.myTRICARE.com
Palmetto Government Benefits Administration (PGBA)	TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 www.myTRICARE.com
TRICARE For Life: **Wisconsin Physicians Services (WPS)**	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890 1-866-773-0404 (TDD: 1-866-773-0405) www.TRICARE4u.com

3.7 Overseas Claims

All Active Duty Service Members	TRICARE Overseas Program P.O. Box 7968 Madison, WI 53707-7968 www.tricare-overseas.com
All Other Beneficiaries—Latin America and Canada	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 www.tricare-overseas.com
All Other Beneficiaries—Eurasia-Africa	TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 www.tricare-overseas.com
All Other Beneficiaries—Pacific	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 www.tricare-overseas.com

3.8 Appeals

	Claims Appeals	**Authorization Appeals**
North Region	Health Net Federal Services, LLC TRICARE Claim Appeals P.O. Box 2606 Virginia Beach, VA 23450-2606	Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 9530 Virginia Beach, VA 23450-9530
South Region	TRICARE South Region Appeals P.O. Box 202002 Florence, SC 29502-2002	Humana Military Healthcare Services, Inc. Attn: Clinical Appeals P.O. Box 740044 Louisville, KY 40201-7444
West Region	TRICARE West Region Claims Department P.O. Box 105492 Atlanta, GA 30348-5492	TRICARE West Region Appeals Department P.O. Box 105493 Atlanta, GA 30348-0862
Overseas (all areas)	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992	TRICARE Overseas Program Claims Appeals P.O. Box 7992 Madison, WI 53707-7992
Pharmacy (stateside)	Express Scripts, Inc. P.O. Box 60903 Phoenix, AZ 85082-0903	Express Scripts, Inc. P.O. Box 60903 Phoenix, AZ 85082-0903
TRICARE For Life	WPS TRICARE For Life, Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490	WPS TRICARE For Life. Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490

Note: Dental appeals information can be found in the *Dental* module appendices.

3.9 Fraud and Abuse

<table>
<tr><th colspan="2">Defense Health Agency</th></tr>
<tr><td colspan="2">Defense Health Agency
Attn: Program Integrity
16041 E. Centretech Parkway
Aurora, CO 80011-9066
Fax: (303)-676-3981
http://www.health.mil/fraud</td></tr>
<tr><th>TRICARE North Region:
Health Net Federal Services</th><th>TRICARE Region South:
Humana Military Healthcare Services</th></tr>
<tr><td>Health Net Federal Services
P.O. Box 105310
Atlanta, GA 30348-5310
1-800-977-6761
E-mail: program.integrity@healthnet.com</td><td>Humana Military Healthcare Services, Inc.
ATTN: Program Integrity
500 W. Main Street, 19th Floor
Louisville, KY 40202
1-800-333-1620</td></tr>
<tr><th colspan="2">TRICARE West Region:
UnitedHealthcare Military & Veterans</th></tr>
<tr><td colspan="2">TRICARE West Region
Program Integrity
P.O. Box 740826
Atlanta, GA 30348-5493</td></tr>
<tr><th>TRICARE for Life (TFL):
Wisconsin Physician Services</th><th>TRICARE Overseas:
International SOS</th></tr>
<tr><td>1-866-773-0404
E-mail: reportit@wpsic.com</td><td>1717 W. Broadway
P.O. Box 7635
Madison, WI 53707
1-877-342-2503
E-mail: TOPProgramIntegrity@internationalsos.com</td></tr>
<tr><th>TRICARE Dental Program:
MetLife</th><th>TRICARE Retiree Dental Program:
Delta Dental</th></tr>
<tr><td>1-800-462-6565</td><td>1-888-838-8737</td></tr>
<tr><th>Active Duty Dental Program:
United Concordia</th><th>TRICARE Pharmacy Program:
Express Scripts, Inc</th></tr>
<tr><td>1-877-968-7455</td><td>1-866-216-7096
E-mail: fraudtip@express-scripts.com</td></tr>
</table>

3.10 Other TRICARE Programs

Continued Health Care Benefits Program (CHCBP)	
www.tricare.mil/CHCBP	
Continued Health Care Benefit Program Application www.tricare.mil/forms **Mail to:** Humana Military Healthcare Services, Inc. Attn: CHCBP P.O. Box 740072 Louisville, KY 40201	**Mail Claims to:** PGBA, LLC P.O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 (Monday to Friday 8AM–6PM) www.myTRICARE.com
TRICARE Young Adult (TYA)	
www.tricare.mil/tya	

3.11 US Family Health Plan (USFHP)

USFHP General Information	
1-800-74-USFHP (1-800-748-7347) www.usfhp.com	
US Family Health Plan (USFHP) Designated Providers	
Johns Hopkins Medical Services Corporation Serving central Maryland, Washington DC, and parts of Pennsylvania, Virginia and West Virginia USFHP Customer Service Department 6704 Curtis Court Glen Burnie, MD 21060 1-800-808-7347 www.hopkinsmedicine.org/usfhp E-mail: usfhpcustomerservice@jhhc.com	**Martin's Point Health Care** Serving Maine, New Hampshire, Vermont, upstate and western New York and the northern tier of Pennsylvania US Family Health Plan at Martin's Point P.O. Box 9746 Portland, ME 04104-5040 1-888-241-4556 www.usfhp.com/martinspoint E-mail: shawnm@martinspoint.org
Brighton Marine Health Center Serving Massachusetts (including Cape Cod), Rhode Island and northern Connecticut US Family Health Plan 77 Warren Street Brighton, MA 02139 1-800-818-8589 www.usfamilyhealth.org	**Pacific Medical Centers (PacMed Clinics)** Serving the Puget Sound area of Washington State Pacific Medical Center (Beacon Hill) 1200 12th Avenue South Seattle, WA 98144 1-888-4-PACMED (1-888-472-2633) www.pacmed.org
CHRISTUS Health Serving southeast Texas and Southwest Louisiana US Family Health Plan P.O. Box 924708 Houston, TX 77292 1-800-67-USFHP (1-800-678-7347) www.christus.usfhp.com	**Saint Vincent Catholic Medical Centers of New York** Serving New York City, Long Island, southern Connecticut, New Jersey, and Philadelphia and area suburbs US Family Health Plan 450 West 33rd St. Mezzanine New York, NY 10001 1-800-241-4848

3.12 Additional Resources

Proof of TRICARE Coverage	
MilConnect website: http://milconnect.dmdc.mil 1-800-538-9552 (say “proof of insurance”) Fax: 1-831-655-8317, TYY/TDD: 1-866-363-2883	Written Requests: Defense Manpower Data Center Support Office (DSO) 400 Gigling Rd Seaside, CA 93955-6771

DMDC/DEERS Support Office (DSO)	
DMDC Website: www.dmdc.osd.mil MilConnect website: http://milconnect.dmdc.mil E-mail: webmaster@osd.pentagon.mil Fax address changes to: 1-831-655-8317	Toll-free: 1-800-538-9552 DSO Research and Analysis (BCACs/DCAOs only): 1-831-583-2500; DSN 1-878-3522/3523 DSO Help Desk (for technical support): 1-800-372-7437 Field Support Help Desk: 1-800-631-2508
Mail address changes to: Defense Manpower Data Center Support Office (DSO) ATTN: COA 400 Gigling Rd Seaside, CA 93955-6771	

Coast Guard Health Benefits Assistance Line	1-800-9-HBA-HBA (1-800-942-2422)
Health Insurance Portability and Accountability Act (HIPAA)	http://health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties E-mail: PrivacyOfficerMail@dha.mil
Medicare Services/Centers for Medicare and Medicaid	www.medicare.gov 1-800-MEDICARE/1-800-633-4227
U.S. Army Wounded Warrior Program	www.wtc.army.mil/aw2 1-877-393-9058
Uniformed Services Employment and Reemployment Rights Act (USERRA)	www.dol.gov/vets
U.S. Public Health Service Beneficiary Medical Program	www.usphs.gov 1-800-368-2777
Women, Infants, and Children (WIC) Overseas	www.tricare.mil/wic

Brainteaser Answer Key

Module 2: TRICARE Options

1. Go long
2. Sailing over the seven seas
3. Apartment
4. Neon light
5. Split second timing
6. Man overboard
7. Tennessee
8. Free for all

Module 3: Prime Remote Options

Picture: In your dreams
Riddle: The letter E

Module 4: Transitional Benefits

Picture: Water under the bridge
Riddle: A stop light

Module 5: Pharmacy

1. Toolbox
2. Topless bathing suit
3. Let bygones be bygones
4. 7-Up Cans
5. Ice Cube
6. Son of a gun
7. GI overseas
8. Blood is thicker than water

Module 6: Dental

Picture: Reverse Psychology
Riddle: A nose

Module 7: National Guard and Reserve

1. Paradox
2. Five pounds overweight
3. Mother-in-law
4. Quarterback, halfback, fullback
5. One step forward, two steps back
6. Stuck up
7. West Indies
8. Crossbow

Module 8: Other Benefits

Picture: A man playing a saxophone/A woman's face.

Module 9: TRICARE and Medicare

1. Bridge over troubled waters
2. Tennis shoes
3. Downpour
4. 49ers
5. Final answer
6. Explain
7. Capital City
8. Adding insult to injury

Module 10: Claims

1. Reading between the lines
2. Go stand in the corner
3. Foreign language
4. Captain Hook
5. Paradise
6. Double Dribble
7. Six feet underground
8. A little misunderstanding between two friends

TRICARE Fundamentals Course

Acronyms

13

Participant Guide

References

TRICARE Operation Manual 2008
TRICARE Policy Manual 2008
TRICARE Reimbursement Manual 2008
TRICARE Systems Manual 2008

The following list includes some of the acronyms that customer support staff may encounter when interacting with beneficiaries, working beneficiary cases, interacting with coworkers, or researching the TRICARE manuals.

Note: This list is not all inclusive.

ABA	Applied Behavior Analysis
ACA	Affordable Care Act
ACD	Autism Care Demonstration
ACN	Appointment Control Number
ADA	American Dental Association
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
ALS	Advanced Life Support
AMA	American Medical Association
APN	Assigned Provider Number
APO	Aerial Post Office
ASC	Ambulatory Surgical Center
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AWP	Average Wholesale Price
BCAC	Beneficiary Counseling and Assistance Coordinator
BLS	Basic Life Support
BMI	Body Mass Index
BRAC	Base Realignment and Closure
BWE	Beneficiary Web Enrollment
CAC	Common Access Card
CACD	Comprehensive Autism Care Demonstration
CAP	Computer/Electronics Accommodation Program
CATCAP	Catastrophic Cap
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CDCF	Central Deductible and Catastrophic Cap File
CDT	Current Dental Terminology
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program for the Uniformed Service (now known as TRICARE)
CHCBP	Continued Health Care Benefits Program
CMAC	CHAMPUS Maximum Allowable Charge
CMS	Center for Medicare and Medicaid Services
CO	Contracting Officer
COBRA	Consolidated Omnibus Budget Reconciliation Act
CONUS	Continental United States
COR	Contracting Officer’s Representative
CRSC	Combat-Related Special Compensation
CPT	Current Procedural Terminology
CSS	Customer Service Support
CY	Calendar Year

DAA	Defense Appropriations Act
DBN	Department of Defense Benefit Number
DC	Direct Care
DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DEOB	Dental Explanation of Benefits
DFAS	Defense Financial and Accounting Service
DHA	Defense Health Agency
DHA-GL	Defense Health Agency, Great Lakes
DHHQ	Defense Health Headquarters
DHP	Defense Health Program
DMDC	Only referred to as DMDC (formerly known as the Defense Manpower Data Center)
DMIS	Defense Medical Information System
DOB	Date of Birth
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoD ID Number	Department of Defense Identification Number
DOES	Defense Online Enrollment System
DOS	Date of Service
DPO	Dental Provider Organization
DPP	Deployment Prescription Program
DRG	Diagnosis Related Group
DS (Logon)	DoD Self-Service (Logon)
DSO	DMDC Support Office
DTF	Dental Treatment Facility
DTS	Defense Travel System
DX	Diagnosis
DXCD	Diagnosis Code
ECHO	Extended Care Health Option
EFMP	Exceptional Family Member Program
EFT	Electronic Funds Transfer
EHHC	ECHO Home Health Care
EHR	Electronic Health Record
EOB	Explanation of Benefits
EOC	Episode of Care
ER	Emergency Room
ESI	Express Scripts, Inc.
ESRD	End Stage Renal Disease
FAQ	Frequently Asked Question
FDA	Food and Drug Administration
FEHB	Federal Employee Health Benefit
FFM	Foreign Force Member
FFS	Fee For Service

FOIA	Freedom of Information Act
FPO	Fleet Post Office
FRC	Federal Records Center
FY	Fiscal Year
GIQD	General Inquiry of DEERS
HA	Health Affairs
HBA	Health Benefits Advisor
HCF	Health Care Finder
HCPC	Healthcare Common Procedure Code
HEDIS	Health Plan Employer Data and Information Set
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
IA	Information Assurance
ICN	Internal Control Number
ICD-X-CM	International Classification of Diseases, X Revision, Clinical Modification
ID	Identification
IP	Inpatient
IPPS	Inpatient Prospective Payment System
IRR	Individual Ready Reserve
JFTR	Joint Federal Travel Regulation
LOD/LOD-D	Line of Duty/Line of Duty Determination
LOS	Length of Stay
MCC	Member Choice Center (pharmacy-benefit related)
MCSC	Managed Care Support Contractor (stateside regional contractors)
MEC	Minimum Essential Coverage
MHS	Military Health System
MOH	Medal of Honor
MSN	Medicare Summary Notice
MTF	Military Treatment Facility
NAL	Nurse Advice Line
NARF	Non-Availability Referral Form
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NDAA	National Defense Authorization Act
NEO	Non-Combatant Evacuation Operations
NOAA	National Oceanic and Atmospheric Administration
NOE	Notice of Eligibility
OASD/HA	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	Outside the Continental United States
ODTF	Overseas Dental Treatment Facility

OGC	Office of General Counsel
OHI	Other Health Insurance
OP	Outpatient
OPPS	Outpatient Prospective Payment System
OSD	Office of the Secretary of Defense
OTC	Over-the-Counter
P-PCM	Physician-Primary Care Manager
P&R	Personnel and Readiness
P&T	Pharmacy & Therapeutics
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCP	Primary Care Physician/Provider
PDTS	Pharmacy Data Transaction Service
PEC	PharmacoEconomic Center
PEPR	Patient Encounter Processing Reporting
PDP	Preferred Dental Provider
PGBA	Palmetto Government Benefits Administrators
PHI	Personal Health Information
PHS	Public Health Service
PII	Personal Identifying Information
POC	Point of Contact or Pharmacy Operations Center
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSA	Prime Service Area
PTSD	Post Traumatic Stress Disorder
QLE	Qualifying Life Event
RAPIDS	Real-Time Automated Processing Identification System
RC	Reserve Component
RCPTA	Reserve Component Purchased TRICARE Application
RD	Regional Director
RTC	Residential Treatment Center
RVU	Relative Value Unit
SAS	Specified Authorization Specialist
SELRES	Selected Reserve
SF	Standard Form
SG	Surgeon General
SNF	Skilled Nursing Facility
SOFA	Status of Forces Agreement
SPOC	Service Point of Contact
SSA	Social Security Administration
SSAN	Social Security Administration Number

SSN	Social Security Number
TAD	Temporary Additional Duty
TAMP	Transitional Assistance Management Program
TAO	TRICARE Area Office
TCSRC	Transitional Care for Service-Related Condition
TDD	Telecommunications Device for the Deaf
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program
TDY	Temporary Duty
TED	TRICARE Encounter Data
TFC	TRICARE Fundamentals Course
TFL	TRICARE for Life
TIN	Taxpayer Identification Number (provider claims) or Temporary Identification Number (for DMDC)
TLAC	TRICARE Latin America and Canada
TMA	TRICARE Management Activity (abolished October 1, 2013)
TMAC	TRICARE Maximum Allowable Charge
TMOP	TRICARE Mail Order Pharmacy
TOL	TRICARE Online
TOM	TRICARE Operations Manual
TOP	TRICARE Overseas Program
TOPD	TRICARE OCONUS Preferred Dentists
TOP POC	TRICARE Overseas Program Point of Contact
TPL	Third Party Liability
TPM	TRICARE Policy Manual
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TQMC	TRICARE Quality Monitoring Contract
TRDP	TRICARE Retiree Dental Program
TRM	TRICARE Reimbursement Manual
TRO	TRICARE Regional Office
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy Benefit
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TSM	TRICARE Systems Manual
TTY	Teletypewriter
TYA	TRICARE Young Adult
UCCI	United Concordia Companies, Inc.
URFS	Unremarried Former Spouse
USERRA	Uniformed Services Employment and Reemployment Rights Act
USFHP	US Family Health Plan
USMTF	Uniformed Services Military Treatment Facility
USPHS	United States Public Health Service

VA	Veterans Affairs/Administration
VHA	Veterans Health Administration
WIC	Women, Infants, and Children Overseas Program
WPS	Wisconsin Physicians Service
WSM	Wounded Service Member
WTU	Warrior Transition Unit
WWR	Wounded Warrior Regiment

TRICARE Fundamentals Course

Definitions

14

Participant Guide

References

2008 TRICARE Operations Manual, Appendix B

The following glossary lists and defines common terms used when working with TRICARE. It doesn't include all terms and definitions. For a complete list, check the TRICARE manuals at http://manuals.tricare.osd.mil.

20th-of-the-Month Rule

Rule that determines the start date of coverage under certain TRICARE options. The effective date of coverage is based on the date the contractor processes the enrollment or application form. If the contractor receives the form by the 20th of the month, coverage starts on the first day of the next month. If the contractor receives the form after the 20th of the month, coverage starts on the first day of the second month.

Note: The form must be received and in processing by the 20th of the month, not postmarked by the 20th.

Access Standards

Appointment standards for accessing care under TRICARE Prime. In general, Prime enrollees should have an appointment for:

- Urgent (acute) care: within 24 hours (1 day).
- Routine care: within 7 days.
- Specialty care or wellness visit: within 4 weeks (28 days).

Also, a Prime enrollee's primary care manager should be within a 30-minute drive of the enrollee's home (under normal driving conditions); specialty care should be available within 1-hour drive time.

Active Duty Service Member (ADSM)

An individual serving in one of the 7 uniformed services of the United States under a call or order that isn't for 30 days or less.

Adjunctive Dental Care

Medically necessary dental care to treat a covered medical (not dental) condition. It's part of the treatment of the medical condition. It may also be used to treat dental trauma that may be or is due to treatment of an injury or disease.

Appeal

A formal written request by a beneficiary, a participating provider, a provider denied TRICARE authorized provider status, or a designated representative, to resolve a dispute about denied coverage, payment, or status.

Authorization for Care

The determination that a requested treatment, service, procedure, or admission is medically necessary, delivered in the appropriate setting, and is a TRICARE benefit. Services that require prior authorization may vary between regions.

Authorized Providers

A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under TRICARE in 32 CFR 199.6. Any physician listed in 32 CFR 199.6 who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in 32 CFR 199.6 are not considered authorized providers unless they are included in a TRICARE demonstration program.

Balance Billing

When a provider bills the difference between billed charges and what TRICARE, other health insurance, and the beneficiary paid. Network and participating providers can't balance bill. By law, non-participating providers can only bill beneficiaries up to 15 percent above the TRICARE-allowable charge.

Basic Core Formulary

A list of drugs full-service military pharmacies must carry.

Beneficiary

A person who, by law, is eligible for TRICARE benefits. Beneficiaries include: ADSMs and active duty family members (ADFMs), retired service members and their families, certain National Guard and Reserve members and their families, survivors and widows, certain unremarried former spouses, Medal of Honor recipients and their families, and others identified as eligible by the respective uniformed services. Family members include spouses and children (biological, adopted, or step) up to age 23, depending on the child's eligibility.

Beneficiary Counseling and Assistance Coordinators (BCACs)

Individuals assigned to military hospitals or clinics, TRICARE Regional Offices (TROs), and TRICARE Area Offices (TAOs), who serve as beneficiary advocates, answer questions, and help solve TRICARE-related problems. Term also includes "Health Benefits Counselors" and "Health Benefits Advisors."

Benefit

Services, supplies, payment amounts, cost-shares and copayments authorized by Public Law (PL) 89-614, 32 CFR 199, and outlined in the TRICARE Policy Manual and the TRICARE Reimbursement Manual.

Billed Charge

The total amount a provider bills for services.

Beneficiary Liability

The legal requirement of a beneficiary, his or her estate, or family member to pay for services and supplies received. Beneficiary liability includes deductibles, copayments, cost-shares, amounts above the TRICARE-allowable charge when a beneficiary uses a non-participating provider, and costs for services and supplies TRICARE doesn't cover.

Cashless-Claimless Service

Applies to TRICARE Overseas Program (TOP) Prime/TOP Prime Remote enrollees. Occurs when enrollees get prior-authorized care from a certified overseas provider. The provider files the claim and the TOP contractor pays the provider. Enrollees don't have to pay up front or file a claim.

Catastrophic Cap

The most a TRICARE beneficiary pays out of pocket for TRICARE-covered services per fiscal year (October 1–September 30). The following don't apply to the catastrophic cap:

- Point-of-service cost-shares and deductibles
- The 15% above the TRICARE-allowable charge paid to non-participating providers
- TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and TRICARE Young Adult (TYA) premiums
- Costs for services TRICARE doesn't cover

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

A program of medical care for spouses and dependent children of disabled or deceased disabled veterans who are eligible under the Department of Veterans Affairs.

Claim

A request for payment for health care services, prescription drugs, and medical equipment and supply items received by a TRICARE beneficiary. A beneficiary, a beneficiary's representative, or a network or non-network provider may file a claim with a contractor using a TRICARE-approved claim form or approved electronic medium.

Clinical Preventive Services

Services, such as health screenings, meant to keep individuals healthy or to discover health problems in a timely manner. Preventive services include pap smears, mammograms, colorectal cancer exams, prostate cancer exams, cholesterol tests, and vaccinations

Confidentiality Requirements

The procedures and controls that protect the confidentiality/privacy of medical information as required by the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, the Privacy Act, and the Health Insurance Portability and Accountability Act (HIPAA).

Contingency Operation

A military operation that, by law, activates or retains members of the uniformed services during a war or during a national emergency declared by the President or Congress.

Continued Health Care Benefit Program (CHCBP)

A premium-based health care program offering coverage for 18 to 36 months after TRICARE eligibility or premium-based program coverage ends.

Contractor

An organization the Defense Health Agency (DHA) contracts with for delivery and payment for services and administrative support, such as enrollment/application processing, quality monitoring, or customer service.

Coordination of Benefits

TRICARE's requirement to collect other health insurance benefits and payment information before making any TRICARE payment. By law, the other health insurance plan is primary payer. Exceptions where TRICARE is first payer: Medicaid, the Indian Health Service, and other programs identified by the Director, DHA (e.g., States Victim Assistance Programs).

Cost-Share

The amount of money a beneficiary pays for covered inpatient and outpatient services (as set forth in 32 CFR 199.4, 199.5, and 199.17). Cost-sharing may also be referred to as "copayment." Cost-share depends on the TRICARE option and the sponsor's status (i.e., active duty or retired).

Date of Determination

The date an appeal reconsideration determination, formal review determination, or hearing final decision is made.

Debt Collection Assistance Officer (DCAO)

Individuals at military hospitals or clinics, TROs, and TAOs, who help beneficiaries with confirmed debt collection issues or a negative credit rating due to unpaid TRICARE claims.

Deductible

The amount beneficiaries pay per fiscal year for outpatient services before TRICARE begins cost-sharing (doesn't apply to Prime options), except when a beneficiary uses the Point-of-Service option.

Defense Enrollment Eligibility Reporting System (DEERS)

The computer based enrollment/eligibility system used for verifying entitlement to health care services for each Uniformed Service member (Active Duty, retired, or a member of a Reserve Component), US-sponsored foreign military, DoD and Uniformed Services civilians, other personnel as directed by the DoD (including the patient population serviced through the Military Health Services System), and their eligible family members. Registration is required.

Defense Health Agency (DHA)

A Department of Defense (DoD) Combat Support Agency, established October 1, 2013, responsible for shared services, functions, and activities of the Military Health System (MHS) and other common clinical and business processes.

Defense Health Agency, Great Lakes (DHA-GL)

The office responsible for coordinating civilian health care services for remotely-located active duty service members, providing pre-authorization for civilian line of duty (LOD) medical care, collaborating with unit representatives regarding LOD care for remotely-located service members, providing authorization for VA medical care for active duty service members accepted under the DoD/VA Memorandum of Agreement (MOA) for a Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI) or Blindness, and authorizing payment of civilian medical claims.

DMDC

Serves under the Office of the Secretary of Defense (OSD) to collect personnel, manpower, training, financial, and other data for the DoD. The data archives the history of personnel in the military and their family for purposes of healthcare, retirement funding, and other administrative needs.

Demonstration

A study or test project to evaluate other methods of delivery and payment for health care services. After a demonstration ends, it may or may not become a part of the TRICARE benefit.

DoD Benefit Number (DBN)

A unique 11-digit family member identifier that ties a family member to a sponsor and identifies the ID cardholder as one who has DoD benefits, such as health care or base exchanges services.

DoD Identification Number (DoD ID)

A 10-digit number that replaces the cardholder's Social Security number (SSN) on the uniformed services ID and the Common Access Card (CAC). The number is used as a means of identifying a specific individual.

Double Coverage

When a TRICARE beneficiary has other insurance, medical service, or health plan that may cover all or part of a beneficiary's TRICARE benefits.

Emergency Care

A serious medical condition that the average person would consider to be a threat to life, limb, sight, or safety.

Enrollee

A TRICARE beneficiary enrolled in a TRICARE Prime option (including the US Family Health Plan [USFHP]).

Enrollment Fees

An annual fee paid by some beneficiaries to enroll in and receive care under a TRICARE Prime option (including USFHP).

Enrollment Transfer (Portability)

A transfer of TRICARE Prime enrollment from one location to another. There are 2 types of enrollment transfers:

- Between regions—involves a change of address, contractor and primary care manager (Note: The term "contractors" includes the USFHP.)
- Within a region—involves a change of address and possibly a change of primary care manager; the actual regional contractor doesn't change

Exceptional Family Member Program (EFMP)

A program for ADFMs with special medical and/or educational needs. The intent is to make sure needed services are available to families at assigned duty stations. EFMP involves the Services' personnel, medical, and DoD education systems. Services mandate enrollment when an ADFM has special needs.

Exclusions

Services and supplies TRICARE can't pay for. Includes covered services and supplies provided by a non-authorized provider or a provider placed on "suspension" by a contractor

Explanation of Benefits (EOB)

An electronic or paper document prepared by insurance carriers, health care organizations, and TRICARE, showing the actions taken on a claim.

Extended Care Health Option (ECHO)

A supplemental program to the TRICARE basic program that provides additional financial resources and services to ADFMs with qualifying mental or physical disabilities. Registration is required.

Fee for Service (FFS)

A system of health insurance payment in which doctors and other health care providers are paid a fee for each service provided.

Fiscal Year (FY)

The federal government's 12-month accounting period which runs from October 1–September 30.

Fitness for Duty

Medical and/or dental status of an ADSM, as determined by the member's service.

Freedom of Information Act (FOIA)

A law enacted in 1967 that gives individuals the right to access information from any federal agency. The DHA and TRICARE contractors have to follow this law.

Good Faith Payments

Payments made to civilian providers for care to persons who presented as TRICARE-eligible but weren't actually eligible on the dates of service. (The ineligible person usually possesses an erroneous or illegal identification card.) To receive a good faith payment, the civilian provider must show he or she used reasonable measures to identify a person as eligible (e.g., copy of ID card, online inquiry) and bill the former beneficiary for services.

Grievance

A written complaint by a beneficiary who thinks a network provider, contractor, subcontractor, or contracted providers failed to furnish the level or quality of care and or service expected. It's for non-appealable issues.

Health Care Provider (HCP)

An individual or institution licensed or authorized to practice medicine or deliver health care services, supplies, or equipment.

Health Information (HIPAA/Privacy Definition)

Any information about an individual's physical or mental health possessed by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This includes information about health care services received and/or paid for.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

An act passed by Congress to combat waste, fraud and abuse, improve portability of health insurance coverage, and simplify health care administration.

Health Maintenance Organization (HMO)

A type of managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to individuals for a set amount of money every month. In most HMOs, individuals can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Most HMOs also require individuals to get referrals from their primary care manager. HMOs focus on prevention and wellness. The TRICARE Prime options are similar to HMOs.

Individually Identifiable Health Information (IIHI) (HIPAA/Privacy Definition)

Parts of an individual's health information that can be used to identify them.

Initial Determination

The first formal written decision (including an EOB) on a TRICARE claim, a request for benefit authorization, a request by a provider for approval as a TRICARE-authorized provider, or a decision disqualifying or excluding a provider as an authorized provider under TRICARE.

Inpatient Care

Services/treatment provided to a person who was admitted to a hospital or other authorized institution.

Inquiry

Requests for information or assistance made by or on behalf of a beneficiary, provider, the public or the government. Written inquiries may be in any format (e.g., letter, memorandum, note attached to a claim). Allowable charge complaints, grievances, and appeals aren't considered inquiries.

Managed Care Support Contractor (MCSC)

Civilian contractors supporting the Military Health System. The contractors are required to provide health, medical, and administrative support services. Term also includes "Regional Contractor". **Note**: The overseas contractor is a health services support contractor, not an MCSC.

Medicaid

A joint federal and state program authorized under Title XIX of the Social Security Act that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state.

Medical Necessity Determination

A review to determine if the recommended health care services are reasonable, necessary, and appropriate for the diagnosis and treatment of illness, injury, pregnancy, mental disorders and well-baby care.

Medical Necessity Determination—Pharmacy

A review by the pharmacy contractor as to whether or not a beneficiary can get a non-formulary drug for the formulary copay (or at no cost if the beneficiary is an ADSM).

Medicare

A federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare-Summary-Notice (MSN)

A notice that people with Original Medicare get in the mail every 3 months for their Medicare Part A and Part B-covered services. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what the Medicare beneficiary must pay. It's not a bill.

Military Dental Treatment Facility

Uniformed service facility that provides dental care, primarily to active duty service members, and may see other beneficiaries based on capacity and capability.

Military Hospital or Clinic

A uniformed service hospital or clinic, usually located on a military installation. Also referred to as a military treatment facility (MTF).

Military Hospital or Clinic-Referred Care

When Prime enrollees need care the military hospital or clinic doesn't offer, they are referred out for civilian care. The regional contractor then reviews the referral and authorizes or denies care. This is also referred to as "MTF-referred care".

National Defense Authorization Act (NDAA)

The NDAA is under the jurisdiction of the Senate and House Armed Services Committees and provides statutory direction across all DoD programs by establishing, changing, or eliminating programs and activities, to include uniformed services health care services.

Negotiated Rate

The payment rate contracted network providers agree to accept for covered services.

Network

The providers or facilities (owned, leased, or arranged) the TRICARE contractors contracted with to provide health care services to TRICARE beneficiaries. The agreements for health care delivery made between the contractor and military hospitals or clinics are part of this definition.

Network Pharmacies

Pharmacies the TRICARE pharmacy contractor contracted with to provide prescription drug services to TRICARE beneficiaries.

Network Provider

An individual or institutional provider who signs a contract with a TRICARE contractor to provide covered services at a negotiated rate to TRICARE beneficiaries. A network provider agrees to follow TRICARE program requirements, file claims, and handle other paperwork for TRICARE beneficiaries.

Non-Network Provider

An individual or institutional provider who doesn't sign a contract with a TRICARE contractor. A non-network provider has to be TRICARE-authorized and may be a participating or non-participating provider.

Non-Participating Provider

A hospital or other authorized institution, a physician or other authorized individual professional provider, or other authorized provider who doesn't agree to accept the TRICARE-allowable charge as payment in full for services. A non-participating provider requests payment from the beneficiary, not TRICARE. In these cases, TRICARE pays the beneficiary, not the provider. The beneficiary then pays the non-participating provider. The non-participating provider may bill the beneficiary up to 15% above the TRICARE-allowable charge. (Some exceptions apply).

Other Health Insurance (OHI)

Alternate or additional primary health insurance or plan coverage other than TRICARE. This doesn't include Medicare or supplemental insurance plans.

Out-of-Pocket Costs

What a beneficiary pays (e.g. enrollment fees, cost-shares, deductibles, copayments).

Participating Provider

A TRICARE-authorized provider who agrees to accept the TRICARE-allowable charge as payment in full. Non-network providers may choose to participate on a claim-by-claim basis.

Pending Claim, Correspondence, or Appeal

A claim, correspondence, or appeal case that was received but a final determination hasn't been made.

Point of Service (POS) Option

Allows Prime option enrollees to get non-emergency care from any TRICARE-authorized provider without getting a referral from his or her PCM. The enrollee pays an outpatient deductible and 50% of the TRICARE-allowable charge.

Preferred Provider Organization (PPO)

An organization of providers who sign contracts with TRICARE contractors to provide services to TRICARE beneficiaries at reduced rates, to file claims on behalf of the beneficiaries, and accept TRICARE assignment on all TRICARE claims. TRICARE Extra is a PPO option for Standard beneficiaries who use network providers.

Preventive Care

Diagnostic and other medical procedures that aren't related to a specific illness, injury, set of symptoms, or obstetrical care, but performed as periodic health screening.

Primary Care

These standard, customary services include care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care; care for routine illness and injury; periodic physical examinations of newborns, infants, children, and adults; immunizations; injections; allergy shots; and patient education and counseling (including family planning and contraceptive advice). Also includes medically necessary diagnostic laboratory and x-ray procedures and tests. Term also includes "Routine Care".

Primary Care Manager (PCM)

A military hospital or clinic provider, team of providers, or a civilian network provider or practice that sees Prime-option enrollees for primary care services. Enrollees agree to seek all non-emergency, non-mental health care services from their assigned PCMs.

Prime Service Area (PSA)

A geographic area where TRICARE Prime is offered. At a minimum, includes areas around military hospitals and clinics and Base Realignment and Closure (BRAC) sites.

Prior Authorization--Pharmacy

For certain drugs, DoD requires the pharmacy contractor to get verification from the prescriber that the beneficiary meets certain criteria to get the drug. The pharmacy contractor will be responsible for applying government prior authorization criteria. In certain circumstances, the contractor will be responsible for developing prior authorization criteria, e.g., quantity limit overrides.

Privacy Act, 5 USC 552a

A law that protects personal privacy and lets individuals know what records about them are collected, maintained, used, or shared; to see and get copies of those records (at the individual's expense); and to correct or add to those records. It requires Government activities that collect, maintain, use, or share any record with personal identifying information, to show those actions are necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual. Also requires that safeguards be in place to prevent misuse or unauthorized release of such information.

Professional Fees

Charges for services from individual medical professionals (e.g. doctor, anesthetist, nurse practitioner, therapist, etc.).

Provider

A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies.

Provider Termination

When a provider's status as a TRICARE-authorized provider ends because the provider no longer meets the criteria to be a TRICARE-authorized provider.

Reconsideration

A written appeal to a contractor following an initial determination.

Referral

The process used to send a Prime option enrollee to another professional provider for consultation or a health care service the referring provider believes is necessary but can't provide.

Region

A geographic area defined by the U.S. Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Regional Director

The individual responsible for supporting TRICARE contract administration in each stateside region and directing the TRICARE Regional Offices.

Residence

For TRICARE purposes, "residence" is a beneficiary's place for day-to-day living. Temporary lodging or housing during periods of temporary duty or during a period of confinement, such as a residential treatment center, isn't considered a residence. Minor children's residence is the residence of the custodial parent(s) or legal guardian's. An incapacitated adult beneficiary's residence is that of the legal guardian. Under split enrollment, when Prime option enrolled family members live away from home (e.g., while attending school), their residence is where they live, not the family's home address.

Respite Care

Short-term care for a home-bound beneficiary so a beneficiary's primary caregivers can get a needed rest or break. Respite care consists of skilled and non-skilled services so the beneficiary's qualifying condition and safety needs are met. Respite care services are provided only to ADSMs.

Retiree

A member or former member of a uniformed service entitled to retired, retainer, or equal uniformed-service pay.

Secondary Payer

The plan or program whose benefits are payable only after the primary payer processes and determines payment on a claim.

Specialty Care

Specialized medical/surgical diagnosis, treatment, or services a primary care provider isn't qualified to provide.

Split Enrollment

Multiple family members enrolled in a TRICARE Prime option under different regional contractors, including stateside and overseas and USFHP-designated providers.

Sponsor

The active duty member, Guard/Reserve member, retiree, or deceased active duty member or retiree through whom that individual and his/her family members are eligible for benefits, to include TRICARE.

Student Status

A dependent of a member or former member of a uniformed service who isn't yet 23, is enrolled as a full-time student in an accredited institution of higher learning, and depends on the sponsor for over 50 percent of his or her financial support.

Supplemental Health Care Program (SHCP)

A program for eligible uniformed service members and other designated patients who require medical care that's not available at a military hospital or clinic and may be purchased from civilian providers under TRICARE payment rules, as long as approved by the uniformed service's clinic/hospital commander or the Director, DHA.

Survivor

A spouse's status 3 years after his or her active duty sponsor's death, as noted by the sponsor's service. Survivors pay the same enrollment fees, cost-shares, and copayments as retiree family members. Also applies to spouses of deceased retired sponsors.

Third Party Liability (TPL) Claims

Reimbursements to the Government when medical care is provided to a TRICARE beneficiary for treatment or injury or illness caused by someone else, requiring a third person to pay damages for that care. The Government requests repayment under the Federal Medical Care Recovery Act.

Third Party Payer

An insurance, medical service, or health plan that pays for or covers a beneficiary's expenses for medical services or supplies (e.g., automobile liability insurance, no fault insurance carrier, worker's compensation program or plan).

Timely Filing

The filing of TRICARE claims within defined time limits (1 year stateside; 3 years overseas; no limit for ADSM claims).

Transitional Assistance Management Program (TAMP)

Provides 180 days of premium-free transitional health care benefits after regular TRICARE benefits end. Available to certain uniformed service members and their eligible family members.

Transitional Care for Service Related Conditions (TCSRC)

The Transitional Care for Service-Related Conditions (TCSRC) Program extends TRICARE coverage to former active duty, Guard, and Reserve members for certain service-related conditions beyond their regular TAMP coverage period. The medical condition must be Service-related, newly discovered/diagnosed during the 180-day TAMP period, able to be resolved within 180 days, and validated by a DoD physician.

Transitional Survivor

A TRICARE-eligible family member whose sponsor was on active duty at his or her time of death. Transitional survivors get the same health care benefits as active duty family members, as long as they maintain TRICARE eligibility. Spouses are considered transitional survivors for 3 years from the date of the sponsor's death. Eligible dependent children remain transitional survivors as long as they are TRICARE eligible.

TRICARE

The DoD's managed health care program for ADSMs and their families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers. TRICARE offers 3 options: TRICARE Standard, TRICARE Extra, and TRICARE Prime.

TRICARE-Allowable Charge

The TRICARE-determined level of payment to providers based on one of the approved reimbursement methods. The TRICARE-allowable charge equals what the government pays plus the beneficiary's cost share.

TRICARE Area Office (TAO)

The office responsible for overseeing health care support services in the overseas region, including Eurasia-Africa, Latin America and Canada, and the Pacific.

TRICARE Dental Program (TDP)

A voluntary premium-based dental plan available to eligible active duty family members, members of the National Guard and Reserve and their families, transitional survivors, and other select beneficiaries.

TRICARE Extra

An option where Standard beneficiaries choose to get care from civilian network providers and pay lower cost shares.

TRICARE For Life (TFL)

Medicare-wraparound coverage for TRICARE-eligible beneficiaries who have Medicare Part A and B. Enrollment isn't required; coverage is automatic when the TRICARE beneficiary has Medicare Part A and Part B (there are some exceptions to the Part B requirement). Coverage is available worldwide. Meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Management Activity (TMA)

A DoD Activity abolished on October 1, 2013.

TRICARE Overseas Program (TOP)

The DoD's health care program in all geographic areas and territorial waters outside of the 50 United States and the District of Columbia.

TRICARE Overseas Program Prime (TOP Prime)

A TRICARE Prime option in overseas locations near uniformed service clinics and hospitals. It's available to uniformed service members permanently assigned to overseas locations and their eligible command-sponsored family members. Enrollment is required. Enrollees get most care from their assigned PCM at a military hospital or clinic. Meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Overseas Program Prime Remote (TOP Prime Remote)

A TRICARE Prime option available to uniformed service members permanently assigned to designated remote overseas locations and to their eligible command-sponsored family members. Enrollment is required. The TOP contractor acts as the enrollee's primary care manager and authorizes care from overseas providers. Meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Plus

A primary care program offered at some military hospitals or clinics. Enrollment is required; approval is based on the military hospital or clinic commander's guidance. Not available to TRICARE Prime option enrollees.

TRICARE Prime

A managed care option available in PSAs. Enrollment is required; some enrollees pay annual enrollment fees. Enrollees are assigned a PCM at a military hospital or clinic or within the regional contractor's network. Enrollees and must follow Prime rules for getting specialty care services (except when enrollees choose to use the POS option). Meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Prime Remote (TPR)

A TRICARE Prime option available to uniformed service members who live and work more than 50 miles (or one hour's drive time) from a military hospital or clinic. Enrollment is required. Enrollees are assigned a network PCM if available. If not available, enrollees can choose any TRICARE-authorized provider as their PCM. Meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Prime Remote for Active Duty Family Members (TPRADFM)

A TRICARE Prime option available to active duty family members who live with TRICARE Prime Remote-enrolled sponsors (with some exceptions). Enrollment is required. Enrollees are assigned a network PCM if available. If not available, enrollees can choose any TRICARE-authorized provider as their PCM. Meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Regional Office (TRO)

An office within the DHA that oversees the health care delivery in the 2 United States-based TRICARE regions: East and West.

TRICARE Reserve Select (TRS)

A voluntary, premium-based health plan qualified Selected Reserve members may buy for themselves and eligible family members. TRS offers TRICARE Standard benefits. If purchased, meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Retired Reserve (TRR)

A voluntary, premium-based health plan qualified Retired Reserve members may buy for themselves and eligible family members. TRR offers TRICARE Standard benefits. If purchased, meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Retiree Dental Program (TRDP)

A voluntary, premium-based dental plan for retired service members and their family members. Available in the United States and all overseas areas.

TRICARE Standard

A fee-for-service health option that doesn't require enrollment. Beneficiaries can get TRICARE-covered services from any TRICARE-authorized provider. Beneficiaries pay an annual outpatient deductible and cost-shares (or percentage) for covered services. Meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Young Adult (TYA)

A voluntary, premium-based health plan qualified adult children can buy after eligibility for "regular" TRICARE coverage ends at age 21 (or 23 if enrolled in college). If purchased, meets or exceeds the requirements for minimum essential coverage under the Affordable Care Act.

Uniformed Services

The 7 uniformed services of the United States: U.S. Army, U.S. Marine Corps, U.S. Navy, U.S. Air Force, U.S. Coast Guard, Commissioned Corps of the United States Public Health Service (PHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994

A Federal law that establishes rights and responsibilities for uniformed Service members and their civilian employers.

United States Public Health Service (USPHS)

An agency within the U.S. Department of Human Health Services with a Commissioned Corps whose members are classified as members of the uniformed services.

Unproven Drugs, Devices, and Medical Treatments or Procedures

Drugs, devices, medical treatments or procedures are considered unproven if:

- Food and Drug Administration (FDA) approval is needed but hasn't been given;
- The device is an FDA Category A Investigational Device Exemption (IDE);
- There is no reliable evidence showing the treatment or procedure was the subject of well-controlled studies that looked at its maximum tolerated dose, its toxicity, its safety, and its desired outcomes as compared with the standard means of treatment or diagnosis; or
- The reliable evidence shows that experts on the treatment or procedure agree that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard treatment or diagnosis

Urgent Care

Medically necessary care required for a sudden illness or injury that isn't life threatening, but requires immediate professional attention to avoid further complications resulting from non-treatment. Treatment is usually performed outside an Emergency Room (ER) setting.

US Family Health Plan (USFHP)

A TRICARE Prime-like option available in 6 geographic locations across the United States that offers benefits to enrolled ADFMs, retirees and their eligible family members, survivors, certain former spouses and other eligible beneficiaries. ADSMs can't enroll in USFHP.

Veteran

A person who served in the active military, naval, or air service, and was discharged or released under conditions other than dishonorable. Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," (which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service) neither the veteran nor his or her family members are eligible for benefits under TRICARE.