TRICARE Standard

TRICARE Standard Handbook

Your Guide to Using TRICARE Standard and TRICARE Extra

TRICARE

DEPARTMENT OF DEFENSE · UNITED STATES OF AMERICA

December 2009

Important Information

TRICARE National Web site:	www.tricare.mil

TRICARE North Region Contractor

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

TRICARE South Region Contractor

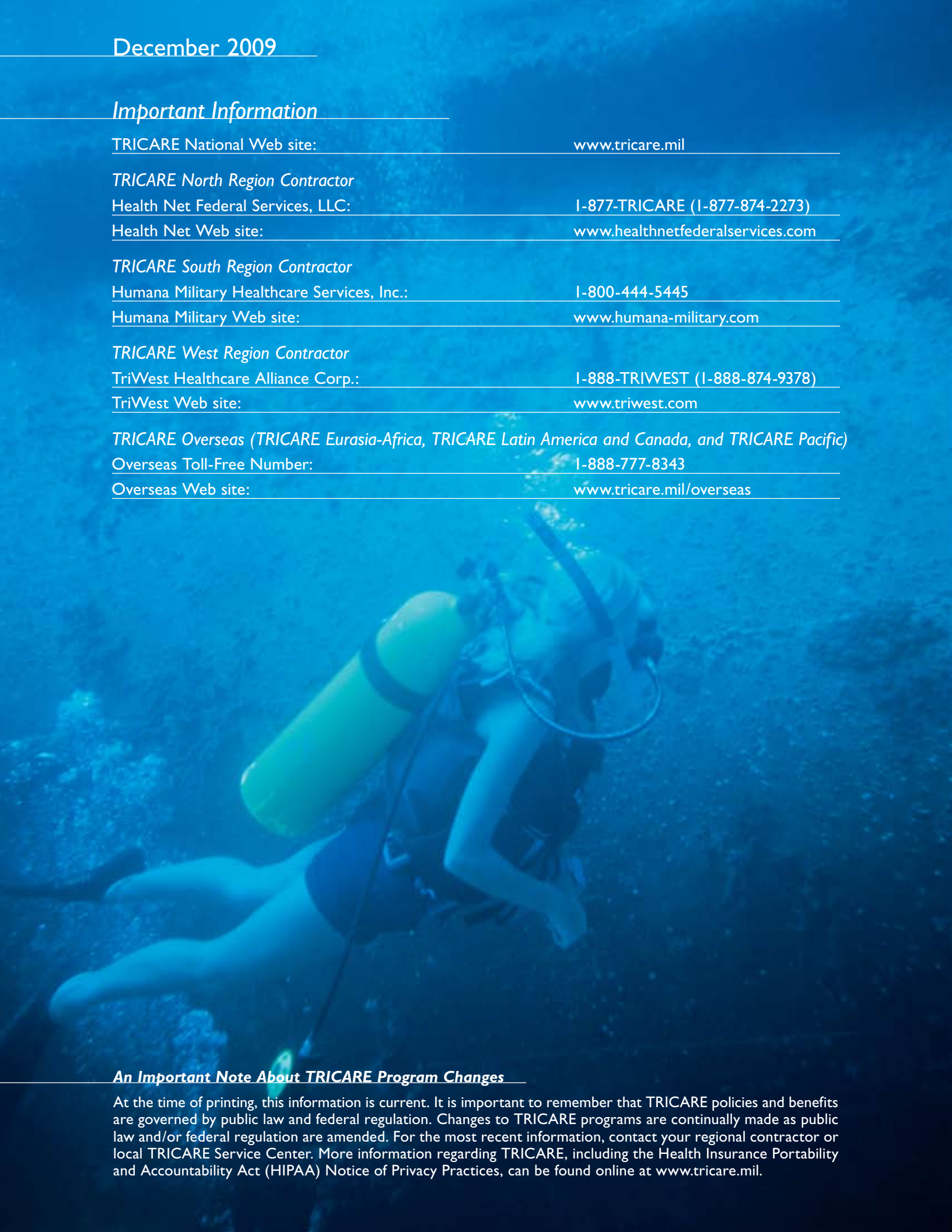
Humana Military Healthcare Services, Inc.:	1-800-444-5445
Humana Military Web site:	www.humana-military.com

TRICARE West Region Contractor

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

TRICARE Overseas (TRICARE Eurasia-Africa, TRICARE Latin America and Canada, and TRICARE Pacific)

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



An Important Note About TRICARE Program Changes

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

Welcome to TRICARE Standard and TRICARE Extra

TRICARE Standard and TRICARE Extra are available to TRICARE beneficiaries who are not able to or choose not to enroll in one of the TRICARE Prime options. Enrollment is not required for TRICARE Standard and TRICARE Extra, which means there are no forms to fill out and no annual enrollment fees.

With TRICARE Standard and TRICARE Extra, you manage your own health care and have the freedom to seek care from any TRICARE-authorized provider you choose. It is important that you understand these options, how they work, and the key differences between them, so that you receive the highest quality, most convenient, and most cost-effective care.

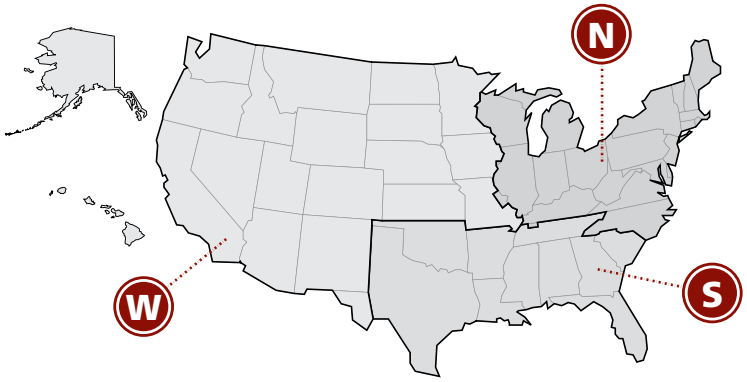
Here are some examples in which TRICARE Standard and TRICARE Extra may be the best option for you:

- You have an established relationship with a particular TRICARE-authorized civilian provider who is not a network provider, and you wish to continue receiving most of your care from that provider.
- You prefer the freedom to schedule appointments with a TRICARE network or non-network provider without having to consult a primary care manager first.
- You live in an area where TRICARE Prime is not available.
- You have employer-sponsored health insurance and prefer to use TRICARE Standard and TRICARE Extra as secondary coverage.

This *TRICARE Standard Handbook* explains the different types of TRICARE providers and outlines TRICARE Standard and TRICARE Extra costs and requirements. If you have questions, there are many resources listed throughout this handbook to help you.

Your TRICARE Regional Contractor

Regional contractors administer the TRICARE program in each TRICARE region. We encourage you to visit your regional contractor's Web site, which includes authorization requirements and other helpful information. If you need assistance, you can also call your regional contractor at the appropriate toll-free number listed below. Your regional contractor also has TRICARE Service Centers located throughout the region, typically at MTFs, where customer service representatives are available to assist you.



TRICARE North Region

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

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

TRICARE South Region

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

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

TRICARE West Region

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

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

Contact your regional contractor if you need assistance using TRICARE Standard and TRICARE Extra. Look in the mail and on your regional contractor's Web site for the *TRICARE Standard Health Matters* newsletter, an annual publication highlighting covered services, customer service options, news, and other important updates.

Sign up to receive regular updates via e-mail at **www.tricare.mil/tricaresubscriptions**. Enter your e-mail address, select the *TRICARE Standard Health Matters* newsletter, and click "Save" at the bottom of the page.

Table of Contents

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

Choosing TRICARE Standard and TRICARE Extra

Eligibility

Beneficiaries who are eligible to use TRICARE Standard and TRICARE Extra include:

- Active duty family members (ADFMs)
- Family members of National Guard and Reserve members on active duty for more than 30 consecutive days
- Retired service members
- Family members of retired service members
- Survivors
- Others (*e.g., certain former spouses, Medal of Honor recipients*)

Beneficiaries who are not eligible to use TRICARE Standard and TRICARE Extra include:

- Active duty service members (ADSMs)
- Activated National Guard and Reserve members*
- Any beneficiary enrolled in one of the TRICARE Prime options (*You must disenroll before using TRICARE Standard and TRICARE Extra.*)
- Dependent parents and parents-in-law

Note: ADSMs and activated National Guard and Reserve members* must enroll in TRICARE Prime or TRICARE Prime Remote (TPR). ADFMs, retired service members and their families, survivors, and others have the choice of enrolling in TRICARE Prime or using TRICARE Standard and TRICARE Extra.

* *During the early-eligibility period, National Guard and Reserve members may be eligible for TRICARE, but you cannot enroll into TRICARE Prime or TPR until you reach your final duty location. The early eligibility period begins when you are activated for more than 30 days in support of a contingency operation. You are eligible for benefits after you receive your delayed effective date orders, up to 90 days before you activate or mobilize. Until then, you should coordinate care with your unit. If eligible, your family members may enroll in TRICARE Prime or TPR during the early-eligibility period.*

Keep Your DEERS Information Current!

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

You have several options for updating and verifying DEERS information:

In Person[1] *(add or delete a family member or update contact information)*	• Visit a local identification card-issuing facility. • Find a facility near you at **www.dmdc.osd.mil/rsl**. • Call to verify location and business hours.
Phone[2]	• 1-800-538-9552 • 1-866-363-2883 (*TTY/TDD*)
Fax[2]	• 1-831-655-8317
Mail[2]	• Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771
Online[2]	• **DEERS Web site:** www.dmdc.osd.mil/appj/address/ • **Beneficiary Web Enrollment Web site:** www.dmdc.osd.mil/appj/bwe/

1. *Only sponsors* (or appointed powers of attorney) *can add or delete a family member. Family members age 18 and older may update their own contact information.*
2. *Use these methods to change contact information only.*

Comparison of TRICARE Standard and TRICARE Extra *Figure 1.1*

	TRICARE Standard[1]	TRICARE Extra
Provider Type	**TRICARE-authorized, non-network**	**TRICARE-authorized, TRICARE network**
Outpatient cost-share, after deductible is met	• **ADFMs:** 20% of the TRICARE-allowable charge • **Retirees, their families, and all others:** 25% of the TRICARE-allowable charge	• **ADFMs:** 15% of the negotiated rate • **Retirees, their families, and all others:** 20% of the negotiated rate

1. Nonparticipating providers may also charge up to 15 percent above the TRICARE-allowable charge. You are responsible for paying this amount. For more information, see "TRICARE Provider Types" in the Getting Care *section.*

Plan Overview

Enrollment is **not** required for TRICARE Standard and TRICARE Extra—there are no enrollment forms to fill out and no enrollment fees. You may use TRICARE Standard and TRICARE Extra interchangeably as often as you like, but it is important to understand the differences between the two.

The key difference between TRICARE Standard and TRICARE Extra is in the providers that you use for care. With TRICARE Standard, you choose TRICARE-authorized providers outside of the TRICARE network and pay higher cost-shares. With TRICARE Extra, you choose hospitals and providers within the TRICARE network and receive discounted cost-shares.

Figure 1.1 provides a quick comparison of the two options. We will discuss specific provider types later in this handbook. For cost details, visit **www.tricare.mil/costs**.

Getting Care

Finding a Provider

When using TRICARE Standard and TRICARE Extra, you may receive care from any TRICARE-authorized provider without a referral. Some services require prior authorization (*discussed later in this section*). The following section describes the different types of providers. Figure 2.1 provides a brief overview of TRICARE provider types.

TRICARE Provider Types

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

Remember, you can use either a network or non-network provider at any time. For example, if an orthopedic surgeon and a physical therapist are treating you, one could be a TRICARE network provider and the other could be a non-network provider. Keep track of the types of providers you are seeing. Visits to a network provider (*TRICARE Extra*) will cost you less out of pocket, and the provider will file claims on your behalf. With a non-network provider (*TRICARE Standard*), you will pay more out of pocket and may have to file your own claims.

To find a TRICARE network or non-network provider, visit the provider locator online at **www.tricare.mil/providerdirectory**. You can also locate a provider in your region by using the network provider directory located on your regional contractor's Web site.

TRICARE Provider Types ***Figure 2.1***

<table>
<tr><th colspan="3">TRICARE-Authorized Providers</th></tr>
<tr><td colspan="3">• TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, ancillary providers (laboratories and radiology centers), and pharmacies. If you see a provider who is not TRICARE-authorized, you are responsible for the full cost of care.
• There are two types of TRICARE-authorized providers: Network and Non-Network.</td></tr>
<tr><th>TRICARE Network Providers</th><th colspan="2">Non-Network Providers</th></tr>
<tr><td rowspan="2">• Using a TRICARE network provider is your best option.
• You are using the TRICARE Extra option when you visit a network provider.
• Regional contractors have established networks, even in areas far from military treatment facilities.
• TRICARE network providers:
  • Have a signed agreement with your regional contractor to provide care
  • Agree to handle claims for you</td><td colspan="2">• Non-network providers do not have a signed agreement with your regional contractor and are, therefore, considered "out of network."
• There are two types of non-network providers: Participating and Nonparticipating.</td></tr>
<tr><td>Participating</td><td>Nonparticipating</td></tr>
<tr><td>• Using a participating provider is your best option if you are seeing a non-network provider.
Participating providers:
  • May choose to participate on a claim-by-claim basis
  • Have agreed to file claims for you, accept payment directly from TRICARE, and accept the TRICARE-allowable charge (less any applicable patient cost-shares paid by you) as payment in full for their services</td><td>• If you visit a nonparticipating provider, you may have to pay the provider first and later file a claim with TRICARE for reimbursement.
Nonparticipating providers:
  • Have not agreed to accept the TRICARE-allowable charge or file your claims
  • Have the legal right to charge you up to 15 percent above the TRICARE-allowable charge for services (You are responsible for paying this amount in addition to any applicable patient cost-shares.)</td></tr>
</table>

Health Care Provider Types

There are many health care provider types with which to familiarize yourself:

- **Specialty care providers:** Specialty care includes providers such as obstetricians (*childbirth doctors*), orthopedic surgeons (*bone doctors*), and gastroenterologists (*stomach and intestine doctors*).
- **Ancillary care providers:** Ancillary care includes providers such as ambulances, laboratories, radiologists (*doctors who look at X-rays*), and home health care providers.
- **Facilities:** Facilities are medical centers or buildings that offer medical and surgical services. Examples of facilities are hospitals, birthing centers (*facilities with nurse-midwives that offer a more natural childbirth experience*), skilled nursing facilities (*facilities such as rest homes where patients need 24-hour medical support*), and ambulatory surgery centers (*facilities where patients receive minor surgeries and are released to go home the same day*).
- **Behavioral health care providers:** Behavioral health care includes a broad range of providers and treatment. Psychiatric nurse specialists, counselors, therapists, and social workers are good starting points for determining the level and type of behavioral health care you need. Refer to "Behavioral Health Care Services" in the *Covered Services, Limitations, and Exclusions* section for more information about behavioral health care provider types.

Emergency Care

TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a "prudent layperson" (*someone with average knowledge of health and medicine*) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb, or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others.

If you require emergency care, call 911 or go to the nearest emergency room. If you are admitted, you may need to obtain authorization depending on the type of care. You or your provider can contact your regional contractor for assistance.

Urgent Care

Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately but does require professional attention within 24 hours. You could require urgent care for conditions such as a sprain, sore throat, or rising temperature, as each of these has the potential to develop into an emergency if treatment is delayed longer than 24 hours.

All Other Care

For all other care, such as routine physicals, ongoing treatment for a chronic condition, visits to a specialist, or covered preventive care, you can schedule an appointment with a TRICARE network or non-network provider. Some services may require prior authorization (*discussed later in this section*).

Care at a Military Treatment Facility

A military treatment facility (MTF) is a military hospital or clinic usually located on or near a military base. You may receive care at an MTF, but only on a space-available basis. MTF appointments are limited, and you will have the lowest priority for receiving care. See Figure 2.2 for MTF appointing priorities.

MTF Appointing Priorities ***Figure 2.2***

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

If you wish to receive care at an MTF, call the MTF first to see if they can provide you with the care you need. To locate an MTF, visit **www.tricare.mil/mtf**. Otherwise, seek care from a civilian TRICARE network or non-network provider.

Note: If you are admitted to an MTF and require any service not available within the MTF (*e.g., ambulance, MRI, CT Scan, or specialist appointment*), those services will be covered by your TRICARE Standard benefit. The MTF will not pay for these services.

Prior Authorization for Care

You can visit the TRICARE-authorized provider of your choice whenever you need care. Referrals are not required, but some services require prior authorization.

A prior authorization is a review of the requested health care service to determine if it is medically necessary at the requested level of care. Some providers may call the regional contractor to obtain prior authorization for you. If you have questions about authorization requirements, visit **www.tricare.mil**.

The following services require prior authorization:

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

This list is **not** intended to be all-inclusive.

Each regional contractor has additional prior authorization requirements. Visit your regional contractor's Web site to learn about each region's requirements, which may change periodically.

Covered Services, Limitations, and Exclusions

TRICARE Standard and TRICARE Extra cover most care that is medically necessary and considered proven. There are special rules and limitations for certain types of care, and some types of care are not covered at all. **This section is not intended to be all-inclusive.** TRICARE policies are very specific about which services are covered and which are not. One of your duties under *TRICARE's Patient Bill of Rights and Responsibilities* is to be knowledgeable about your TRICARE coverage and program options. It is in your best interest to take an active role in verifying coverage. Visit **www.tricare.mil** for additional information about covered services and benefits.

Outpatient Services

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

Outpatient Services: Coverage Details *Figure 3.1*

Service	Description
Ambulance Services	The following ambulance services are covered: • Emergency transfers between a beneficiary's home, accident scene, or other location and a hospital • Transfers between hospitals • Ambulance transfers from a hospital-based emergency room to a hospital more capable of providing the required care • Transfers between a hospital or skilled nursing facility and another hospital-based or freestanding outpatient therapeutic or diagnostic department/facility The following are excluded: • Use of an ambulance service instead of taxi service when the patient's condition would have permitted use of regular private transportation • Transport or transfer of a patient primarily for the purpose of having the patient nearer to home, family, friends, or personal physician • Medicabs or ambicabs that function primarily as public passenger conveyances transporting patients to and from their medical appointments **Note:** Air or boat ambulance is only covered when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the beneficiary to the nearest hospital with appropriate facilities, and the patient's medical condition warrants speedy admission or is such that transfer by other means is not advisable.
Ancillary Services	Covers certain diagnostic radiology and ultrasounds, diagnostic nuclear medicine, pathology and laboratory services, and cardiovascular studies
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Generally covered if prescribed by a physician and if directly related to a medical condition. Covered DMEPOS generally includes: • DMEPOS that are medically necessary and appropriate and prescribed by a physician for a beneficiary's specific use • Duplicate DMEPOS items that are necessary to provide a fail-safe, in-home life-support system (*In this case, "duplicate" means an item that meets the definition of DMEPOS and serves the same purpose but may not be an exact duplicate of the original DMEPOS item. For example, a portable oxygen concentrator may be covered as a backup for a stationary oxygen generator.*) **Note:** Prosthetic devices must be approved by the U.S. Food and Drug Administration.

Outpatient Services: Coverage Details (continued)

Service	Description
Emergency Services	TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a "prudent layperson" (*someone with average knowledge of health and medicine*) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb, or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others
Home Health Care	Covers part-time or intermittent skilled nursing services and home health care services (*All care must be provided by a participating home health care agency and have prior authorization from the regional contractor.*)
Individual Provider Services	Covers office visits; outpatient, office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services (*e.g., physical and occupational therapy and speech pathology services*); and medical supplies used within the office
Laboratory and X-ray Services	Generally covered if prescribed by a physician (*Some exceptions apply, e.g., chemo-sensitivity assays and bone density X-ray studies for routine osteoporosis screening.*)

Inpatient Services

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

Inpatient Services: Coverage Details *Figure 3.2*

Service	Description
Hospitalization *(semi-private room/ special care units when medically necessary)*	Covers general nursing; hospital, physician, and surgical services; meals (*including special diets*); drugs and medications; operating and recovery room care; anesthesia; laboratory tests; X-rays and other radiology services; medical supplies and appliances; and blood and blood products **Note:** Surgical procedures designated "inpatient only" may only be covered when performed in an inpatient setting.
Skilled Nursing Facility Care *(semi-private room)*	Covers regular nursing services; meals (*including special diets*); physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances (*TRICARE covers an unlimited number of days as medically necessary.*)

Clinical Preventive Services

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

Clinical Preventive Services: Coverage Details *Figure 3.3*

Service	Description
Comprehensive Health Promotion and Disease Prevention Examinations	A comprehensive clinical preventive exam is covered if it includes an immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening. School enrollment physicals for children ages 5–11 are also covered.
Targeted Health Promotion and Disease Prevention Services	The screening examinations listed below may be covered if provided in conjunction with a comprehensive clinical preventive exam. The intent is to maximize preventive care.

Cancer Screenings	• **Colonoscopy:** Perform a colonoscopy once every 10 years starting at age 50, or as listed below for individuals at increased risk for:
	  • Hereditary non-polyposis colorectal cancer syndrome: Perform a colonoscopy once every two years beginning at age 25, or five years younger than earliest age of diagnosis in affected relative(s), whichever is earlier, and then annually after age 40.
	  • Familial risk of sporadic colorectal cancer: For first-degree relatives with sporadic colorectal cancer or adenoma before age 60, or with multiple first-degree relatives with colorectal cancer or adenomas, perform a colonoscopy every three to five years, beginning 10 years earlier than the youngest affected relative.
	• **Fecal occult blood testing:** Conduct testing annually starting at age 50.
	• **Mammograms:** Perform a mammography annually for those over age 39. For high-risk patients, a baseline mammogram is appropriate at age 35 and annually thereafter.
	  • Magnetic resonance imaging (MRI): Perform an MRI annually for asymptomatic beneficiaries age 35 or older considered to be at high risk for developing breast cancer by American Cancer Society® guidelines. The guidelines include women with a:
	  • BRCA1 or BRCA2 gene mutation
	  • First-degree relative (*parent, child, or sibling*) with a BRCA1 or BRCA2 gene mutation
	  • Lifetime risk of approximately 20–25 percent or greater as defined by BRCAPRO or other models that are largely dependent on family history
	  • History of chest radiation between ages 10–30
	  • History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with one of these syndromes
	• **Physical exam for colorectal cancer:** A digital rectal exam should be included in periodic health exams of individuals age 40 and older.
	• **Proctosigmoidoscopy or sigmoidoscopy:** Conduct the procedure once every three to five years beginning at age 50.
	• **Prostate cancer:** Perform a digital rectal exam and prostate-specific antigen screening annually for certain high-risk men ages 40–49 and all men over age 50.
	• **Routine Pap smears:** Perform a Pap smear annually for women starting at age 18 (*younger if sexually active*) or less often at patient and provider discretion (*though not less than every three years*). Routine human papillomavirus (HPV) screenings are not covered.
	• **Skin cancer:** Exams are covered at any age for a beneficiary who is at high risk due to family history or increased sun exposure.

Clinical Preventive Services: Coverage Details (continued)

Service	Description
Cardiovascular Diseases	• **Cholesterol test:** Testing is covered for a lipid panel at least once every five years, beginning at age 18. • **Blood pressure screening:** Screening is covered annually for children (*ages 3–6*) and a minimum of every two years after age 6 (*children and adults*).

Eye Examinations	• **Well-child care coverage (*infants and children up to age 6*):**
	  • **Infants:** One eye and vision screening is covered at birth and at 6 months.
	  • **Children (*ages 3–6*):** One routine eye exam is covered every two years. Active duty family member (ADFM) children are covered for one routine eye exam annually.
	• **Adults and children (*over age 6*):** Active duty service members and ADFMs receive one eye exam each year.
	• **Diabetic patients (*any age*):** Eye exams are not limited. One eye exam per year is recommended.
	• **Retired service members, their families, and others:** Not covered after age 6.

Hearing	Preventive hearing examinations are only allowed under the well-child care benefit. A newborn audiology screening should be performed on high-risk newborns before hospital discharge or within the first three months after birth. Evaluative hearing tests may be performed at other ages during routine exams.
Immunizations	Age-appropriate vaccines, including annual influenza vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). The HPV vaccine is covered for all females ages 11–26 who have not completed the vaccine series, regardless of sexual activity or clinical evidence of previous HPV infection. The HPV vaccine is not covered after age 26. The TRICARE medical (*not pharmacy*) benefit covers a single dose of the shingles vaccine Zostavax,® administered in a provider's office, for beneficiaries age 60 and older. Coverage is effective the date the recommendations are published in the CDC's *Morbidity and Mortality Weekly Report*. Refer to the CDC's Web site at **www.cdc.gov** for a current schedule of recommended vaccines. **Note:** Immunizations for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered.
Infectious Disease Screening	TRICARE covers screening for infectious diseases, including hepatitis B, rubella antibodies and HIV, and screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, hepatitis A and B, meningococcal meningitis, and tuberculosis. Routine HPV screening is not covered.
Patient and Parent Education Counseling	Counseling services expected of good clinical practice that are included with the appropriate office visit are covered at no additional charge for dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; dental health promotion; accident and injury prevention; stress; bereavement; and suicide risk assessment.
School Physicals	Covered for children ages 5–11 if required in connection with school enrollment. **Note:** Annual sports physicals are not covered.
Well-Child Care *(birth to age 6)*	Covers routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference measurement; routine immunizations; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with American Academy of Pediatrics (AAP) and CDC guidelines. Your child can receive preventive care well-child visits as frequently as the AAP recommends, but no more than nine visits in two years. Visits for diagnosis or treatment of an illness or injury are covered separately under outpatient care.

Behavioral Health Care Services

Active duty family members (ADFMs) can receive the first eight outpatient behavioral health care visits per fiscal year (*October 1–September 30*) without prior authorization from your regional contractor. Before the ninth visit, your behavioral health care provider must obtain prior authorization from your regional contractor.

Note: Active duty service members (ADSMs) must have prior authorization before seeking outpatient behavioral health care.

Authorized Behavioral Health Care Providers

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

- **Certified psychiatric nurse specialists** are licensed, master's-level psychiatric nurses with an additional American Nurses Association certification in behavioral health care. They perform psychotherapy and manage medications.

- **Mental health, licensed professional, and pastoral counselors** have a master's degree in counseling. They perform counseling and psychotherapy services but cannot prescribe medication. In order to provide services to TRICARE beneficiaries, these providers require written physician referral and ongoing clinical supervision from a doctor of medicine (MD) or doctor of osteopathic medicine (DO) prior to your initial visit.
- **Certified marriage and family therapists** have a master's degree in counseling, with an emphasis on family and marriage therapy. They perform individual counseling and family and marriage therapy but cannot prescribe medication.
- **Licensed clinical social workers** have a master's-level degree in social work, with additional training in psychotherapy and counseling. They perform psychotherapy and counseling services but cannot prescribe medication.
- **Clinical psychologists** have a doctoral-level degree (*doctor of philosophy or doctor of psychology*) in psychology. They perform psychotherapy, psychological testing, and counseling services but usually cannot prescribe medication.
- **Psychiatrists** are physicians who have a general medical degree (*MD or DO*) and have completed advanced residency training in psychiatry. Most psychiatrists treat persons with more serious disturbances for which medication is helpful (*e.g., Major Depression, Bipolar Disorder, Attention Deficit/Hyperactivity Disorder*). Psychiatrists perform psychotherapy, manage medication, and work in collaboration with the provider types listed above.

If you are unsure about the type of provider that would best meet your needs, visit the *Mental Health and Behavior* Web page at **www.tricare.mil** for more information.

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

Behavioral Health Care Services: Outpatient Coverage Details ***Figure 3.4***

Service	Description

Outpatient Psychotherapy *(physician referral and supervision required when seeing licensed or certified mental health counselors and pastoral counselors)*	The following outpatient psychotherapy limits apply:
	• **Psychotherapy:** Two sessions per week, in any combination of the following types:
	  • **Individual *(adult or child)*:** 60 minutes per session; may extend to 120 minutes for crisis intervention
	  • **Family or conjoint:** 90 minutes per session; may extend to 180 minutes for crisis intervention
	  • **Group:** 90 minutes per session
	• **Collateral visits**
	• **Psychoanalysis**

Psychological Testing and Assessment	Testing and assessment is covered when medically or psychologically necessary and provided in conjunction with otherwise-covered psychotherapy. Psychological tests are considered to be diagnostic services and are not counted toward the limit of two psychotherapy visits per week. **Limitations:** • Testing and assessment is generally limited to six hours per fiscal year (*October 1–September 30*) (*Testing requires a review for medical necessity.*) **Exclusions:** Psychological testing is not covered for the following circumstances: • Academic placement • Job placement • Child custody disputes • General screening in the absence of specific symptoms • Teacher or parental referrals • Diagnosed specific learning disorders or learning disabilities
Medication Management	If you take prescription medications for a behavioral health care condition, you must be under the care of a provider who is authorized to prescribe those medications. Your provider will manage the dosage and duration of your prescription to ensure you are receiving the best care possible.

Figure 3.5 provides coverage details for inpatient behavioral health care services. **Note:** This chart is **not** intended to be all-inclusive.

Behavioral Health Care Services: Inpatient Coverage Details ***Figure 3.5***

Service	Description
Acute Inpatient Psychiatric Care	May be covered on an emergency or nonemergency basis. Prior authorization from your regional contractor is required for all nonemergency inpatient admissions. In emergency situations, authorization is required for continued stay. **Limitations:** • **Patients age 19 and older:** 30 days per fiscal year (FY)[1] or in any single admission • **Patients age 18 and under:** 45 days per FY[1] or in any single admission • Inpatient admissions for substance use disorder detoxification and rehabilitation count toward the 30- or 45-day limit **Note:** Stay limits may be waived if determined to be medically or psychologically necessary.
Partial Hospitalization Program (PHP)	Psychiatric PHPs provide interdisciplinary therapeutic services at least three hours a day, five days a week, in any combination of day, evening, night, and weekend treatment programs. The following rules apply: • Prior authorization from your regional contractor is required. PHP admissions are not considered emergencies. • Facilities must be TRICARE-authorized. • PHPs must agree to participate in TRICARE. **Limitations:** • PHP care is limited to 60 treatment days (*whether full- or partial-day treatment*) per FY[1] or for a single admission. These 60 days are not offset by or counted toward the 30- or 45-day inpatient limit.
Residential Treatment Center (RTC) Care	RTC care provides extended care for children and adolescents with psychological disorders that require continued treatment in a therapeutic environment. The following rules apply: • Facilities must be TRICARE-authorized. • Unless therapeutically contraindicated, the family and/or guardian should actively participate in the continuing care of the patient through either direct involvement at the facility or geographically distant family therapy. • Prior authorization from your regional contractor is required. RTC admissions are not considered emergencies. • RTC care is considered elective and will not be covered for emergencies. • Admission primarily for substance use rehabilitation is not authorized. • Care must be recommended and directed by a psychiatrist or clinical psychologist. **Limitations:** • Care is limited to 150 days per FY[1] or for a single admission. (*Limitations may be waived if determined to be medically or psychologically necessary.*) • RTC care is only covered for patients up to age 21.

1. October 1–September 30

Figure 3.6 provides coverage details for substance use disorder services (*up to three benefit periods per beneficiary, per lifetime*). **Note:** This chart is **not** intended to be all-inclusive.

Behavioral Health Care Services: Substance Use Disorder Services Coverage Details ***Figure 3.6***

Service	Description
Inpatient Detoxification	TRICARE covers emergency and inpatient hospital services for the treatment of the acute phases of substance use withdrawal (*detoxification*) when the patient's condition requires the personnel and facilities of a hospital. The following limits apply: • **Diagnosis-related group-exempt facility:** Seven days per episode • Services count toward 30- or 45-day inpatient behavioral health care limit • Services do not count toward 21-day rehabilitation limit
Inpatient Rehabilitation	Rehabilitation (*residential or partial*) is limited to 21 days per year, per benefit period.[1] All inpatient stays count toward the 30- or 45-day inpatient limit.
Outpatient Care	Outpatient care must be provided by an approved, substance use disorder facility. The following limits apply: • **Individual or group therapy:** 60 visits per benefit period[1] • **Family therapy:** 15 visits per benefit period[1] • **Partial hospitalization program care:** 21 treatment days per fiscal year (*October 1–September 30*)

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

Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. All treatment for substance use disorders requires prior authorization from your regional contractor.

For additional information about covered and non-covered behavioral health care services and to learn how to access care, visit **www.tricare.mil**.

TRICARE Assistance Program

The TRICARE Assistance Program (TRIAP) is a Web-based program available to eligible beneficiaries, including TRICARE Standard and TRICARE Extra beneficiaries in the United States. ADSMs and their spouses of any age are eligible, but dependent family members must be 18 or older. TRIAP uses audio-visual and instant messaging features to provide online access to behavioral health care counseling for short-term, non-medical issues. You can contact licensed professionals 24 hours a day, seven days a week.

TRIAP enables you to have a private, solution-focused discussion with a counselor about many personal life issues, including:

- Stress management (*work, family, personal*)
- Family difficulties and pressures
- Deployments and other family separations
- Relationships and marriage
- Parent-child communication
- Self-esteem

TRIAP services do not require referrals or authorizations, but you will need a phone and a computer. You may access TRIAP an unlimited number of times, and services are confidential and non-reportable (*not documented on your military record*). TRIAP does not provide medication management, financial services, or emergency care. For more information and to learn about your region's technology requirements, visit your regional contractor's Web site or contact your regional contractor.

Telemental Health Program

The Telemental Health program uses secure audio-visual conferencing to connect eligible beneficiaries, including TRICARE Standard and TRICARE Extra beneficiaries in the United States, with offsite TRICARE network providers. Telemental Health provides medically necessary behavioral health care services, including:

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

Telemental Health interaction may involve live, two-way audio-visual visits between patients and medical professionals. Beneficiaries can access Telemental Health services at TRICARE-authorized Telemental Health-participating facilities by using a telecommunications system to contact TRICARE network providers at remote locations.

Behavioral health care limitations, authorization requirements, deductibles, and cost-shares apply. For more information, visit the *Mental Health and Behavior* Web page at **www.tricare.mil**.

Pharmacy Options

TRICARE offers comprehensive prescription drug coverage and several options for filling your prescriptions. To fill a prescription, you need a written prescription and a valid uniformed services identification (ID) card or Common Access Card (CAC).

The TRICARE Pharmacy Program is administered by Express Scripts, Inc. (Express Scripts). More information on the TRICARE Pharmacy Program is available at **www.tricare.mil/pharmacy** or **www.express-scripts.com/TRICARE**.

Military Treatment Facility Pharmacy

A military treatment facility (MTF) pharmacy is the least expensive option for filling prescriptions. At an MTF pharmacy, you may receive up to a 90-day supply of most medications at no cost. Most MTF pharmacies accept prescriptions written by both civilian and military providers, regardless of whether or not you are enrolled at the MTF.

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

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

Mail Order Pharmacy

The Mail Order Pharmacy is your least expensive option when not using an MTF pharmacy. With the Mail Order Pharmacy, there is only one copayment for each prescription filled (*up to a 90-day supply*). Additionally, prescriptions are delivered to you with free standard shipping, and refills can be easily ordered online, by phone, or by mail. The Mail Order Pharmacy also provides you with refill reminders, convenient notifications about your order status, and assistance with renewing expired prescriptions. If you have questions about your prescriptions, pharmacists are available 24 hours a day, seven days a week, to talk confidentially with you.

For faster processing of your mail-order prescription, you can register before placing your first order. Once you are registered, your provider can fax or call in your prescriptions. You may register for the Mail Order Pharmacy using any of the options in Figure 3.7 on the following page.

Express Scripts will send your medications directly to your home within about 14 days of receiving your prescription. If you have prescription drug coverage through other health insurance (OHI), you can use the Mail Order Pharmacy if the medication is not covered under your OHI or if you exceed the OHI's coverage dollar limit.

Mail Order Pharmacy Registration Methods *Figure 3.7*

Online	Visit **www.express-scripts.com/TRICARE**
Phone	Call 1-877-363-1303 or 1-877-540-6261 (*TDD/TTY*)
Mail	Download the registration form from **www.express-scripts.com/TRICARE**, and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954

Member Choice Center

The Member Choice Center makes it easy to reduce your out-of-pocket costs by transferring your current maintenance medication prescriptions to the Mail Order Pharmacy. If you prefer the convenience of home delivery, contact the Member Choice Center to convert your current retail or MTF prescriptions to the Mail Order Pharmacy. Mail-order copayments apply.

Visit **www.express-scripts.com/TRICARE** and click on the "Make the Switch to Mail Order Pharmacy Home Delivery" feature, or call **1-877-363-1433** to get started. **Note:** To use the Member Choice Center, you must have a maintenance prescription dispensed at a retail pharmacy or MTF. The Member Choice Center will contact your provider to obtain a new written prescription for home delivery.

TRICARE Retail Network Pharmacies

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

This option allows you to fill your prescriptions at TRICARE network pharmacies across the country without having to submit a claim. You have access to a network of approximately 60,000 retail pharmacies in the United States and its territories (*including Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). To find the nearest TRICARE retail network pharmacy, visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303**.

Non-Network Pharmacies

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

Quantity Limits

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

Prior Authorization

Some drugs require prior authorization from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics Committee, brand-name medications with generic equivalents, medications with age limitations, and medications prescribed for quantities exceeding normal limits. For a general list of prescription drugs that are covered under TRICARE, and for drugs that require prior authorization or that have quantity limits, visit **www.tricareformularysearch.org**. If you do not have Internet access, call **1-877-363-1303** to inquire about a specific drug.

Generic Drug Use Policy

Generic drugs are medications approved by the U.S. Food and Drug Administration (FDA) and clinically equivalent to brand-name medications. Generic drugs provide the same safe, effective treatment as brand-name drugs. It is DoD policy to use generic medications instead of brand-name medications whenever possible. A brand-name drug with a generic equivalent may be dispensed only after the prescribing physician completes a clinical assessment that indicates use of the brand-name drug is medically necessary and after Express Scripts grants approval. If a generic-equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name copayment. If you fill a prescription with a brand-name drug that is not considered medically necessary and when a generic equivalent is available, you will be responsible for paying the entire cost of the prescription.

Non-Formulary Drugs

The DoD Pharmacy and Therapeutics Committee may recommend to the Director of the TRICARE Management Activity that certain drugs be placed in the third, "non-formulary" tier. These medications include any drug in a therapeutic class determined to be not as relatively clinically effective or as cost-effective as other drugs in the same class. For an additional cost, third-tier drugs are available through the Mail Order Pharmacy or retail network pharmacies. You may be able to fill non-formulary prescriptions at formulary costs if your provider can establish medical necessity by completing and submitting the appropriate TRICARE pharmacy medical necessity form for the non-formulary medication. Forms and medical necessity criteria are available online at **www.pec.ha.osd.mil/forms_criteria.php** or by calling Express Scripts at **1-877-363-1303**.

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

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

Specialty Medication Care Management

Specialty medications are usually high-cost; self-administered; injectable, oral, or infused drugs that treat serious chronic conditions (*e.g., multiple sclerosis, rheumatoid arthritis, hepatitis C*). These drugs typically require special storage and handling, are difficult to administer, and are not readily available at your local pharmacy. Specialty medications may also have side effects that require pharmacist and/or nurse monitoring.

The Specialty Medication Care Management program is structured to improve your health through continuous health evaluation, ongoing monitoring, assessment of educational needs, and management of medication use. This program provides:

- Access to proactive, clinically based services for specific diseases designed to help you get the most benefit from your medication
- Monthly refill reminder calls
- Scheduled deliveries to your specified location
- Specialty consultation with nurse/pharmacist at any point during your therapy

These services are provided to you at no additional cost when you receive your medications through the Mail Order Pharmacy, and participation is voluntary. If you or your provider orders a specialty medication from the Mail Order Pharmacy, you will receive additional information from Express Scripts about the Specialty Medication Care Management program and how to get started.

Using the Mail Order Pharmacy to fill specialty medication prescriptions provides you with access to the Specialty Medication Care Management program benefits described above. You may submit a specialty medication prescription by mail, or your provider may submit it by fax. If you are currently using another pharmacy to fill your specialty medication prescription, you can contact the Member Choice Center at **1-877-363-1433** to switch to the Specialty Medication Care Management program. With specific mailing instructions from you or

your provider, the Mail Order Pharmacy will ship your specialty medication to your home. For your convenience and safety, the Mail Order Pharmacy will contact you to arrange delivery before the medication is shipped.

Note: Some specialty medications may not be available through the Mail Order Pharmacy because the medication's manufacturer limits the drug's distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, the Mail Order Pharmacy will either forward your prescription to a pharmacy of your choice that can fill it or will provide you with instructions about where to send the prescription to have it filled. To determine if your specialty medication is available through the Mail Order Pharmacy, visit **www.tricareformularysearch.org**.

Dental Options

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

TRICARE Dental Program

The TDP is a voluntary dental insurance program administered by United Concordia, available to eligible ADFMs and National Guard and Reserve and Individual Ready Reserve members and their eligible family members. Active duty personnel (*and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 90 days prior to their report date*) are not eligible for the TDP. They receive dental care through the ADDP. For information about the TDP, visit the TDP Web site at **www.TRICAREdentalprogram.com** or call United Concordia toll-free at **1-800-866-8499**.

TRICARE Retiree Dental Program

The TRDP is a voluntary dental insurance program administered by the Federal Services division of Delta Dental® of California (Delta Dental). The TRDP offers comprehensive, cost-effective dental coverage for uniformed services retirees and their eligible family members, retired National Guard and Reserve members (*including those who are entitled to retired pay but will not begin receiving it until age 60*) and their eligible family members, certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. For information about the TRDP, visit the TRDP Web site at **www.trdp.org** or call Delta Dental toll-free at **1-888-838-8737**.

Maternity Care

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

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

Newborns are covered separately. To ensure your newborn is covered by TRICARE, see "Having a Baby or Adopting a Child" in the *Changes to Your TRICARE Coverage* section.

The following services are not covered by TRICARE:

- Fetal ultrasounds that are not medically necessary (*e.g., to determine your baby's sex*), including three- and four-dimensional ultrasounds

- Services and supplies related to noncoital reproductive procedures (*e.g., artificial insemination*)
- Management of uterine contractions with drugs that are not FDA-approved for that use (*i.e., off-label use*)
- Home uterine activity monitoring and related services
- Unproven procedures (*e.g., lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent miscarriages, salivary estriol test for preterm labor*)
- Umbilical cord blood collection and storage, except when stem cells are collected for subsequent use in the treatment of tumor, blood, or lymphoid disease
- Private hospital rooms (*TRICARE generally does not cover private rooms; however, some MTFs may have private postpartum rooms.*)

Maternity Ultrasounds

TRICARE covers medically necessary maternity ultrasounds, including those needed to:

- Estimate gestational age due to unknown date of last menstrual period, irregular periods, size/date difference of greater than two weeks, or pregnancy while on oral contraceptive pills (*Confirmation of estimated gestational age is not a medically necessary indication.*)
- Evaluate fetal growth when the fundal height growth is significantly greater than expected (*more than 1 cm per week*) or less than expected (*less than 1 cm per week*)
- Conduct a biophysical evaluation for fetal well-being when the mother has certain conditions (*e.g., insulin-dependent diabetes mellitus, hypertension, systemic lupus, congenital heart disease, renal disease, hyperthyroidism, prior pregnancy with unexplained fetal demise, multiple gestations, post-term pregnancy after 41 weeks, intrauterine growth retardation, oligoor polyhydramnios, preeclampsia, decreased fetal movement, isoimmunization*)
- Evaluate a suspected ectopic pregnancy
- Determine the cause of vaginal bleeding
- Diagnose or evaluate multiple births
- Confirm cardiac activity (*e.g., when fetal heart rate is not detectable by Doppler, suspected fetal demise*)
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
- Evaluate fetus condition in late registrants for prenatal care

A physician is not obligated to perform ultrasonography on a patient who is at low risk and has no medical indications.

Some providers offer patients routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation. **TRICARE does not cover routine ultrasound screening.** TRICARE only covers maternity ultrasounds with valid medical indication that constitutes medical necessity. Refer to **www.tricare.mil** or your regional contractor's Web site for additional details on maternity ultrasound coverage.

Hospice Care

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

Hospice Benefit Coverage

The hospice benefit covers four levels of care:

- Routine home care
- Continuous home care
- Inpatient respite care
- General hospice inpatient care

Note: Respite care is covered when necessary and is limited to no more than five days at a time. General inpatient care is limited to varying short-term stays.

Hospice patients may shift among the levels of care, depending on their needs, the needs of family members caring for them, and the determinations of the medical team managing their care. Care may include:

- Counseling
- Medical equipment, supplies, and medications
- Medical social services
- Medically necessary short-term inpatient care
- Nursing care
- Other covered services related to the terminal illness
- Physical and occupational services
- Physician services
- Speech and language pathology

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

Note: Hospice care is not available overseas except in U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

For more information on TRICARE's hospice coverage, visit **www.tricare.mil/mybenefit**.

TRICARE Extended Care Health Option

TRICARE Extended Care Health Option (ECHO) provides financial assistance to qualifying ADFMs based on specific mental or physical disabilities, and it offers beneficiaries an integrated set of services and supplies beyond those offered by the basic TRICARE programs. Potential ECHO beneficiaries must be ADFMs, have a qualifying condition, and be registered to receive ECHO benefits. A record of ECHO registration is stored with the beneficiary's Defense Enrollment Eligibility Reporting System (DEERS) information.

Conditions qualifying an ADFM for ECHO coverage include:

- Moderate or severe mental retardation
- A serious physical disability
- An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
- A diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (*under age 3*) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability
- Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems

Note: Active duty sponsors with family members seeking ECHO benefits **must enroll** in their service's Exceptional Family Member Program (*unless waived in specific situations*) and register for ECHO in order to be eligible. There is no retroactive registration for the ECHO program. All ECHO services require prior authorization from the regional contractor.

ECHO Benefits

ECHO provides coverage for the following products and services:

- Applied Behavioral Analysis Therapy (*which includes the Autism Services Demonstration*) and other types of special education (*which can include applied behavioral analysis but excludes education for which the school system is responsible*) that are not available through local community resources
- Assistive services (*e.g., those from a qualified interpreter or translator*)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC)
- Rehabilitative services
- Respite care (*during any month when at least one other ECHO benefit is received and limited to the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.*)

- ECHO respite care: Up to 16 hours of care
- EHHC respite care: Up to eight hours per day, five days per week (*for those who qualify*)
- Training for special education and use of assistive technology devices
- Institutional care when a residential environment is required
- Transportation under certain limited circumstances

For information on the ECHO program, including costs and maximum cost-shares (*i.e., ECHO cap*), visit the ECHO Web site at **www.tricare.mil/echo**.

DoD Enhanced Access to Autism Services Demonstration

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

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

The Enhanced Access to Autism Services Demonstration allows non-certified paraprofessional providers or tutors to provide autism-related services (*in particular, applied behavioral analysis*), under the supervision of a TRICARE-authorized certified therapist, to military family members in the United States. You must be registered in ECHO to receive Autism Services Demonstration services.

Note: The allowed cost of services provided by the Enhanced Access to Autism Services Demonstration accrues to the ECHO fiscal year government maximum cost-share. For more information, visit the ECHO Web site at **www.tricare.mil/echo**.

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

Services or Procedures with Significant Limitations

Figure 3.8 shows a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist. Visit **www.tricare.mil** for additional information. **Note:** This list is **not** intended to be all-inclusive.

Services or Procedures with Significant Limitations ***Figure 3.8***

Service	Description
Abortions	Abortions are only covered when the life of the mother would be endangered if the pregnancy were carried to term. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.
Breast Pumps	Heavy-duty, hospital-grade electric breast pumps (*including services and supplies related to the use of the pump*) for mothers of premature infants are covered. An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period. Hospital-grade electric breast pumps may also be covered after the premature infant is discharged from the hospital with a physician-documented medical reason. This documentation is also required for premature infants delivered in non-hospital settings. Breast pumps of any type, when used for reasons of personal convenience, are excluded, even if prescribed by a physician.
Cardiac and Pulmonary Rehabilitation	Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.
Cosmetic, Plastic, or Reconstructive Surgery	Surgery is only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after cancer surgery, or reconstruct the breast after cancer surgery.

Services or Procedures with Significant Limitations (continued)

Service	Description
Cranial Orthotic Device or Molding Helmet	Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly.
Dental Care and Dental X-rays	Both are covered only for adjunctive dental care (*i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition*).
Education and Training	Education and training are only covered under the TRICARE ECHO and diabetic outpatient self-management training services. Diabetic outpatient self-management training services must be performed by programs approved by the American Diabetes Association® (ADA). The provider's ADA "Certificate of Recognition" must accompany the claim for reimbursement.
Eyeglasses or Contact Lenses	ADSMs may receive eyeglasses at MTFs at no cost. For all other beneficiaries, the following are covered: • Contact lenses and/or eyeglasses for treatment of infantile glaucoma • Corneal or scleral lenses for treatment of keratoconus • Scleral lenses to retain moisture when normal tearing is not present or is inadequate • Corneal or scleral lenses to reduce corneal irregularities other than astigmatism • Intraocular lenses, contact lenses, or eyeglasses for loss of human lens function resulting from intraocular surgery, ocular injury, or congenital absence **Note:** Adjustments, cleaning, and repairs for eyeglasses are not covered.
Facility Charges for Non-adjunctive Dental Services	Hospital and anesthesia charges related to routine dental care for children under age 5, or those with disabilities, may be covered in addition to dental care related to some medical conditions.
Food, Food Substitutes or Supplements, or Vitamins	Food, food substitutes and supplements, or vitamins are covered when used as the primary source of nutrition for enteral, parenteral, or oral nutritional therapy. Intraperitoneal nutrition therapy is covered for malnutrition as a result of end-stage renal disease.
Gastric Bypass	Gastric bypass, gastric stapling, gastroplasty, or laparoscopic adjustable gastric banding (*Lap-Band® surgery*)—to include vertical banded gastroplasty—is covered when one of the following conditions is met: • The patient is 100 pounds over the ideal weight for height and bone structure and has one of these associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (*and other severe respiratory diseases*), hypothalamic disorders, and severe arthritis of the weight-bearing joints. • The patient is 200% or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category. • The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (*a takedown*).
Genetic Testing	Testing is covered when medically proven and appropriate, and when the results of the test will influence the patient's medical management. Routine genetic testing is not covered.
Hearing Aids	Hearing aids are covered only for active duty family members who meet specific hearing loss requirements.
Intelligence Testing	Testing is covered only when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders.
Laser/LASIK/ Refractive Corneal Surgery	Surgery is covered only to relieve astigmatism following a corneal transplant.
Private Hospital Rooms	Private rooms are not covered unless ordered for medical reasons or because a semiprivate room is not available. Hospitals subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room but will only receive the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.
Shoes, Shoe Inserts, Shoe Modifications, and Arch Supports	Shoe and shoe inserts are covered only in very limited circumstances. Orthopedic shoes may be covered if they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered.

Exclusions

In general, TRICARE excludes services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (*including mental disorder*), injury, or for the diagnosis and treatment of pregnancy or well-child care. All services and supplies (*including inpatient institutional costs*) related to a non-covered condition or treatment, or provided by an unauthorized provider, are excluded.

The following specific services **are excluded under any circumstance. This list is not intended to be all-inclusive.** Visit **www.tricare.mil** for additional information.

- Acupuncture
- Alterations to living spaces
- Artificial insemination, including in vitro fertilization, gamete intrafallopian transfer, and all other such reproductive technologies
- Autopsy services or post-mortem examinations
- Birth control/contraceptives (*non-prescription*)
- Bone marrow transplants for treatment of ovarian cancer
- Camps (*e.g., for weight loss*)
- Care or supplies furnished or prescribed by an immediate family member
- Charges that providers may apply to missed or rescheduled appointments
- Counseling services that are not medically necessary for the treatment of a diagnosed medical condition (*e.g., educational, vocational, and socioeconomic counseling; stress management; lifestyle modification*)
- Custodial care
- Diagnostic admissions
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chairlifts
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships, or other such charges or items
- Experimental or unproven procedures
- Foot care (*routine*), except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes
- General exercise programs, even if recommended by a physician and regardless of whether rendered by an authorized provider
- Inpatient stays:
  - For rest or rest cures
  - To control or detain a runaway child, whether or not admission is to an authorized institution
  - To perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis
  - In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- Learning disability services
- Medications:
  - Drugs prescribed for cosmetic purposes
  - Fluoride preparations
  - Food supplements
  - Homeopathic and herbal preparations
  - Multivitamins
  - Over-the-counter products (*except insulin and diabetic supplies*)
  - Weight reduction products
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopaths
- Non-surgical treatment of obesity or morbid obesity
- Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone
- Postpartum inpatient stay for a mother to stay with a newborn infant (*usually primarily for the purpose of breastfeeding the infant*) when the infant (*but not the mother*) requires the extended stay, or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (*but not the newborn infant*) requires extended postpartum inpatient stay

- Preventive care, such as routine, annual, or employment-requested physical examinations; routine screening procedures; or immunizations, except as provided under the clinical preventive services benefit (*See "Clinical Preventive Services" earlier in this section.*)
- Psychiatric treatment for sexual dysfunction
- Services and supplies:
  - Provided under a scientific or medical study, grant, or research program
  - Furnished or prescribed by an immediate family member
  - For which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE-eligible
  - Furnished without charge (*i.e., cannot file claims for services provided free-of-charge*)
  - For the treatment of obesity, such as diets, weight-loss counseling, weight-loss medications, wiring of the jaw, or similar procedures (*For gastric bypass, see "Services or Procedures with Significant Limitations" earlier in this section.*)
  - Inpatient stays directed or agreed to by a court or other governmental agency (*unless medically necessary*)
  - Required as a result of occupational disease or injury for which any benefits are payable under a workers' compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted
  - That are (*or are eligible to be*) fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (*In such instances, TRICARE is the secondary payer for any remaining charges.*)
- Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth
- Smoking cessation supplies
- Sterilization reversal surgery
- Surgery performed primarily for psychological reasons (*such as psychogenic surgery*)
- Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE
- Transportation except by ambulance
- X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer-screening mammography, cancer screening, Pap tests, and other tests allowed under the clinical preventive services benefit

Claims

Health Care Claims

If you are using the TRICARE Extra option, your provider will submit claims on your behalf. If you are using the TRICARE Standard option, you may be required to submit your own health care claims. Claims should be submitted to the claims processor in the region **in which you live**.

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

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

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

Note: Providers submit inpatient facility claims.

You may be required to pay up front for services if you see a TRICARE-authorized non-network provider who chooses not to participate on the claim. In this case, TRICARE will reimburse you directly for the TRICARE-allowable charge, less any applicable deductible and cost-share. Remember that nonparticipating providers may charge you up to 15 percent above the TRICARE-allowable charge for services, in addition to your cost-share and/or deductible.

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

Visit **www.tricare.mil/claims** for claims processing information.

Regional Claims Processing Information *Figure 4.1*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Send claims to: Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740	**Send claims to:** TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031	**Send claims to:** West Region Claims P.O. Box 77028 Madison, WI 53707-1028
Check the status of your claim at **www.myTRICARE.com** or **www.healthnetfederalservices.com**.	Check the status of your claim at **www.myTRICARE.com** or at **www.humana-military.com**.	Check the status of your claim at **www.triwest.com**.

Pharmacy Claims

You will not need to file pharmacy claims to fill prescriptions at an MTF pharmacy, through the Mail Order Pharmacy, or at a TRICARE retail network pharmacy. However, if you fill a prescription at a non-network pharmacy in the United States or its territories, you must pay the full price of your prescription up front and file a claim for reimbursement.

To file a claim:

1. Download *DD Form 2642* at **www.tricare.mil/claims**.
2. Complete the form and attach the required paperwork, as described on the form.
3. Mail the form and paperwork to:

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

Prescription claims require the following information for each drug:

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

Contact Express Scripts, Inc. (Express Scripts) at **1-877-363-1303** with questions about filing claims.

Coordinating Benefits with Other Health Insurance

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

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

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

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

TRICARE Program Integrity
16401 East Centretech Parkway
Aurora, CO 80011

You may also report noncompliance online at **www.tricare.mil/fraud**.

How TRICARE Calculates Payment with OHI

TRICARE regulations require coordination of benefits with OHI coverage. Due to these regulations, TRICARE does not always pay the OHI copayment or the balance remaining after the OHI payment. However, your liability is usually eliminated. Payment calculations differ by provider status as detailed below.

TRICARE Network Providers and Most Inpatient Facilities

If your OHI pays more than the TRICARE-allowable amount, no payment is authorized, the charge is considered paid in full, and the provider may not bill you. Otherwise, TRICARE pays the lesser of:

- The TRICARE-allowable amount less the OHI payment

- The amount TRICARE would have paid without OHI
- The beneficiary's liability (*OHI copayment and/or deductible*)

Non-Network Providers Who Accept TRICARE Assignment (Participating)

TRICARE pays the lesser of:

- The billed amount less the OHI payment
- The amount TRICARE would have paid without OHI
- The beneficiary's liability (*OHI copayment and/or deductible*)

Providers Who Do Not Accept TRICARE Assignment (Nonparticipating)

Nonparticipating providers may only bill you up to 115 percent of the TRICARE-allowable charge. If your OHI paid more than 115 percent of the TRICARE-allowable charge, no TRICARE payment is authorized, the charge is considered paid in full, and the provider may not bill you. Otherwise, TRICARE pays the lesser of:

- 115 percent of the allowed amount less the OHI payment
- The amount TRICARE would have paid without OHI
- The beneficiary's liability (*OHI copayment and/or deductible*)

Staff Model and Group Health Maintenance Organizations and Other Capitated OHI Plan Providers

If you are enrolled in one of these OHI plans, the provider and/or group either work directly for the Health Maintenance Organization (HMO) or are paid a monthly or annual amount rather than a fee for each service. Under these plans, you may only receive a copayment receipt; an itemized bill or explanation of benefits (EOB) may not be available. In these cases, you can submit *DD Form 2642* with a copy of the receipt. For processing, the copayment is considered the billed amount. Deductibles and cost-shares are applied, and you may only receive partial reimbursement of your HMO copayment.

Pharmacy Claims

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

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

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

Once you have met one of these requirements, you may submit your prescription to the Mail Order Pharmacy. See "Mail Order Pharmacy" in the *Covered Services, Limitations, and Exclusions* section for instructions on how to use the Mail Order Pharmacy program.

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

Pharmacy Claim Appeals

If you disagree with the determination on your pharmacy claim (*i.e., if your claim is denied*), you or your appointed representative has the right to request a reconsideration. The request (*or appeal*) for reconsideration must be in writing, signed, and postmarked or received by Express Scripts within 90 calendar days from the date of the decision and must include a copy of the claim decision.

Your signed, written request must state the specific matter with which you disagree and must be sent to the following address **no later than 90 days** from the date of the notice:

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

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

Appealing a Claim or Authorization Denial

TRICARE has a multilevel appeals process to address claim and authorization denials. You may appeal the denial of a requested authorization of services or TRICARE decisions regarding claims payment. Submit appeals to your regional contractor. For more detailed information on the appeals process, see "Appealing a Decision" in the *For Information and Assistance* section or visit **www.tricare.mil/claims**.

Third-Party Liability

The Federal Medical Care Recovery Act allows TRICARE to be reimbursed for treatment costs if you are injured in an accident caused by someone else. The *Statement of Personal Injury Third Party Liability* (DD Form 2527) will be sent to you if a claim appears to have third-party liability involvement. Within 35 calendar days, you must complete and sign this form and follow the directions for returning it to the appropriate claims processor. You can download *DD Form 2527* at **www.tricare.mil/claims** or from your regional contractor's Web site.

Explanation of Benefits

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

After reviewing the EOB, you have the right to appeal certain decisions regarding your claims and must do so in writing within 90 days of the date of the EOB notice. You should keep EOBs with your health insurance records for future reference. (*For more information about appeals, see the* For Information and Assistance *section*.)

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

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

Debt Collection Assistance Officers

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

When you visit a DCAO for assistance, you must bring or submit documentation associated with a collection action or adverse credit rating, including debt collection letters, EOB statements, and medical and/or dental bills from providers. The more information you can provide, the faster the cause of the problem can be determined. The DCAO will research your claim, provide you with a written resolution of your collection problem, and inform the collection agency that action is being taken to resolve the issue. DCAOs cannot provide legal advice or repair your credit rating, but they can help you through the debt collection process by providing documentation for the collection or credit-reporting agency to explain the circumstances relating to the debt. To find a DCAO near you, visit the DCAO directory online at **www.tricare.mil/bcacdcao**.

Changes to Your TRICARE Coverage

TRICARE Standard and TRICARE Extra continue to provide health coverage for you and your family as you experience major life events. You will, however, need to take specific actions to make sure you remain TRICARE-eligible. For each life event listed in this section, the first step is to update your information in the Defense Enrollment Eligibility Reporting System (DEERS).

You have several options for updating and verifying DEERS information. See "Keep Your DEERS Information Current!" in the *Choosing TRICARE Standard and TRICARE Extra* section of this handbook for details.

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

Getting Married or Divorced

Marriage

It is extremely important for sponsors to register new spouses in DEERS to ensure they are eligible for TRICARE. To register a new spouse in DEERS, the sponsor will need to provide a copy of the marriage certificate to the nearest uniformed services identification (ID) card-issuing facility. The new spouse will also be required to show two forms of ID (*e.g., any combination of Social Security card, driver's license, birth certificate, current military ID card, or Common Access Card [CAC]*). Once your spouse is registered in DEERS, he or she will receive a uniformed services ID card and will be eligible for TRICARE. When accessing care, your spouse will be asked to show his or her ID card.

Divorce

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

Children

After a divorce, a child (*biological or adopted*) remains TRICARE-eligible up to age 21 (*or age 23 if enrolled in college full time and if the sponsor provides at least 50 percent of the financial support*), as long as his or her DEERS information is current. Please contact DEERS to verify what documentation is needed to extend coverage.

Although a child normally does not get his or her own uniformed services ID card until age 10, a child younger than 10 should have an ID card if in the custody of a parent or guardian who is not TRICARE-eligible or who is not the custodial parent. Patient privacy may be a factor for divorced parents attempting to obtain information about received health care services.

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

Former Spouses

Certain former spouses are eligible to continue TRICARE Standard and TRICARE Extra coverage as long as they:

- Do not remarry (*If a former spouse remarries, the loss of benefits remains applicable even if the remarriage ends in death or divorce.*)
- Are not covered by an employer-sponsored health plan
- Are not also a former spouse of a North Atlantic Treaty Organization or "Partners for Peace" nation member
- Meet the requirements of one of the two situations described in Figure 5.1 on the following page.

Former spouses who are TRICARE-eligible must change their personal information in DEERS so their name and Social Security number (SSN) are listed for the primary contact information. The former spouse's TRICARE eligibility is shown in DEERS under his or her SSN, not the sponsor's.

Eligibility Requirements for Former Spouses *Figure 5.1*

1	• The former spouse must have been married to the same member or former member for at least 20 years, and at least 20 of those years must have been creditable in determining the member's eligibility for retirement pay. • The former spouse is eligible for TRICARE coverage after the date of the divorce, dissolution, or annulment.[1] • Eligibility continues as long as the preceding requirements continue to be met and the former spouse does not remarry.
2	• The former spouse must have been married to the same military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. • The former spouse is eligible for TRICARE coverage for only one year from the date of the divorce, dissolution, or annulment.[1]

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

Having a Baby or Adopting a Child

Children are automatically covered as TRICARE Prime beneficiaries for 60 days after birth or adoption as long as one other family member is enrolled in TRICARE Prime. If you are a new parent, you must take **both** of the following steps **within 60 days of the date of birth or adoption** to ensure that your child has continuous TRICARE Prime coverage after the first 60 days:

1. Register your child in DEERS at a uniformed services ID card-issuing facility. A birth certificate or certificate of live birth from the hospital is required. If your child is not registered in DEERS within one year after the date of birth or adoption, DEERS will show "loss of eligibility," and the child will no longer be TRICARE-eligible until registered in DEERS.
2. Enroll your child in TRICARE Prime within 60 days of birth or adoption by submitting a *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876) to your regional contractor. On day 61, if you have not enrolled your child in TRICARE Prime, he or she will be covered under TRICARE Standard and TRICARE Extra.

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

If no family member is enrolled in TRICARE Prime at the time of your child's birth or adoption, he or she is automatically covered by TRICARE Standard and TRICARE Extra. Coverage will be continuous as long as you register your child in DEERS within 365 days of birth.

Going to College

Your children remain TRICARE-eligible until age 21 (*or age 23 if enrolled in college full time and if the sponsor provides at least 50 percent of the financial support*), as long as their DEERS information is kept up to date. To extend benefits for your college student beyond his or her 21st birthday, contact DEERS to verify what documentation is needed.

TRICARE Standard and TRICARE Extra provide continuous coverage when your child goes to college. Coverage remains the same, but your child will need to find a new provider. Advise your son or daughter to save all health care receipts in case you need to file a claim for reimbursement.

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

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

Traveling

Traveling within the United States

If you need emergency care while traveling in the continental United States, visit the nearest emergency room or call 911.

If you seek care from a TRICARE network provider, the provider will file the claim with your regional contractor for you. If you seek care from a TRICARE-authorized non-network provider, you may have to pay up front, save your receipts, and file the claim with your regional contractor. Claims are always filed with the regional contractor in your home region, not with the regional contractor in the area in which you are traveling.

Traveling Overseas

If you need emergency or urgent care while traveling overseas, contact the TRICARE Area Office (TAO) for the overseas area where you are traveling or the nearest American Embassy Health Unit to find a host nation provider. Visit **www.usembassy.state.gov** for a list of every American Embassy and Consular Office worldwide. Figure 5.2 lists contact information for the TAO in each overseas area.

When traveling overseas, you can use the TRICARE Standard option to receive care from any host nation provider. The TRICARE Overseas Program Standard option is similar to the stateside program, including cost-shares and deductibles. The TRICARE Extra option is not available overseas.

Note: When seeking care from a host nation provider, you should be prepared to pay up front for services and file a claim with TRICARE for reimbursement in the region where you live.

Filling Prescriptions on the Road

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

TRICARE Retail Network Pharmacy

You can fill prescriptions at any TRICARE retail network pharmacy in the United States, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. To find the nearest TRICARE retail network pharmacy, visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303**.

Military Treatment Facility Pharmacy

If you are traveling, you can fill a new prescription at any military treatment facility (MTF) pharmacy free of charge, if it is on the MTF formulary and in stock. All you will need is the written prescription

TRICARE Area Office Contact Information *Figure 5.2*

TRICARE Eurasia-Africa	TRICARE Latin America and Canada	TRICARE Pacific
Europe, Africa, and the Middle East	Central and South America, the Caribbean Basin, Canada, Puerto Rico, and the U.S. Virgin Islands	Guam, Japan, Korea, Asia, New Zealand, India, and Western Pacific remote countries
• **Comm.:** 011-49-6302-67-6314 • **DSN:** 496-6314 • **Toll-free:** 1-888-777-8343 • **Fax:** 011-49-6302-67-6372 • **E-mail:** teoweb@europe.tricare.osd.mil • **Online:** www.tricare.mil/eurasiaafrica	• **Comm.:** 1-706-787-2424 • **DSN:** 773-2424 • **Toll-free:** 1-888-777-8343 • **Fax:** 1-706-787-3024 • **E-mail:** taolac@tma.osd.mil • **Online:** www.tricare.mil/tlac	• **Comm.:** 011-81-6117-43-2036 • **DSN:** 643-2036 • **Remote Sites:** 011-65-6338-9277 • **Toll-free:** 1-888-777-8343 • **Fax:** 011-81-6117-43-2037 • **DSN Fax:** 643-2037 • **E-mail:** TPAO.CSC@med.navy.mil • **Online:** www.tricare.mil/pacific

and your uniformed services ID card or CAC. An MTF pharmacy will determine if you can obtain a refill of a prescription that was originally filled at another MTF.

Mail Order Pharmacy

If you will be staying away from home for a longer period of time, you can plan ahead to receive prescriptions through the TRICARE Mail Order Pharmacy. Provide Express Scripts, Inc. (Express Scripts) with your temporary address so prescriptions can be mailed to you at your travel destination. The Mail Order Pharmacy is only available overseas if you have an APO or FPO address. **Note to military retirees:** If you and your family are living or traveling overseas without serving in an official capacity, you do not have APO or FPO mail access. Therefore, you cannot receive medications by mail through the Mail Order Pharmacy. Visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303** for assistance.

Non-Network Pharmacy

If there is no other option, you can fill prescriptions at any non-network pharmacy. You will be required to pay for prescriptions up front and file a claim with Express Scripts for reimbursement. See the *Claims* section for details about filing a pharmacy claim. Active duty service members will be fully reimbursed for covered, prescribed medications.

Filling Prescriptions Overseas

Your pharmacy coverage is limited overseas. TRICARE recommends that you fill all of your prescriptions before traveling overseas. TRICARE retail network pharmacies are only located in the United States, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. You must have an APO or FPO address to use the Mail Order Pharmacy overseas, and the prescription must be from a U.S.-licensed provider. Be prepared to pay up front for medications and file a claim for reimbursement for non-MTF and non-network pharmacy services when traveling overseas.

Moving

Moving within the United States

Whether you are moving to another area within the same TRICARE region or to a different TRICARE region, moving with TRICARE Standard and TRICARE Extra is easy. All you need to do is update your personal information in DEERS, find a new provider, and continue to receive care when you need it.

To find a provider, visit the provider locator online at **www.tricare.mil/providerdirectory**. The regional contractors also have network provider directories on their Web sites to locate providers in the respective regions.

If you move to a new region, be sure to learn who your new regional contractor is and where to file your claims. See the *Claims* section for details.

Moving Overseas

You can use the TRICARE Standard option and receive care from any host nation provider overseas. The TRICARE Overseas Program Standard option, including cost-shares and deductibles, is similar to the stateside program. There are some limits for overseas health care services and pharmacy coverage. Contact the TAO for the overseas area where you are moving or the nearest American Embassy Health Unit to find a host nation provider. For TAO contact information, see "Traveling Overseas" in this section. For a list of American Embassies and Consular Offices worldwide, visit **www.usembassy.state.gov**.

Separating from the Service

If your active duty sponsor separates from the uniformed services, TRICARE coverage may or may not continue, depending on the circumstances of your separation. TRICARE offers transitional health care options through the Transitional Assistance Management Program (TAMP) and the Continued Health Care Benefit Program (CHCBP), which offer temporary coverage until you have a new health plan.

Contact a Beneficiary Counseling and Assistance Coordinator (BCAC) to discuss your family's eligibility for these programs. You also can visit **www.tricare.mil** for more information.

Transitional Assistance Management Program

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

- Involuntarily separating from active duty under honorable conditions
- A National Guard or Reserve member separating from a period of active duty that lasted more than 30 consecutive days in support of a contingency operation
- Separating from active duty following involuntary retention (*stop-loss*) in support of a contingency operation
- Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation
- Separating from active duty with an agreement to become a member of the Selected Reserve of the Ready Reserve of a reserve component
- Separating from active duty due to sole survivorship discharge

If you qualify for coverage under TAMP, you will have 180 days of transitional health benefits after the sponsor separates. During this 180-day period, you may enroll in TRICARE Prime if you reside in a TRICARE Prime Service Area, or you will be covered under TRICARE Standard and TRICARE Extra. Rules and processes for these programs will apply. Your costs will be the same as those for active duty family members (ADFMs).

Continued Health Care Benefit Program

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

CHCBP acts as a bridge between military health care benefits and your new civilian health care plan. CHCBP benefits are comparable to TRICARE Standard with the same benefits, providers, and program rules. For more information about CHCBP, visit Humana Military's Web site at **www.humana-military.com** or call **1-800-444-5445**.

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

TRICARE Reserve Select

TRICARE Reserve Select (TRS) is a premium-based health care plan that qualifying National Guard and Reserve members may purchase. TRS offers coverage similar to TRICARE Standard and TRICARE Extra, but a monthly premium is charged. You will receive comprehensive coverage and can obtain care from any TRICARE-authorized provider. Annual deductibles and cost-shares apply. Visit **www.tricare.mil/reserve/reserveselect** for more information about TRS coverage.

Retiring from Active Duty

When your active duty sponsor retires, he or she will experience a "change in status." When your sponsor's status is updated in DEERS, you will all receive new uniformed services ID cards showing the new "retired" status.

Until retirement, your sponsor is enrolled in either TRICARE Prime or TRICARE Prime Remote (TPR). If sponsors do not reenroll into TRICARE Prime, they will use TRICARE Standard and TRICARE Extra. **Note:** TPR is not available to retirees.

When your status changes to family member of a retired service member, the TRICARE Standard and TRICARE Extra cost-shares and catastrophic cap will increase. Here are a few of the other

TRICARE Standard and TRICARE Extra changes you will experience when your active duty sponsor retires:

Outpatient Cost-Shares and Copayments	• Increase to retired family rates
Catastrophic Cap	• Increases to retired family rate
Health Care Services	• Eye exams no longer covered • Hearing aids no longer covered
Medicare-Eligibility	• Must purchase Medicare Part B (*when eligible*) to remain TRICARE-eligible

Visit **www.tricare.mil/costs** for additional information regarding program costs.

Becoming Entitled to Medicare

Active Duty Status

While on active duty status, if a family member becomes entitled to premium-free Medicare Part A—at age 65 or due to a disability or end-stage renal disease—TRICARE becomes the second payer after Medicare. ADFMs are not required to have Medicare Part B coverage to remain TRICARE-eligible, but are encouraged to enroll in Medicare Part B as soon as they become eligible to ensure continuous TRICARE coverage and avoid late enrollment surcharges when their sponsor's active duty status ends. Medicare-eligible beneficiaries under age 65 have the option to enroll in TRICARE Prime and only pay TRICARE Prime cost-shares for outpatient services. Inpatient services would be covered first by Medicare Part A, then by TRICARE as secondary payer.

Retired Status

Once no longer on active duty status, if you or a family member is entitled to premium-free Medicare Part A, enrollment in Medicare Part B is required to remain TRICARE-eligible. TRICARE benefits will be terminated for any period of time during which you have only Medicare Part A.

TRICARE beneficiaries under age 65 with Medicare Part A and Part B have the option to enroll in TRICARE Prime if it is available. **Note:** Retirees and their family members are not eligible for TPR or TRICARE Prime Remote for Active Duty Family Members.

Survivor Coverage

If your sponsor dies while serving on active duty for a period of more than 30 days, you are automatically eligible for transitional TRICARE survivor benefits as long as your DEERS information is up to date and you are either of the following:

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

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

Surviving Spouse: You remain eligible as a "transitional survivor" for three years following your sponsor's death and will have ADFM benefits and costs. After three years, you remain TRICARE-eligible as a "survivor" and will pay retiree rates and enrollment fees.

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

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

Loss of Eligibility

Upon loss of TRICARE eligibility, each family member will automatically receive a certificate of creditable coverage. The certificate of creditable coverage is a document that serves as evidence of prior health care coverage under TRICARE, so that you cannot be excluded from a new health plan for pre-existing conditions. Certificates may be issued in the following circumstances:

- Upon the sponsor's separation from active duty, a certificate will be issued to the sponsor listing all eligible family members.
- Upon the loss of eligibility for a dependent child (*age 21, or 23 if enrolled in college full time and if the sponsor provides at least 50 percent of the financial support*), a certificate will be issued to the dependent child.
- Upon loss of coverage after divorce, a certificate will be issued to the former spouse as soon as the information is updated in DEERS.

Certificates automatically reflect the most recent period of continuous coverage under TRICARE. Certificates issued upon request of a beneficiary will reflect each period of continuous coverage under TRICARE that ended within the 24 months prior to the date of loss of eligibility. Each certificate identifies the name of the sponsor or family member for whom it is issued, the dates TRICARE coverage began and ended, and the certificate issue date.

Send written requests for certificates of creditable coverage to the Defense Manpower Data Center Support Office at:

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

The request must include:

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

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

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

For Information and Assistance

Beneficiary Counseling and Assistance Coordinators

Beneficiary Counseling and Assistance Coordinators (BCACs) can help you with TRICARE and Military Health System inquiries and concerns and can advise you about obtaining health care. BCACs are located at military treatment facilities (MTFs) and TRICARE Regional Offices. To locate a BCAC, visit **www.tricare.mil/bcacdcao** and use the online directory.

Appealing a Decision

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

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

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

Appeal Requirements

Your appeal must meet the requirements listed in Figure 6.1.

TRICARE Appeal Requirements ***Figure 6.1***

1	An appropriate appealing party must submit the appeal. Proper appealing parties include: • You, the beneficiary • Your custodial parent (*if you are a minor*) or your guardian • A person appointed, in writing, by you to represent you for the purpose of the appeal • An attorney filing on your behalf • Non-network participating providers If a party other than those listed above is going to submit the appeal, you must complete and sign the *Appointment of Representative and Authorization to Disclose Information* form, which is available on your regional contractor's Web site. Appeals submitted without this form will not be processed. **Note:** Network providers are not appropriate appealing parties, unless appointed, in writing, by you.
2	The appeal must be submitted in writing. See Figure 6.2 on the following page for the appeals submission address for your region.
3	The issue in dispute must be an appealable issue. The following are not appealable issues: • Allowable charges • Eligibility • Denial of services from an unauthorized provider • Denial of treatment plan when an alternative treatment plan is selected
4	An appeal must be filed within 90 days of the date on the explanation of benefits or denial notification letter.
5	There must be an amount in dispute to file an appeal. In cases involving an appeal of a denial of an authorization in advance of receiving the actual services, the amount in dispute is deemed to be the estimated TRICARE-allowable charge for the services requested. There is no minimum amount to request a reconsideration.

Regional Appeals Filing Information *Figure 6.2*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Claims Appeals: Health Net Federal Services, LLC TRICARE Claim Appeals P.O. Box 870148 Surfside Beach, SC 29587-9748 **Claims Appeals Online:** www.healthnetfederalservices.com **Claims Appeals by Fax:** 1-888-458-2554 **Prior Authorization Appeals:** Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 870142 Surfside Beach, SC 29587-9742 **Prior Authorization Appeals Fax:** 1-888-881-3622	**Claims Appeals:** TRICARE South Region Appeals P.O. Box 202002 Florence, SC 29502-2002 **Prior Authorization Appeals:** Humana Military Healthcare Services, Inc. ATTN: Clinical Appeals P.O. Box 740044 Louisville, KY 40201-9973 **Behavioral Health Appeals:** ValueOptions Behavioral Health ATTN: Appeals and Reconsideration Department P.O. Box 551138 Jacksonville, FL 32255-1138	**Claims Appeals:** TriWest Healthcare Alliance Corp. Claims Appeals P.O. Box 86508 Phoenix, AZ 85080 **Prior Authorization Appeals:** TriWest Healthcare Alliance Corp. Reconsideration Department P.O. Box 86508 Phoenix, AZ 85080

Filing an Appeal

Appeals must be filed with your regional contractor within 90 days from the date that appears on the explanation of benefits or denial notification letter. If you are not satisfied with a decision rendered on an appeal, there may be further levels of appeal available to you. For specific information about filing an appeal in your region, visit your regional contractor's Web site or contact your regional contractor.

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

Appeals should contain the following:

- Beneficiary's name, address, and telephone number
- Sponsor's Social Security number (SSN)
- Beneficiary's date of birth
- Beneficiary's or appealing party's signature

A description of the issue or concern must include:

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

Send your appeal to your regional contractor. See Figure 6.2 for regional appeals filing information.

Filing a Grievance

A grievance is a written complaint or concern about a non-appealable issue regarding a perceived failure by any member of the health care delivery team—including TRICARE-authorized providers, military providers, regional contractors, or subcontractor personnel—to provide appropriate and timely health care services, access, or quality, or to deliver the proper level of care or service.

The grievance process allows full opportunity to report, in writing, any concern or complaint regarding health care quality or service. Any TRICARE civilian or military provider; TRICARE beneficiary; sponsor; or parent, guardian, or other representative of an eligible dependent child may file a grievance. Your regional contractor is responsible for the investigation and resolution of all grievances. Grievances are generally resolved within 60 days of receipt. Following resolution, the party who submitted the grievance will be notified of the review completion.

Grievances may include such issues as:

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

When filing a grievance, include the following:

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

Description of the issue or concern must include:

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

File grievances with your regional contractor. See Figure 6.3 on the following page for grievance filing information.

Reporting Suspected Fraud and Abuse

Fraud happens when a person or organization takes action to deliberately deceive others to gain an unauthorized benefit. Health care abuse occurs when providers supply services or products that are medically unnecessary or that do not meet professional standards.

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

To report fraud or abuse regarding the pharmacy program, contact Express Scripts, Inc.:

- **Phone:** 1-800-332-5455, ext. 367079
- **E-mail:** fraudtip@express-scripts.com

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

Regional Grievance Filing Information

Figure 6.3

TRICARE North Region	TRICARE South Region	TRICARE West Region
Address all grievances to: Health Net Federal Services, LLC TRICARE Grievances P.O. Box 870150 Surfside Beach, SC 29587-9750 **Submit by fax:** 1-888-317-6155 **Submit online at:** www.healthnetfederalservices.com	**Address all grievances to:** Regional Grievance Coordinator Humana Military Healthcare Services, Inc. 8123 Datapoint Drive Suite 400 San Antonio, TX 78229 **For behavioral health care concerns, send your information to:** Grievance Specialist ValueOptions P.O. Box 551188 Jacksonville, FL 32255-1188	**Address all grievances to:** TriWest Healthcare Alliance Corp. ATTN: Customer Relations Dept. P.O. Box 42049 Phoenix, AZ 85080

Regional Fraud and Abuse Reporting Information

Figure 6.4

TRICARE North Region	TRICARE South Region	TRICARE West Region
• **Phone:** 1-800-977-6761 • **Fax:** 1-888-881-3644 • **Online:** www.healthnetfederalservices.com • **Mail:** HNFS Program Integrity P.O. Box 870147 Surfside Beach, SC 29587-9747	• **Phone:** 1-800-333-1620 • **Online:** www.humana-military.com • **Mail:** Humana Military Healthcare Services, Inc. ATTN: Program Integrity 500 W. Main Street, 19th floor Louisville, KY 40202	• **Phone:** 1-888-584-9378 • **Fax:** 1-602-564-2458 • **Online:** www.triwest.com

Acronyms

ADDP	Active Duty Dental Program
ADFM	Active duty family member
ADSM	Active duty service member
BCAC	Beneficiary Counseling and Assistance Coordinator
CAC	Common Access Card
CHCBP	Continued Health Care Benefit Program
DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DoD	Department of Defense
DRG	Diagnosis-related group
DTF	Dental treatment facility
ECHO	TRICARE Extended Care Health Option
EHHC	ECHO Home Health Care
EOB	Explanation of benefits
FY	Fiscal year
MTF	Military treatment facility
OHI	Other health insurance
PHP	Partial hospitalization program
RTC	Residential treatment center
SSN	Social Security number
TAMP	Transitional Assistance Management Program
TAO	TRICARE Area Office
TDP	TRICARE Dental Program
TPR	TRICARE Prime Remote
TRDP	TRICARE Retiree Dental Program
TRIAP	TRICARE Assistance Program
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center

Glossary

Beneficiary Counseling and Assistance Coordinator (BCAC)

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

Catastrophic Cap

The catastrophic cap is the maximum out-of-pocket expenses for which TRICARE beneficiaries are responsible in a given fiscal year (*October 1–September 30*).

Continued Health Care Benefit Program (CHCBP)

CHCBP is a premium-based health care program you may purchase after loss of TRICARE eligibility if you qualify. CHCBP offers temporary transitional health coverage and must be purchased within 60 days after TRICARE eligibility ends.

Cost-share

A cost-share is the percentage or portion of costs that the beneficiary must pay for inpatient or outpatient care.

Debt Collection Assistance Officer (DCAO)

DCAOs are persons located at military treatment facilities and TRICARE Regional Offices to assist you in resolving health care collection-related issues. Contact a DCAO if you received a negative credit rating or were sent to a collection agency due to an issue related to TRICARE services.

Defense Enrollment Eligibility Reporting System (DEERS)

DEERS is a database of uniformed services members (*sponsors*), family members, and others worldwide who are entitled under law to military benefits, including TRICARE. Beneficiaries are required to keep DEERS updated. DEERS is the official record system for TRICARE eligibility.

Explanation of Benefits (EOB)

An EOB is a statement sent to a beneficiary showing that a claim was processed, and it indicates the amount paid to the provider. If denied, an explanation of denial is provided.

Military Treatment Facility (MTF)

An MTF is a medical facility (*e.g., hospital, clinic*) owned and operated by the uniformed services and usually located on or near a military base. Beneficiaries can locate an MTF by visiting **www.tricare.mil/mtf**.

National Guard and Reserve

The National Guard and Reserve includes the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the Coast Guard Reserve.

Negotiated Rate

The negotiated rate is the rate TRICARE network providers and TRICARE participating non-network providers have agreed to accept for covered services.

Network Provider

A TRICARE network provider is a professional or institutional provider who has a contractual relationship with a TRICARE regional contractor to provide care at a contracted rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries and typically administers care to TRICARE Prime and TRICARE Standard beneficiaries using TRICARE Extra (*the preferred provider option*). A network provider accepts the negotiated rate as payment in full for services rendered.

Non-Network Provider

A non-network provider is one who has no contractual relationship with a TRICARE regional contractor but is authorized to provide care to TRICARE beneficiaries. There are

two categories of non-network providers—participating and nonparticipating.

Nonparticipating Non-Network Provider

A nonparticipating non-network provider is a TRICARE-authorized hospital, institutional provider, physician, or other provider that furnishes medical services and supplies to TRICARE beneficiaries but who has not signed a contract and does not agree to accept the TRICARE-allowable charge or file claims for TRICARE beneficiaries.

Other Health Insurance (OHI)

OHI is any non-TRICARE health insurance that is not considered a supplement. This insurance is acquired through an employer, entitlement program, or other source. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, or other programs or plans as identified by the TRICARE Management Activity.

Participate on a Claim

When TRICARE-authorized providers participate on a claim, also known as "accepting assignment," they agree to file the claim for you, accept payment directly from TRICARE, and accept the TRICARE-allowable charge, less any applicable patient cost-share paid by you, as payment in full for services.

Participating Non-Network Provider

A participating non-network provider agrees to file claims for TRICARE beneficiaries, accept payment directly from TRICARE, and accept the TRICARE-allowable charge as payment in full for services delivered. Non-network providers may participate on a claim-by-claim basis. Providers may seek payment of applicable copayments, cost-shares, and deductibles from the beneficiary.

Prime Service Area (PSA)

A PSA is an area around military treatment facilities and in other predetermined areas, as defined by ZIP codes where TRICARE Prime is offered.

Prior Authorization

Prior authorization is the process of reviewing certain medical, surgical, and behavioral health services to ensure medical necessity and appropriateness of care before services are rendered or within 24 hours of an emergency admission. Visit **www.tricare.mil** for a list of services that require prior authorization.

Regional Contractor

A regional contractor is a TRICARE civilian partner who provides health care services and support in the TRICARE regions. Health Net Federal Services, LLC, is the regional contractor for the North Region; Humana Military Healthcare Services, Inc., is the regional contractor for the South Region; and TriWest Healthcare Alliance Corp. is the regional contractor for the West Region.

Transitional Assistance Management Program (TAMP)

TAMP provides transitional health care for certain uniformed services members (*and eligible family members*) who separate from active duty.

TRICARE-Allowable Charge

The TRICARE-allowable charge (*also called allowable charge*) is the maximum amount TRICARE will pay for services.

TRICARE-Authorized Provider

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

TRICARE Supplement

A TRICARE supplement is a health plan you may purchase specifically to supplement your TRICARE Standard and TRICARE Extra coverage. It pays after TRICARE. A TRICARE supplement is not employer-sponsored health insurance.

Appendix

Sample Explanation of Benefits Statements

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

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

How to Read Your TRICARE EOB for the North Region

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

North Region Explanation of Benefits Statement Sample

Figure 9.1

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

(2) Health Net
Federal Services
WWW.HEALTHNETFEDERALSERVICES.COM

TRICARE EXPLANATION OF BENEFITS

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

(3)	Date of Notice:	October 22, 2009
(4)	Sponsor SSN:	***-**-9898
	Sponsor Name:	TRICARE SPONSOR
(5)	Beneficiary Name:	TRICARE BENE

(6) **TRICARE BENE**
5362 ANY STREET
ANYCITY XX 88888-9999

(7) **Partial benefits were payable to:**
PATHOLOGY LABDOE
STE 999
9999 N JERGENS ST
TOLEDO OH 99999

(8) **Claim Number: 999999999-00-00**

Services Provided By/ Date of Services (9)	Services Provided (10)	Amount Billed (11)	TRICARE Approved (12)	APC#	See Remarks (13)
PATHOLOGY LABDOE					
09/02/2009	001 Emergency dept visit (99282)	32.84		11111	1, 2. 3
09/02/2009	001 Repair superficial wound(s) (12002)	161.84	161.84	11111	1, 2
Totals:		194.68	161.84		

Claim Summary (14)

Amount Billed:	194.68
TRICARE Approved:	161.84
Non-covered:	32.84
Paid by Beneficiary:	0.00
Other Insurance:	0.00
Paid to Provider:	161.84
Paid to Beneficiary:	0.00
Check Number:	6990666666

Beneficiary Liability Summary (15)

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

(16)

Benefit Period Summary (17)

Fiscal Year Beginning:
October 01, 2009

	Individual	Family
Deductible:	0.00	0.00
Catastrophic Cap:		0.00

Remarks: (18)

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

2 - YOUR CLAIM HAS BEEN PROCESSED UNDER THE SUPPLEMENTAL HEALTH CARE PROGRAM. IF YOU HAVE QUESTIONS ABOUT THE PROCESSING OF YOUR CLAIM PLEASE CALL PGBA AT 1-877-874-2273. IF YOU WISH TO APPEAL YOUR CLAIM YOU MUST SUBMIT YOUR REQUEST IN WRITING TO YOUR SERVICE POINT OF CONTACT.

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

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

THIS IS NOT A BILL

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

TRICARE North

How to Read Your TRICARE EOB for the South Region

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

South Region Explanation of Benefits Statement Sample

Figure 9.2

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

(2) HUMANA MILITARY
HEALTHCARE SERVICES
★ ★ ★ ★ ★
www.humana-military.com

TRICARE EXPLANATION OF BENEFITS

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

(3) Date of Notice: October 1, 2009
(4) Sponsor SSN: ***-**-6789
(5) Sponsor Name: **NAME OF SPONSOR**
Beneficiary Name: **NAME OF BENEFICIARY**

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

(7) Benefits were payable to:
PROVIDER OF MEDICAL CARE
ADDRESS
CITY STATE ZIP CODE

(8) **Claim Number: 9279X0000-00-00**

Services Provided By/ Date of Services (9)		Services Provided (10)	Amount Billed (11)	TRICARE Approved (12)	See Remarks (13)
PROVIDER OF MEDICAL CARE					
10/01/2009	001	Initial comprehensivc preve (99381)	97.00	85.10	1, 2
10/01/2009	001	Diptheria, tetanus toxoids, (90698)	101.00	78.84	1
10/01/2009	001	Pnuemococcal conjugate vacci (90669)	110.00	95.48	1
Totals:			308.00	259.42	

Claim Summary (14)

Amount Billed:	308.00
TRICARE Approved:	259.42
Non-covered:	259.42
Paid by Beneficiary:	259.42
Other Insurance:	259.42
Paid to Provider:	259.42
Paid to Beneficiary:	0.00
Check Number:	

Beneficiary Liability Summary (15)

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

Benefit Period Summary (16)

Fiscal Year Beginning:
October 01, 2009

	Individual	Family
Deductible:	0.00	0.00
Catastrophic Caps:		9.00

Remarks: (17)

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

2 - VISIT WWW.HUMANA-MILITARY.COM AND WWW.MYTRICARE.COM TO MANAGE YOUR HEALTH CARE ONLINE. FIND A PROVIDER, READ YOUR BENEFITS INFORMATION, CHECK INDIVIDUAL CLAIM AND REFERRAL STATUS, ELIGIBILITY, AND MUCH MORE.

(18) **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.

TRICARE

Page 1 of 1

How to Read Your TRICARE EOB for the West Region

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

West Region Explanation of Benefits Statement Sample *Figure 9.3*

TRICARE West

TRICARE EXPLANATION OF BENEFITS

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

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

(2) Date of Notice	08/14/2009
(3) Sponsor SSN	234567890
(4) Sponsor Name	John B. Nice
(5) Patient Name	John B. Nice
(6) Claim Number	2002212 053 0017930
Check Number	C0001545337
Provider Number	752906887 76550 0001
Provider Name	ABC Valley Clinic

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

THIS IS NOT A BILL.

SERVICES PROVIDED BY (8)	DATE OF SERVICE (9)	AMOUNT BILLED (10)	TRICARE ALLOWED (11)	REMARKS (12)
Michael Smith, MD	03/23/09–03/27/09	$000,000.00	$000,000.00	003
Total		$000,000.00	$000,000.00	

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

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

	Beginning October 1, 2009		Beginning October 1, 2008		Beginning October 1, 2007	
	Limit	Met to Date	Limit	Met to Date	Limit	Met to Date
Individual Deductible	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00
Family Deductible	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00
Catastrophic cap	$0,000.00	$0,000.00	$0,000.00	$0,000.00	$0,000.00	$0,000.00

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

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

(18) TriWest Healthcare Alliance

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Notes

Patient Bill of Rights and Responsibilities

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

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

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

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

You also have the responsibility to:

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

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

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

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

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

www.tricare.mil

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