

## From the Desk of the CMO

Dr. David N. Tornberg  
Chief Medical Officer  
TRICARE Management Activity

Dear TRICARE Beneficiary,

The leaders at TRICARE Management Activity want you to know that our top priority will always be your health. Together, with our civilian health care partners, we want to ensure reliable access to quality health care, superb customer service, and constant support to the readiness of our military members.

As a TRICARE Standard beneficiary, you enjoy a flexible, robust benefit with reliable worldwide access to care, no premiums and the freedom to seek care from almost any provider. In an effort to help you understand the TRICARE program, this newsletter offers information on how to get care, when you need prior authorization, how to file a claim and much more.

Along with this newsletter, TRICARE offers other resources, including the TRICARE Standard Web site at [www.tricare.osd.mil/TRICAREStandard](http://www.tricare.osd.mil/TRICAREStandard).

This edition of *TRICARE Standard Health Matters* will help you understand the Standard benefit and other health-related news. Remember, you are entitled to individual attention and accurate health care information. If you have questions or concerns at any time, rest assured that we are here to help. ■

## Setting the Standard for Health Care

Welcome to the *TRICARE Standard Health Matters* newsletter. TRICARE Management Activity is pleased to present this new, annual publication to our TRICARE Standard beneficiaries.

Look to this newsletter each year to bring you updates about TRICARE Standard, as well as a concise review of the details that will help you make the right decisions about your benefits.

Here's an overview of the information you will find in this edition of *TRICARE Standard Health Matters*:

### Comprehensive Coverage

TRICARE Standard provides comprehensive health care coverage for active duty family members<sup>1</sup>,

retired service members and their families, survivors and eligible former spouses<sup>2</sup>. Essentially, it includes TRICARE-covered services that are considered medically necessary. For specific information about TRICARE-covered benefits and exclusions, see "TRICARE Reference Room: Coverage and Costs" on page 4 or visit the TRICARE Web site at [www.tricare.osd.mil](http://www.tricare.osd.mil).

### Choose Any Provider

TRICARE Standard is a "fee-for-service" plan. This means you can visit any TRICARE-authorized/certified provider for the care you need (see "Understand Your Provider Options" on page 6 for more details). TRICARE Standard

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<sup>1</sup>Active duty family members include family members of National Guard/Reserve members on active duty orders for more than 30 consecutive days.

<sup>2</sup>TRICARE Standard is not available to active duty service members, including National Guard/Reserve members on active duty for more than 30 consecutive days.

## Save a Little Extra with TRICARE Extra

TRICARE Extra is exactly what the name says. Extra ... savings for you.

Your health care benefits are the same with TRICARE Extra as they are with TRICARE Standard. To use TRICARE Extra, all you need to do is select a TRICARE network provider.

Because network providers have agreed to accept a negotiated rate for services, you pay a discounted cost-share—5 percent less than when visiting a non-network provider (see "TRICARE Reference Room: Coverage and Costs" on page 4 for information on Standard/Extra costs). Network providers also will submit your TRICARE claims for you.

You do not have to use one option exclusively over the other. You can receive care under either TRICARE Standard or TRICARE Extra whenever you need care. ■



# Don't Let Your Coverage Lapse

## Keep DEERS Up to Date

The Defense Enrollment Eligibility Reporting System (DEERS) is a database that maintains information about service members, their families and others who are eligible for military benefits. Before rendering services or filling prescriptions, network providers and pharmacies verify your eligibility for TRICARE. If your DEERS records are incorrect or outdated, you may be denied coverage.

Many life events change your TRICARE status and require you to update DEERS, such as:

- Changes in status from active duty to retired
- Permanent change of station
- Change of address
- Changes in marital status
- Newborns or adopted children
- Student status for children age 21 and over\*
- Medicare entitlement, whether due to age, disability or end-stage renal disease

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*\*TRICARE covers eligible children until age 21. For TRICARE coverage beyond the age of 21, the child must be enrolled full-time at an accredited institution of higher education, and the sponsor must provide more than 50 percent of the student's financial support. TRICARE benefits end when the child reaches age 23 or when full-time student status ends, whichever comes first. If a child is incapacitated prior to age 21 or while in school, ages 21-23, TRICARE coverage may continue as long as the child is incapacitated, not married and is incapable of self-support.*

When you notify DEERS of status changes, you often will need to provide important documentation, such as marriage, birth and death certificates.

### Updating DEERS

It is the sponsor's responsibility to ensure that family members are registered correctly in DEERS and that all status information is kept current at all times. To notify DEERS of status changes, you can do so in the following ways:

- Visit your military personnel office or uniformed services ID card issuing facility, which can be located online at [www.dmdc.osd.mil/rsl](http://www.dmdc.osd.mil/rsl).
- Fax DEERS at 1-831-655-8317.
- Mail changes to Defense Manpower Data Center Support Office, Attention: COA, 400 Gigling Road, Seaside, CA 93955-6771.

For changes in phone number, address or e-mail, all beneficiaries can use the methods listed above or:

- Visit [www.tricare.osd.mil/DEERSAddress](http://www.tricare.osd.mil/DEERSAddress).
- Call 1-800-538-9552, Monday-Friday, 6 a.m. to 3:30 p.m. PST, except Federal holidays.

Once you have updated DEERS, your regional contractor will be notified automatically of any changes and will update your file accordingly. ■

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## Setting the Standard for Health Care

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offers the greatest flexibility in choosing a provider since you don't need a referral or an initial consultation. You can just make the appointment for most types of services. However, you may need prior authorization for certain types of care (see "No Referrals Required" on page 7 for more about referral and prior authorization requirements).

### Personal Responsibility

Having the flexibility to see any TRICARE-authorize/certified provider comes with greater responsibility on your part. Essentially you are managing your own health care because, while you may have a family doctor, you are

not assigned to a specific primary care physician.

- You make the appointments.
- You arrange for specialty care (some services may require prior authorization).
- On occasion when a provider does not file claims for TRICARE Standard beneficiaries, you may need to pay the provider first and file a claim with TRICARE for reimbursement (see "TRICARE Standard Claims Filing" on page 8 for specifics).

### Out-of-Pocket Costs

There are no annual enrollment fees or monthly premiums for TRICARE Standard. But you are responsible for

specific cost-shares for care after your annual deductible is met. See "TRICARE Reference Room" on page 4 for additional information about your out-of-pocket costs.

### Answers Close at Hand

When you're confused or have a concern about your benefits, help is just a phone call, Web site or in-person visit away. From TRICARE Service Centers to Beneficiary Counseling and Assistance Coordinators to regional contractor Web sites and customer service lines, you always have multiple resources at your disposal (see "We're Here to Help" on page 3 for details). ■

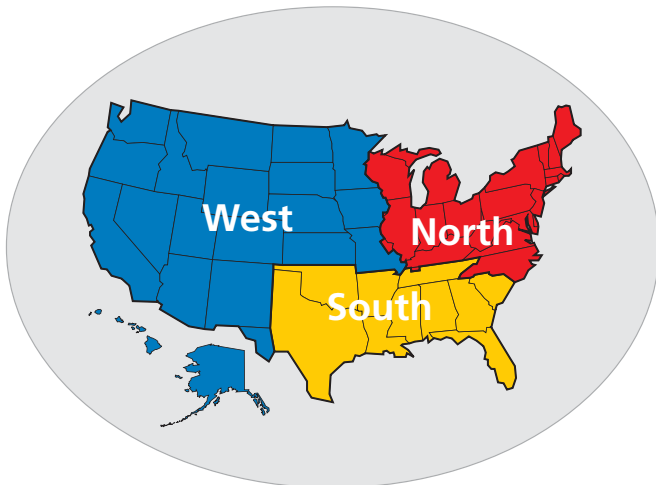
# We're Here to Help

As a TRICARE beneficiary, you are entitled to prompt, accurate answers to your benefits questions. TRICARE has established an easy-to-reach support system to help you, whether you call, use the Internet or visit with customer service personnel. The following information offers a quick-reference guide to that support system.

## Regional Contractors

Regional contractors are your primary point of contact for obtaining civilian health care under the TRICARE Standard and TRICARE Extra options. They offer comprehensive Web sites and customer service call centers to assist you with claims, authorizations, benefits interpretation, provider selection and more.

The table below provides each regional contractor's contact information.



## TRICARE Service Centers

TRICARE Service Centers (TSCs) are staffed with customer service representatives to assist you. You can contact a TSC representative about any of the following issues:

- TRICARE benefits interpretation
- Claims status
- Claims resolution and assistance
- Eligibility status
- A list of TRICARE network providers and pharmacies
- Appeals and fraud information

TSCs are located throughout the country within military treatment facilities (MTFs), on military installations or in the community. You can locate a nearby TSC by using the TSC locator on the TRICARE Web site at [www.tricare.osd.mil/tricare-servicecenters](http://www.tricare.osd.mil/tricare-servicecenters).

## BCACs

Beneficiary Counseling and Assistance Coordinators (BCACs) can help you with TRICARE and Military Health System inquiries and concerns and can advise you on obtaining health care. BCACs are located at your local MTF and at the TRICARE Regional Offices.

BCACs participate in retiree events and frequently provide TRICARE seminars to those new to TRICARE and to beneficiary organizations. To identify and locate a BCAC near you, visit the BCAC directory online at [www.tricare.osd.mil/bcacdcao](http://www.tricare.osd.mil/bcacdcao).

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TRICARE North Region	TRICARE South Region	TRICARE West Region
<b>Contractor:</b> Health Net Federal Services, Inc.	<b>Contractor:</b> Humana Military Healthcare Services, Inc.	<b>Contractor:</b> TriWest Healthcare Alliance
<b>Telephone:</b> 1-877-TRICARE (1-877-874-2273)	<b>Telephone:</b> 1-800-444-5445	<b>Telephone:</b> 1-888-TRIWEST (1-888-874-9378)
<b>Web site:</b> <a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a>	<b>Web site:</b> <a href="http://www.humana-military.com">www.humana-military.com</a>	<b>Web site:</b> <a href="http://www.triwest.com">www.triwest.com</a>
<b>Region locations:</b> 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)	<b>Region locations:</b> Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee (excluding the Ft. Campbell area), and Texas (excluding the El Paso area)	<b>Region locations:</b> Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding the Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner including El Paso), Utah, Washington, and Wyoming

# TRICARE Reference Room: Coverage and Costs

**H**ow well do you know the full range of your health care coverage? Do you know what to expect when you need an outpatient surgical procedure, a mammogram or even maternity care?

The following information is meant to serve as a summarized guide to your benefits as a TRICARE Standard beneficiary. For more details about TRICARE Standard, visit [www.tricare.osd.mil/tricarestandard](http://www.tricare.osd.mil/tricarestandard).

## What's Covered, What's Not?

In general, TRICARE covers most outpatient and inpatient care that is considered medically necessary and proven. Many preventive services are also covered. (See the chart on page 5 for listings of covered outpatient, inpatient and preventive services.)

Like any other health care plan, TRICARE excludes services deemed not proven or not medically necessary. (See sidebar, "List of Excluded Services.")

## Who Can I See?

As a TRICARE Standard beneficiary, you may seek covered services from any provider who is TRICARE-authorized. It is important that you always verify in advance that a provider is TRICARE-authorized, or you may be required to pay for the services yourself. To check a provider's authorized status, visit [www.tricare.osd.mil/standardprovider](http://www.tricare.osd.mil/standardprovider).

If you choose a TRICARE-authorized provider who also belongs to the TRICARE network of providers for your region, your cost-shares will be lower because you will be using the TRICARE Extra program option. To check a provider's network status, visit [www.tricare.osd.mil/providerdirectory](http://www.tricare.osd.mil/providerdirectory).

Read "Understand Your Provider Options" on page 6 for a more detailed explanation of the types of providers you can see.

## How Much Will It Cost?

Before TRICARE will cost-share for covered services, you must meet an annual deductible: \$50 per person or \$100 per family for active duty family members E-4 and below; \$150 per person or \$300 per family for E-5 and above, survivors, retirees and family members.

The TRICARE Standard cost-share (after the deductible is satisfied) for most outpatient services is as follows:

- 20 percent for active duty family members
- 25 percent for retirees, their families, survivors and others

When using a "nonparticipating" provider, charges may exceed the TRICARE maximum allowable charge. You are responsible for charges up to 15 percent above the TRICARE maximum allowable charge.

The TRICARE Extra cost-share (after the deductible is satisfied) for most outpatient services is as follows:

- 15 percent for active duty families
- 20 percent for retirees, their families, survivors and others

## What's the Most I Will Pay?

TRICARE places a catastrophic cap on beneficiaries' out-of-pocket expenses. This means that there is a limit on the amount beneficiaries pay for TRICARE-covered benefits each fiscal year.

The annual cap for active duty family member TRICARE Standard beneficiaries is \$1,000. For all other beneficiaries using TRICARE Standard, the annual cap is \$3,000.

Your catastrophic cap is calculated by adding together your out-of-pocket expenses for annual deductibles, cost-shares, inpatient care, outpatient care and prescription medication costs. It is important for you to keep your explanation of benefits (EOB) statements as a record of your medical expenses to track your catastrophic cap.

## Where Can I Get More Information?

In addition to visiting the TRICARE Web site for answers to your medical coverage questions, you can utilize the Web site and customer service call center provided by your regional contractor (see page 3).

TRICARE Service Centers and Beneficiary Counseling and Assistance Coordinators also offer the help you need (see "We're Here to Help" on page 3 for details). ■

## List of Excluded Services

- Acupuncture
- Artificial insemination
- Autopsy services or post-mortem examinations
- Birth control (non-prescription)
- Camps (e.g., weight loss)
- Care/supplies furnished/prescribed by an immediate family member
- Care that is not medically or psychologically necessary
- Diagnostic admissions
- Experimental or unproven procedures
- Foot care (routine)
- Laser/LASIK/Refractive corneal surgery
- Learning disabilities
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopathy
- Psychiatric treatment for sexual dysfunction
- Sex changes or sexual inadequacy treatment
- Telephone counseling consultation

This list is not all-inclusive. Call your regional contractor if you have questions about covered services.

# TRICARE Reference Room: Coverage and Costs

Covered Services* for TRICARE Standard and TRICARE Extra		
Outpatient Services	Inpatient Services	Clinical Preventive Services
<p><b>Individual Provider Services</b> Office visits; outpatient office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services, e.g., physical therapy, speech pathology services, and occupational therapy; medical supplies used within the office, including casts, dressings, and splints</p>	<p><b>Hospitalization</b> Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and surgical services; meals, including special diets; drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; X-rays and other radiology services; necessary medical supplies and appliances; and blood and blood products. Unlimited services, as medically necessary.</p>	<p>TRICARE covers a wide range of clinical preventive services. Some of these services are only covered when included as part of an office visit. Check with your regional contractor for details. They include:</p> <ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Patient and parent education or counseling services</li> <li>• Infectious disease screening</li> <li>• Cardiovascular screenings</li> <li>• Hearing examinations, evaluations and screenings</li> <li>• Well-Child care (see “Well-Child Services”)</li> <li>• A variety of cancer screenings</li> </ul> <p><i>Please Note: Annual sports physicals are <b>not</b> a covered benefit under TRICARE.</i></p> <p>TRICARE Standard and TRICARE Extra adult beneficiaries are not covered for clinical preventive eye examinations, but their children are covered for them under the Well-Child benefit (see “Well-Child Services”). However, active duty family members using TRICARE Standard and TRICARE Extra are entitled to an annual routine eye exam.</p>
<p><b>Laboratory and X-ray Services</b></p>	<p><b>Maternity</b> TRICARE helps pay for maternity care during pregnancy, delivery of the baby and up to six weeks after the baby is born. Hospital and professional services (prenatal, postnatal) included. Unlimited services, as medically necessary.</p>	
<p><b>Ancillary Services</b> Certain diagnostic radiology and ultrasound; diagnostic nuclear medicine; pathology and laboratory services; and cardiovascular studies</p>	<p><b>Skilled Nursing Facility (SNF) Care</b> Semiprivate room; regular nursing services; meals, including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances. Unlimited services, as medically necessary.</p>	
<p><b>Emergency Services</b> Emergency care obtained on an outpatient basis, both network and non-network, in or out of the region</p>	<p><b>Inpatient Behavioral Health</b></p>	
<p><b>Ambulance Services</b> When medically necessary and when needed for a medical condition that is covered by TRICARE</p>	<p><b>Hospitalization for Mental Illness</b> Up to 30 days per fiscal year for adults age 19 and over; up to 45 days per fiscal year for age 18 and under</p>	
<p><b>Durable Medical Equipment (DME), Prosthetic Devices and Medical Supplies (Prescribed by a Physician)</b> For DME, prosthetic devices and medical supplies, care is subject to TRICARE policy after an office or home health visit when medically necessary and a covered benefit.</p>	<p>Residential treatment centers: Up to 150 days in a TRICARE-authorized/certified residential treatment center for children and adolescents. Services must be preauthorized.</p>	
<p><b>Eye Examinations</b> One routine examination per year for active duty family members <i>Retirees not covered</i></p>	<p><b>Inpatient Substance Use Treatment</b></p>	
<p><b>Immunizations for Required Overseas Travel</b> Immunizations are required for ADFMs whose sponsors have permanent change-of-station orders to overseas locations. <i>Retirees not covered</i></p>	<p><b>Detoxification:</b> Up to seven days for detoxification per year</p> <p><b>Rehabilitation:</b> Up to 21 days for rehabilitation per 365 days. Days may be a combination of inpatient care and partial hospitalization. Maximum of one rehabilitation program per year and three per lifetime. Must be preauthorized and must be provided in a TRICARE-authorized/certified substance abuse disorder rehabilitation facility whether freestanding or hospital-based. Detoxification and rehabilitation days count toward the benefit limit for mental health benefits.</p>	
<p><b>Ambulatory Surgery (Same Day)</b> When surgery is conducted at a hospital-based or freestanding ambulatory surgical center that is TRICARE-authorized/certified</p>	<p><b>Partial Hospitalization for Substance Abuse</b></p>	
<p><b>Outpatient Behavioral Health Services</b> You can obtain the first eight behavioral health outpatient visits per year without authorization. TRICARE covers a maximum of one hour of outpatient therapy up to two times each week. For outpatient substance abuse, benefits are limited to 60 group therapy sessions and 15 family therapy sessions per benefit period.</p>	<p><b>Rehabilitation:</b> Up to 21 days for rehabilitation per 365 days. Days may be a combination of inpatient care and partial hospitalization. Maximum of one rehabilitation program per year and three per lifetime.</p>	
		<p><b>Well-Child Services</b></p> <p>Well-Child Care is for children from birth to 6 years old and includes the following services:</p> <ul style="list-style-type: none"> <li>• Routine newborn care</li> <li>• Comprehensive health promotion and disease prevention exams</li> <li>• Vision and hearing screenings</li> <li>• Height, weight and head circumference measurements</li> <li>• Routine immunizations</li> <li>• Developmental and behavioral appraisal in accordance with the American Academy of Pediatrics (AAP) and CDC guidelines</li> </ul> <p><i>*The listing of covered services in this chart is not all-inclusive.</i></p>

## Understand Your Provider Options

**T**RICARE Standard beneficiaries have the flexibility to seek care from any TRICARE network or TRICARE-authorized non-network provider. To help you understand the types of providers you may choose, here are some descriptions.

### Network Providers

Each of the three TRICARE regions—North, South and West—offers a civilian provider network. The TRICARE provider network includes civilian doctors, hospitals and other health care providers who meet special credentialing standards.

If you choose to obtain care from a network provider, you will be using the TRICARE Extra option, which offers discounted cost-shares (see “TRICARE Reference Room: Coverage and Costs” on page 4 for more information). Additionally, network providers are required to file claims on your behalf.

### Non-network Providers

A non-network provider is one who has not established a TRICARE network contractual relationship with the regional contractor in your TRICARE region, but who is authorized to provide care to TRICARE beneficiaries.

There are two types of non-network providers: participating and nonparticipating.

- *Participating non-network providers* agree to accept TRICARE reimbursement rates as payment in full for services, and they will submit claims to TRICARE for you. TRICARE pays participating providers; you are responsible for applicable cost-shares.
- *Nonparticipating non-network providers* do not agree to accept TRICARE reimbursement rates as payment in full for services. Nonparticipating providers may or may not file your claims. You'll most likely be required to pay the provider first and then file your own claim (DD Form 2642) with TRICARE for

reimbursement. Additionally, nonparticipating providers may charge you up to 15 percent above the TRICARE allowable charge. This amount cannot be reimbursed when you file your claims, nor does it count towards your TRICARE deductible.

As you can see, you'll save money and time by visiting a non-network provider who participates with TRICARE.

### Non-authorized Providers

Non-authorized providers are not certified by TRICARE to render services to TRICARE beneficiaries. **Please note:** If you receive care from a non-authorized provider, you will be responsible for the entire bill for the health care services you receive.

If your provider is not TRICARE-authorized/certified, he or she may contact the regional contractor in your TRICARE region to become a TRICARE-authorized/certified provider, either as a non-network or network provider. Some providers will never become authorized as a TRICARE provider as they are excluded from doing so (e.g., chiropractors).

### Online Provider Directories

To check a provider's TRICARE-authorized/certified status, visit the TRICARE Standard Directory at [www.tricare.osd.mil/standardprovider](http://www.tricare.osd.mil/standardprovider).

To check a provider's TRICARE network status, visit your region's provider directory via [www.tricare.osd.mil/providerdirectory](http://www.tricare.osd.mil/providerdirectory).

You can also call your regional contractor for assistance in locating a provider (see page 3 for contact information).

Regardless of which TRICARE-authorized/certified provider you visit, you must also make sure that the services you seek are covered by TRICARE. Otherwise, you could be responsible for the entire bill. See “TRICARE Reference Room” on page 4. ■

## We're Here to Help

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### Debt Collection Assistance Officers

Debt Collection Assistance Officers (DCAOs) are also located at the TRICARE Regional office and at each MTF to assist you in resolving health care collection-related issues. Contact a DCAO if you have received a negative credit rating or have been sent to a collection agency due to TRICARE services.

To find a DCAO near you, visit the DCAO directory online at [www.tricare.osd.mil/bcaedcao](http://www.tricare.osd.mil/bcaedcao).

### [www.tricare.osd.mil](http://www.tricare.osd.mil)

You can consult TRICARE's online resource, [www.tricare.osd.mil](http://www.tricare.osd.mil), for the most up-to-date information about TRICARE. The TRICARE Web site allows you to view benefits and cost information, locate an MTF or TSC, download TRICARE forms and brochures, and much more.

Remember, help with your TRICARE Standard benefits is always just a call, click or visit away. ■

# No Referrals Required

## But Know the Rules on Prior Authorizations

**A**s a TRICARE Standard beneficiary, you can see almost any doctor or specialist you want—no referrals required. Simply call the provider to make an appointment (remember to check the provider’s TRICARE-authorized/certified status when you call—see “Understand Your Provider Options” on page 6), and present your uniformed services ID card when you arrive.

For many, this freedom to self-refer is the key reason for using TRICARE Standard and TRICARE Extra.

The ability to manage your own care comes with a few responsibilities, including knowing the rules for obtaining prior authorization from your regional contractor for certain outpatient and inpatient services.

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. In most cases, you should call your regional contractor for authorization assistance prior to seeking care.

The chart below offers regional contractor contact information and the more commonly requested services that require prior authorization in each region. **Please note:** The list is not all-inclusive.

### Prior Authorizations and OHI

If you have other health insurance (OHI), you should follow the referral and authorization rules of your plan. You are not required to obtain prior authorization from your TRICARE regional contractor for most covered services, except those services listed in the chart below. See “Coordinating TRICARE with Other Health Insurance” on page 9 for more information.

### Appealing Denials

Occasionally, prior authorization requests are denied. Some reasons for denials include the following:

- It is determined that the requested service could be provided at another level of care (at a doctor’s office rather than a hospital, for example).
- It is determined that the service is not medically necessary.
- It is determined that the service is not a TRICARE benefit.

If your prior authorization request has been denied, you have the right to appeal in writing to the following addresses:

#### North Region

Health Net Federal Services, Inc.  
c/o PGBA, LLC/TRICARE  
Authorization Appeals  
P.O. Box 870142  
Surfside Beach, SC 29587-9742

#### South Region—Medical

Humana Military Healthcare Services  
Attn: Clinical Appeals  
P.O. Box 740044  
Louisville, KY 40201-9973

#### South Region—Behavioral Health

ValueOptions Behavioral Health  
Attn: Appeals and Reconsideration  
Department  
P.O. Box 551138  
Jacksonville, FL 32255-1138

#### West Region

TriWest Healthcare Alliance  
Attn: Reconsideration Unit  
P.O. Box 42049  
Phoenix, AZ 85080

If you need help with an appeal or have additional questions about prior authorizations or benefit coverage, call your regional contractor. ■

### Services that Require Prior Authorization

TRICARE North Region 1-877-TRICARE	TRICARE South Region 1-800-444-5445	TRICARE West Region 1-888-TRIWEST
<ul style="list-style-type: none"> <li>• Adjunctive dental care</li> <li>• Extended Care Health Option</li> <li>• Home health services</li> <li>• Hospice care</li> <li>• Inpatient behavioral health admissions (including substance abuse)</li> <li>• Outpatient behavioral health care beyond the eighth visit</li> <li>• Psychoanalysis</li> <li>• Transplants (solid organ and stem cell)</li> <li>• Durable medical equipment</li> <li>• Obstetrical care</li> <li>• Hysterectomy</li> </ul>	<ul style="list-style-type: none"> <li>• Adjunctive dental care</li> <li>• Extended Care Health Option</li> <li>• Home health services</li> <li>• Hospice care</li> <li>• Inpatient behavioral health admissions (including substance abuse)</li> <li>• Outpatient behavioral health care beyond the eighth visit</li> <li>• Psychoanalysis</li> <li>• Transplants (solid organ and stem cell)</li> <li>• Blepharoplasty</li> <li>• Hysterectomy</li> <li>• Mammoplasty</li> <li>• Septoplasty</li> <li>• Speech therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Adjunctive dental care</li> <li>• Extended Care Health Option</li> <li>• Home health services</li> <li>• Hospice care</li> <li>• Inpatient behavioral health admissions (including substance abuse)</li> <li>• Outpatient behavioral health care beyond the eighth visit</li> <li>• Psychoanalysis</li> <li>• Transplants (solid organ and stem cell)</li> <li>• MRI or MRA</li> <li>• PET/SPECT/bone scans</li> <li>• Occupational, physical, speech therapy</li> <li>• Durable medical equipment</li> <li>• Hearing aids</li> <li>• Clinical trials</li> </ul>

# TRICARE Standard Claims Filing

## File Properly to Maximize Your Benefits

**T**RICARE Standard beneficiaries who use non-network nonparticipating providers usually have to file their own claims. You may even be required to pre-pay for services and receive reimbursement once your TRICARE claim is processed. To ensure timely payment, follow these simple steps.

**First**, regularly update your information in the Defense Enrollment Eligibility Reporting System (DEERS). See “Don’t Let Your Coverage Lapse” on page 2 for details.

**Next**, use the DD Form 2642 claim form, available by calling your regional contractor, online at [www.tricare.osd.mil/claims](http://www.tricare.osd.mil/claims), as well as at any military treatment facility or TRICARE Service Center. Attach a **readable** copy of the provider’s bill to the claim form, making sure it contains the following:

1. Provider’s name/address (If more than one provider’s name is on the bill, circle the name of the person who treated you.)
2. Date and place of each service
3. Description of each service or supply furnished
4. Charge for each service
5. Diagnosis (If the diagnosis is not on the bill, make sure to complete block 8a on the DD Form 2642.)

Make sure you complete all 12 blocks of the form correctly, including the sponsor’s Social Security number, and sign it.

**Submit** claims within one year at the latest to your regional contractor’s claims processor. If receiving care while traveling, file TRICARE claims based on where you reside, not where you received care.

### NORTH

Health Net Federal Services, Inc.  
c/o PGBA, LLC TRICARE  
P.O. Box 870140  
Surfside Beach, SC 29587-9740

### SOUTH

TRICARE South Region  
Claims Department  
P.O. Box 7031  
Camden, SC 29020-7031

### WEST

West Region Claims  
P.O. Box 77028  
Madison, WI 53707-7028

For more information about filing medical claims with TRICARE, contact your regional contractor or visit [www.tricare.osd.mil/claims](http://www.tricare.osd.mil/claims). ■

## How to File Prescription Drug Claims

TRICARE beneficiaries who use a retail pharmacy that is not part of the TRICARE Retail Pharmacy (TRRx) network usually must pay 100 percent of the cost of the prescription up front and file a DD Form 2642 claim form with Express Scripts, Inc., for reimbursement.

Before reimbursement is granted for non-network pharmacy claims, you must meet an annual TRICARE deductible. Once the deductible is met, you will pay a cost-share of \$9 or 20 percent, whichever is greater, for each formulary generic or formulary brand-name prescription, or you will pay 20 percent of the total cost or \$22, whichever is greater, for each non-formulary prescription.

Prescription claims require the following information for each drug:

- Name of the patient
- Name of drug, strength, date filled, number of 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

Mail claims to:

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

Claims must be filed within one year of the date of service, but it is best not to wait. File your claims as soon as possible after you pay for your prescription.

To avoid needing to file a claim and to lower your required cost-share, visit a TRICARE network pharmacy or use the TRICARE Mail Order Pharmacy (TMOP) program. Read “TRICARE Pharmacy Benefit: So Many Affordable Choices” on page 10 for more information about these other options for filling drug prescriptions.

TRICARE Standard beneficiaries with other health insurance (OHI) prescription drug coverage also may be required to file a claim with Express Scripts for reimbursement. See “Coordinating TRICARE with Other Health Insurance” on page 9 for details. ■

# Coordinating TRICARE with Other Health Insurance

**D**o you have other health insurance (OHI)? TRICARE Standard beneficiaries with OHI can follow these basic guidelines to help ensure claims are paid correctly and without hassle.

1. Find out which plan pays first. Your OHI is required to pay before TRICARE makes a payment. If you are entitled to a public program, be aware that TRICARE pays second to Medicare, but pays primary to Medicaid, TRICARE supplements, the Indian Health Service and other programs/plans as identified by TRICARE Management Activity.
2. When you have OHI, follow your plan's guidelines for referrals and prior authorizations. For TRICARE, it also is critical to obtain prior authorization for certain services (see "No Referrals Required" on page 7 for a list) or your claims may be denied.  
  
If your OHI denies your claim because you did not follow the plan's rules, TRICARE will not make a primary payment and may not make a secondary payment. For TRICARE to make a secondary payment in such cases, you must obtain a statement from the OHI indicating the amount it would have paid had requirements been met.
3. If your OHI is a health maintenance organization (HMO), make sure your provider is an authorized provider for both your OHI and TRICARE. Otherwise, you may be required to pay out of pocket for the care.

## Don't Toss the EOB Statements

The TRICARE explanation of benefits (EOB) statement provides a record of your medical care and TRICARE payments. You will receive an EOB following every health care visit when you are responsible for a portion of the visit's costs.

The TRICARE EOB statement—which is not a bill—tells you which processes to follow if you are not satisfied with the TRICARE payment, and it serves as documentation for a possible income tax deduction.

EOB statements also are critical to coordinating your TRICARE and OHI claims.

### When TRICARE Pays Second

Following a health care visit, your provider submits a claim to your OHI plan first. The OHI pays its benefits as the first payer and then sends you and the provider an EOB statement indicating the amount paid.

Next, your provider should send a claim form (CMS 1500) or you should send a claim form (DD Form 2642) with information from the primary insurer's EOB statement to TRICARE for secondary payment (see "TRICARE Standard

Claims Filing" on page 8 for details). TRICARE does not always pay the beneficiary's copayment or balance remaining after the OHI payment. Refer to the TRICARE Web site at [www.tricare.osd.mil](http://www.tricare.osd.mil) for details.

### When TRICARE Pays First

Besides serving as primary payer to Medicaid, TRICARE supplements, the Indian Health Service and other TMA-identified programs, TRICARE pays first when your OHI benefits have been exhausted or when a service is not covered under your OHI but is covered under TRICARE. However, you must first submit your claim to your OHI for a denial, which must then be attached to the claim submitted to TRICARE.

If the service is not covered under the OHI, you may submit other creditable documentation showing the noncoverage. In these cases, you or your provider should send a claim form directly to TRICARE for payment (see "TRICARE Standard Claims Filing" on page 8 for details).

## Prescription Drug Claims and OHI

If you have prescription drug coverage from another plan, you must use that policy first when filling prescriptions at a retail pharmacy. You may seek full or partial reimbursement from TRICARE for out-of-pocket costs by mailing a DD Form 2642 pharmacy claim to:

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

Claims must be filed within one year of the date of service, but it is best not to wait. File your claims as soon as possible after you pay for your prescription.

To receive maximum coverage from TRICARE, you should fill prescriptions either at a military treatment facility pharmacy or at a pharmacy in the TRICARE Retail Pharmacy (TRRx) network. To find a TRICARE retail pharmacy or for more information about filing pharmacy claims, visit [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE) or call 1-866-DoD-TRRx (1-866-363-8779).

TRICARE Standard beneficiaries with OHI prescription drug coverage may not use the TRICARE Mail Order Pharmacy (TMOP) program unless the medication is not covered under the other plan, or unless the dollar limit of coverage under the other plan has been exceeded.

For more information about coordinating TRICARE Standard and OHI, visit [www.tricare.osd.mil/TRICAREStandard](http://www.tricare.osd.mil/TRICAREStandard). ■

# TRICARE Pharmacy Benefit

## So Many Affordable Choices

As a TRICARE beneficiary, you have two nationwide pharmacy programs at your fingertips—the TRICARE Mail Order Pharmacy (TMOP) program and the TRICARE Retail Pharmacy (TRRx) program.

With TMOP, you can fill up to a 90-day supply of most medications and have it delivered right to your mailbox. With the TRRx program, you can fill up to a 30-day supply of most medications at any of the more than 54,000 retail pharmacies in the TRICARE network.

To use TMOP, simply complete a registration form, available online at [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE), and then mail your written prescription and copayment to Express Scripts (the TRICARE contractor for both the TMOP and TRRx programs). Within 10-14 days, the medications will be sent directly to you. For more information, call 1-866-DoD-TMOP (1-866-363-8667).

Because the TRRx network spans across the United States, Puerto Rico, the U.S. Virgin Islands and Guam, finding a pharmacy is easy. Visit the pharmacy locator online at [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE) or call 1-866-DoD-TRRx (1-866-363-8779) to find a TRICARE network pharmacy near you.

TRICARE beneficiaries also have the option to fill prescriptions at any military treatment facility (MTF) pharmacy free of charge, as long as the medication is on the MTF's local formulary.

You may choose to fill prescriptions at non-network pharmacies, as well, but this is not recommended because the cost-share is higher and you'll have to file a claim for reimbursement.

No matter where you choose to fill your prescription, always remember to check the label on your medication prior to taking it to verify that you've been given the correct drug.

### Three Drug Tiers

Your pharmaceutical copayment is based on where you choose to have your prescription filled and whether the drug is classified as formulary generic (Tier 1), formulary brand name (Tier 2) or non-formulary (Tier 3).

#### Formulary Generic (Tier 1)

The Department of Defense (DoD) has a long-standing generic drug policy that requires prescriptions be filled with the generic product, if one is available, at the lower generic copayment.

Generic medications work the same as their brand-name counterparts in dosage, strength, performance and use. They must meet the same Food and Drug Administration quality and safety standards.

#### Formulary Brand Name (Tier 2)

If your doctor prescribes a formulary brand-name drug rather than its generic equivalent, he or she must establish "medical necessity" with Express Scripts before you can fill the prescription. Otherwise you may be responsible for the entire cost of the medication.

Medical necessity waivers are approved for one or more of the following reasons:

- The patient must experience, or would be likely to experience, significant adverse effects from the generic.

- The generic has resulted in, or is likely to result in, therapeutic failure.
- The patient has previously responded to the brand name, and changing to the generic would incur clinical risk.

Upon approval, Express Scripts will send you a "letter of medical necessity," which you must present with your prescription.

#### Non-formulary (Tier 3)

In 2004, the DoD established a Uniform Formulary process that created a new third-tier cost-share for medications that are designated "non-formulary."

Certain drugs, which are not as clinically effective or cost-effective relative to other drugs within the same therapeutic class, are added to a non-formulary list.

TRICARE beneficiaries can still get these non-formulary drugs but at a higher copayment. If your doctor establishes medical necessity for a non-formulary drug, then you may qualify to pay the formulary copayment instead.

Different criteria must be met for non-formulary drugs. For more information visit [www.tricare.osd.mil/pharmacy](http://www.tricare.osd.mil/pharmacy).

For the most updated non-formulary list or for more information about the Uniform Formulary process, you can access the Formulary Search Tool at [www.tricareformulary.org](http://www.tricareformulary.org). ■

TRICARE Pharmacy Cost Comparison			
Place of Service	Formulary Generic	Formulary Brand Name	Non-formulary
MTF Pharmacy	\$0	\$0	N/A
TMOP (up to a 90-day supply)	\$3	\$9	\$22
TRRx (up to a 30-day supply)	\$3	\$9	\$22
Non-network Pharmacy (up to a 30-day supply)	20% of total cost or \$9, whichever is greater, after deductible* has been met		20% of the total cost or \$22, whichever is greater, after deductible* has been met

\* E1-E4 ADFMs: \$50 per person/\$100 per family; all others: \$150 per person/\$300 per family

## Becoming Eligible for Medicare? Learn about TFL

**W**hen you become eligible for Medicare benefits, you also become eligible for TRICARE For Life (TFL) benefits. TFL is TRICARE's Medicare-wraparound coverage—meaning that for Medicare and TRICARE-covered services, Medicare pays first, and TRICARE pays second, covering your actual out-of-pocket costs.

If you are entitled to Medicare Part A due to age, disability or end-stage renal disease, you must also purchase Medicare Part B to continue your TRICARE coverage. (Exception: Active duty family members are not required to purchase Part B until their sponsor retires from active service.)

If you currently have only Medicare Part A, you may enroll in Medicare Part B during the General Enrollment Period (GEP), which runs from Jan. 1 to March 31 each year. If you enroll in Part B during the GEP, coverage begins on July 1 of the year you enroll. For more information about enrolling in Medicare Part B:

- Call 1-800-772-1213 (TTY/TDD: 1-800-325-0778 for the hearing impaired)
- Visit SSA online at [www.ssa.gov](http://www.ssa.gov)

### Updating DEERS Triggers TFL Eligibility

Becoming Medicare eligible is a status-changing event that requires you to update your records in the Defense Enrollment Eligibility Reporting System (DEERS) database. Doing so will trigger your eligibility for TFL.

You can update your DEERS information in several ways: phone, fax, mail or Internet (see the article, "Don't Let Your Coverage Lapse: Keep DEERS Up to Date," on page 2).

### What TFL Covers

Here's how TRICARE and Medicare work together:

- For services covered by both Medicare and TRICARE, Medicare pays first and TRICARE pays second.
- For services covered by TRICARE but not Medicare, Medicare pays nothing, TRICARE pays its portion and you are responsible for the applicable TRICARE deductible and cost-shares.
- For services covered by Medicare but not TRICARE, Medicare is the first payer, TRICARE pays nothing and you are responsible for the Medicare deductible and cost-shares.
- For services not covered by Medicare or TRICARE, you are responsible for the entire bill.

### Accessing Care

You may visit any Medicare-authorized provider who accepts Medicare. Check with your regional contractor to

see if your provider is also TRICARE-authorized/certified or visit the TRICARE provider directory at [www.tricare.osd.mil/ProviderDirectory](http://www.tricare.osd.mil/ProviderDirectory).

### Claims and Customer Service

Once you transition to TFL, Wisconsin Physicians Service-TRICARE For Life (WPS-TFL) becomes your new point of contact for assistance.

Your provider will file claims with Medicare. Medicare will pay its portion and then forward the claim directly to WPS-TFL for secondary payment. Then WPS-TFL will reimburse the provider.

If you also have other health insurance (OHI), Medicare pays first and forwards the claim to the OHI company, which pays second. In these instances, you will need to file a paper claim (DD Form 2642, available online at [www.tricare.osd.mil/claims](http://www.tricare.osd.mil/claims)) with WPS-TFL (P.O. Box 7890, Madison, WI 53707-7890).

### TFL Overseas

If you are planning to live overseas in an area other than a U.S. Territory, you will still be eligible for TFL when you become Medicare-eligible. But since Medicare does not operate overseas, your TFL coverage functions the same as TRICARE Standard benefits, i.e., TRICARE is always primary payer. Overseas TFL beneficiaries are still required to maintain eligibility for Medicare and purchase Part B coverage.

If you have additional questions about TFL, contact WPS at 1-866-773-0404 (TDD: 1-866-773-0405) or visit the WPS Web site at [www.tricare4u.com](http://www.tricare4u.com) or [www.tricare.osd.mil/tfl](http://www.tricare.osd.mil/tfl). ■

### Brush Up: TRICARE Dental Benefits

#### TRICARE Dental Program

**Administered by:** United Concordia Companies, Inc.

**Who's eligible:** Family members of active duty service members, as well as National Guard/Reserve members and their families

**Network of dentists:** 57,000+ providers

**More information:** [www.TRICAREdentalprogram.com](http://www.TRICAREdentalprogram.com) and 1-800-866-8499

**To enroll:** 1-888-622-2256

#### TRICARE Retiree Dental Program

**Administered by:** Delta Dental of California, Federal Services Division

**Who's eligible:** Retirees, their families, survivors and others

**Network of dentists:** 67,000+ providers

**More information/to enroll:** [www.trdp.org](http://www.trdp.org) and 1-888-838-8737

# TRICARE Standard Health Matters

## TRICARE

### An Excellent Value

- Generous coverage
- Superior health care
- Decisions are health driven, not insurance driven
- High satisfaction with care
- Low out-of-pocket costs
- Easy access

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This *TRICARE Standard Health Matters* publication will help you learn about your TRICARE Standard benefits and services. At the time of printing, the information in this newsletter is current. It is important to remember that TRICARE policies and benefits are governed by public law. Changes to TRICARE programs are continually made as public law is amended. For the most recent TRICARE information, including information on the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, please visit [www.tricare.osd.mil](http://www.tricare.osd.mil).