TRICARE®
Prime Handbook

Your guide to program benefits
**Important Information**

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<th>TRICARE Web site</th>
<th><a href="http://www.tricare.mil">www.tricare.mil</a></th>
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<td><strong>TRICARE North Region Contractor</strong></td>
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<td>Health Net Federal Services, LLC:</td>
<td>1-877-TRICARE (1-877-874-2273)</td>
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<td><strong>TRICARE Overseas (TRICARE Eurasia-Africa, TRICARE Latin America and Canada, and TRICARE Pacific)</strong></td>
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<tr>
<td>Overseas Toll-Free Number:</td>
<td>1-888-777-8343</td>
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<tr>
<td>Overseas Web site:</td>
<td><a href="http://www.tricare.mil/overseas">www.tricare.mil/overseas</a></td>
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**An Important Note About TRICARE Program Changes**

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

Dear TRICARE Prime Member:

Your decision to enroll in TRICARE Prime was an important one. To make the best use of your benefits, please read this TRICARE Prime Handbook. There are many resources listed throughout the handbook to help you if you have questions or need more information.

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

Health Care Services

With TRICARE Prime, you will receive most of your care from a primary care manager (PCM) that you select or are assigned. Your PCM can be either a military treatment facility (MTF) provider or a civilian TRICARE network provider. PCMs and other provider types are described in the Getting Started section of this handbook.

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

Regional contractors administer the TRICARE program in each TRICARE region. This handbook refers regularly to your regional contractor and describes differences among the regions. In cases where there are differences, refer to the information specific to your region. We encourage you to visit your regional contractor’s Web site, which includes information about how to change PCMs, how to enroll a child, covered and non-covered services, referral and authorization requirements, and other helpful information. You can call your regional contractor toll-free for assistance at the numbers listed below. In addition, your regional contractor has TRICARE Service Centers located throughout the region, typically at MTFs, that have customer service representatives 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).

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</tr>
</tbody>
</table>

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

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</tbody>
</table>

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.

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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 registration in DEERS is the key to receiving timely, effective TRICARE benefits, including doctor appointments, prescriptions, and payment of health care expenses.

You have several options for updating and verifying DEERS information:

| In Person¹ (add or delete a family member or update contact information) | • Visit a local identification card-issuing facility.  
| | • Find a facility near you at www.dm国防部.d.osd.mil/rsl.  
| | • Call to verify location and business hours.  
| Phone² | • 1-800-538-9552  
| | • 1-866-363-2883 (TTY/TDD)  
| Fax² | • 1-831-655-8317  
| Mail² | • Defense Manpower Data Center Support Office  
| | 400 Gigling Road  
| | Seaside, CA 93955-6771  
| Online³ | • DEERS Web Site: www.dm国防部.d.osd.mil/appj/address/  
| | • Beneficiary Web Enrollment Web site: www.dm国防部.d.osd.mil/appj/bwe/  

**Important Note for National Guard and Reserve Members and Their Families**

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

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

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

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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.
3. Please see “Beneficiary Web Enrollment” in the Getting Started section for more information about online tools.
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For information about your patient rights and responsibilities, see the inside back cover of this handbook.
Getting Started

TRICARE Provider Types

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

Military Treatment Facilities

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

Civilian Providers

Figure 1.1 explains the different types of civilian TRICARE providers.

Department of Veterans Affairs Health Care Facilities

Most Department of Veterans Affairs (VA) health care facilities have agreed to join the TRICARE network. While VA facilities may or may not provide primary care, many provide specialty care. If you need care, and a participating VA health care facility near you can provide that care (within TRICARE access standards), you may be asked to use that VA facility. Be sure to find out the VA facility’s

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TRICARE Provider Types

**TRICARE-Authorized Providers**

- TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers 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.

**TRICARE Network Providers**

- In the TRICARE Prime program, you will receive most of your care from MTF or TRICARE network providers. Network providers:
  - Have a signed agreement with your TRICARE regional contractor to provide care
  - Agree to handle claims for you

**Non-Network Providers**

- Non-network providers do not have a signed agreement with your regional contractor and are therefore considered “out of network.” In most cases, you will not receive care from non-network providers unless approved by your regional contractor. You may seek care from a non-network provider in an emergency or if you are using the point-of-service option.
- There are two types of non-network providers: Participating and Nonparticipating.

**Participating**

- 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

**Nonparticipating**

- 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.)
status as a TRICARE network or non-network provider before you receive TRICARE-covered health care at a VA facility. The VA Liaison at your TRICARE Regional Office can assist you. Visit www.tricare.mil/regionaloffice.cfm for TRICARE Regional Office contact information.

Note: All ADSMs who are referred to a VA medical facility must have an authorization.

**Your Primary Care Manager**

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

If you have a civilian PCM, you are encouraged to make initial contact with your new PCM within 30 days to establish yourself as a new patient. TRICARE recommends an open and active relationship between you and your doctor so you can work together to meet your health care needs.

A PSA is a geographic area where TRICARE Prime benefits are offered. It is typically an area around an MTF or other predetermined areas as defined by ZIP codes.

**On-Call Providers**

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

**Other Health Care Provider Types**

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

- **Specialty Care Providers:** Specialty care providers offer treatment that your PCM cannot provide. Under TRICARE Prime, your PCM will provide referrals to receive services from specialty care providers and will coordinate the referral request with your regional contractor when necessary. Some examples of specialty care providers include obstetricians (*child birth doctors*), orthopedic surgeons (*bone doctors*), and gastroenterologists (*stomach and intestine doctors*).

- **Ancillary Care Providers:** Ancillary providers are similar to specialty care providers in that your PCM (or *specialty care provider on behalf of your PCM*) will need to coordinate a referral request to see them. Some examples of ancillary care providers include 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/or surgical services. Some examples of facilities are hospitals, birthing centers (*facilities with nurse-midwives that offer a more natural child birth experience*), skilled nursing facilities (*facilities such as rest homes where patients need medical support 24 hours a day*), and ambulatory surgery centers (*facilities where patients receive a minor surgery and are released to go home the same day*).

- **Behavioral Health Care Providers:** If you need behavioral health care, talk with your PCM. Your PCM can provide an initial assessment and may even be able to provide treatment. From there, your PCM can recommend additional treatment, if necessary, with the appropriate behavioral health provider to suit your needs. Non-ADSMs may see a network provider for the first eight outpatient behavioral health care visits per fiscal year (FY) (*October 1–September 30*) without a referral or authorization. Note: Behavioral health includes a broad range of MTF or civilian providers and treatments. Psychiatric nurse specialists, counselors, therapists, and social workers are also 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 provider types.
Changing Your Primary Care Manager

You may change your PCM at any time, provided the new PCM is accepting new patients and your request complies with local MTF and access to care guidelines. Once you have selected a new PCM from your regional contractor’s provider directory (available on each regional contractor’s Web site), complete a TRICARE Prime Enrollment Application and PCM Change Form (DD Form 2876) with the new PCM’s name and address. You only need to complete the portions of the DD Form 2876 related to the PCM change.

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

In the United States, you can also change your PCM on the Beneficiary Web Enrollment (BWE) Web site at www.dmdc.osd.mil/appj/bwe. When you select or change your PCM through the BWE Web site, the site will not factor in drive time from your home to your PCM. You should be aware of the drive time before you choose a PCM. Enrolling through the BWE Web site confirms that you waive your access standards. Note: The online PCM change option is not available to ADSMs enrolled in TRICARE Prime. ADSMs should submit the DD Form 2876 to their regional contractor by mail or through a TRICARE Service Center (TSC). See “Your TRICARE Regional Contractor” in the Welcome to TRICARE Prime section for contact information.

TRICARE Prime Annual Enrollment Fees

There are no enrollment fees for ADSMs and active duty family members (ADFM) enrolled in TRICARE Prime, TRICARE Prime Remote (TPR), or TRICARE Prime Remote for Active Duty Family Members (TPRADFM). Retired service members and their eligible family members, survivors, former spouses, and others enrolled in TRICARE Prime are required to pay an annual enrollment fee, which is applied to the catastrophic cap. Visit www.tricare.mil/costs for enrollment fees and payment options.

Be aware that TRICARE has a limited refund policy. In most cases, TRICARE Prime enrollment fees will not be refunded. If you are close to age 65 and therefore close to eligibility for TRICARE For Life (TFL), you should not choose the annual payment option. Figure 1.2 on the following page details your enrollment fee payment options.

Beneficiary Web Enrollment

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

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

• Valid Certified Common Access Card (CAC)
• Defense Financial and Accounting Services myPay PIN
• DoD Self-Service Logon

Through BWE, you can:

• Enroll or disenroll
• Transfer your enrollment to a new location
• Request a new PCM (Refer to “Changing Your Primary Care Manager” in this section for additional information on using BWE to change your PCM.)

• Make an initial enrollment fee credit card payment (Ongoing payments paid through Electronic Funds Transfer or allotment will be billed separately.)

• Add other health insurance information (when initially enrolling)

• Request a new TRICARE Prime enrollment card

• View your enrollment information

**Enrollment Cards**

You and each enrolled family member will receive a TRICARE Prime enrollment card. Your TRICARE Prime enrollment effective date is printed on this card. Included with the card is a letter identifying your PCM’s name and telephone number. Write your PCM’s name and telephone number on your card. TRICARE network providers may require you to show the enrollment card as well as your uniformed services identification (ID) or CAC at the time of service. **Note:** A health care provider photocopying your ID or CAC for authorized purposes is legal.

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

**Disenrollment**

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

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**TRICARE Prime Enrollment Fee Payment Options**

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<tr>
<td>Monthly</td>
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<tr>
<td>Allotment from Retired Pay</td>
<td>Complete an Enrollment Fee Allotment Authorization form (available at <a href="http://www.tricare.mil">www.tricare.mil</a> or from your regional contractor). Once authorized, your TRICARE Prime enrollment fee is automatically deducted from your retirement pay on a monthly basis. You must pay for the first three months when you enroll to allow time for the allotment to be established.</td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td>Provide your correct banking information to your regional contractor. Once authorized, your TRICARE Prime enrollment fee is automatically deducted from your bank account on a monthly basis. You must pay for the first three months when you enroll to allow time for EFT to be established.</td>
</tr>
<tr>
<td>Quarterly or Annually</td>
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</tr>
<tr>
<td>Check, Cashier’s Check, or Money Order</td>
<td>A bill for your TRICARE Prime enrollment fee will be sent on a quarterly or annual basis, depending on your selection. Instructions for paying your bill are on the billing statement.</td>
</tr>
<tr>
<td>Visa® or MasterCard®</td>
<td>Your initial payment will be charged to your credit card, and you will be sent a bill for each subsequent payment. Return the bill to your regional contractor along with the credit card authorization for each billing period. For your convenience, you also can make credit card payments online. Initial payments can be made through TRICARE’s Beneficiary Web Enrollment (BWE) Web site at <a href="http://www.dmdc.osd.mil/appj/bwe/">www.dmdc.osd.mil/appj/bwe/</a>, and subsequent payments can be made through your regional contractor’s Web site.</td>
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**Sponsor Status Change**

Any change in the sponsor’s status (e.g., retirement or National Guard and Reserve member deactivation) will cause you to be disenrolled automatically from TRICARE Prime. To avoid a lapse in coverage, you should submit a new enrollment application to your regional contractor before the date of the status change if you will remain eligible for TRICARE Prime after the change.

**Nonpayment of Enrollment Fees**

If you are required to pay enrollment fees and you do not pay them when due, you will be disenrolled from TRICARE Prime. When disenrolled for nonpayment, you are subject to a 12-month lockout during which you will not be permitted to reenroll in TRICARE Prime.

Learn about automatic payment options by visiting [www.tricare.mil/mybenefit](http://www.tricare.mil/mybenefit) or by contacting your regional contractor.

**Voluntary Disenrollment**

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

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

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

**Loss of Eligibility**

If your DEERS record indicates loss of TRICARE eligibility, your TRICARE Prime coverage will automatically end. If you believe you are still eligible for TRICARE, you will need to update your DEERS record to reestablish your eligibility. Once DEERS is updated, you must reenroll in TRICARE Prime or you will be covered under TRICARE Standard and TRICARE Extra.

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

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

Making an Appointment

To make an appointment, contact your PCM’s office. There is no need to contact your regional contractor to schedule appointments.

Access Standards for Care

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

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

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

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

Additionally, it is important to understand your provider’s specific policies regarding cancelled or missed appointments. Some providers charge a missed appointment fee, which is not covered by TRICARE. Please be sure to notify your provider’s office within the appropriate time, usually 24 to 48 hours prior, if you will not be able to make your scheduled appointment.

Waiving Access Standards

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

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

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

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

If the waiver is approved by the MTF for beneficiaries residing less than 100 miles from the MTF, it remains in effect until the beneficiary changes residency location. A waiver for beneficiaries who reside more than 100 miles from an MTF must be approved by the TRICARE Regional Office and the MTF. It will remain in effect through the beneficiary’s current enrollment period, so long as he or she does not change residences.
Note: Each MTF can specify whether or not they will accept beneficiaries who live more than 30 minutes’ drive time from the MTF and can make a determination on mileage limitations or include specific ZIP codes. Signing a waiver of access standards does not guarantee enrollment to the MTF of your choice.

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

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

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

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.

You do not need to call your PCM or regional contractor before receiving emergency medical care. However, in all emergency situations, you must notify your PCM within 24 hours of or on the business day following admission to coordinate ongoing care and to ensure you receive proper authorization.

Nonemergency Care for Active Duty Service Members

If you are an active duty service member (ADSM) traveling or between duty stations, you must receive all nonemergency care at an MTF if one is available. If an MTF is not available, prior authorization and a referral from your PCM is required before receiving nonemergency civilian care. Make sure you or the requesting provider calls your regional contractor for assistance with referral coordination.

Urgent Care

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

In most cases, you can receive urgent care from your PCM by making a same-day appointment. If you do not coordinate urgent care with your PCM or regional contractor, the care will be covered under the point-of-service (POS) option,* resulting in higher out-of-pocket costs. For cost details, visit www.tricare.mil/costs. If you are away from home and urgent treatment cannot wait until you return home to see your PCM, you must contact your PCM for a referral or call your regional contractor for assistance before receiving care.

* The POS option does not apply to ADSMs, children for the first 60 days following their birth or adoption, emergency care, or beneficiaries with other health insurance.

Routine (Primary) Care

Routine (primary) care includes general office visits for the treatment of symptoms, chronic or acute illnesses and diseases, and follow-up care for an ongoing medical condition. Routine care also includes preventive care measures to help keep you healthy. You will receive most of your routine or primary care from your PCM.
You do not need a referral to visit your PCM. If your PCM is unable to provide the care needed, he or she will refer you to another provider. If you receive any routine care from another provider without a referral from your PCM, you will be using the POS option, resulting in higher out-of-pocket costs. For cost details, visit www.tricare.mil/costs.

**Services that Do Not Require Referrals**

Some services may be obtained without a PCM referral. These include clinical preventive services and the first eight outpatient behavioral health care visits to a network provider per fiscal year (FY) (October 1–September 30). When seeking clinical preventive services or behavioral health care, you must use a network provider. If you seek care from a non-network provider without a referral from your PCM, you will be using the POS option, resulting in higher out-of-pocket costs. For cost details, visit www.tricare.mil/costs.

For more information about these services, see the *Covered Services, Limitations, and Exclusions* section. Remember, you will never need a referral for emergency care. **Note:** ADSMs always require a referral for any civilian care, including clinical preventive services, behavioral health care, or specialty care.

**Specialty Care**

There are times when you will need to see a specialist for a diagnosis or treatment that your PCM cannot provide. Your PCM will provide referrals to access services from specialty providers and will coordinate the referral request with your regional contractor, if necessary. If you receive specialty care without a referral from your PCM, you will be using the POS option, resulting in higher out-of-pocket costs. For cost details, visit www.tricare.mil/costs.

* The POS option does not apply to ADSMs, children for the first 60 days following their birth or adoption, emergency care, or beneficiaries with other health insurance.

**Referrals for Specialty Care**

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

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

**Specialty-to-Specialty Referrals**

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

**Specialty Care Far From Home—Travel Reimbursement**

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

TRICARE will use government rates to estimate the reasonable cost and will reimburse the actual costs of travel expenses up to the government rate for the area concerned. To review the rates, visit www.defensetravel.dod.mil/perdiem/pdrates.html.

In some cases, a non-medical attendant (NMA) who travels with the patient may also be authorized for travel reimbursement. The NMA must be a parent or guardian, or another adult family member age 21 or older.
To qualify, you must have a valid referral and travel orders from a TRICARE representative at your MTF (if enrolled to an MTF PCM) or from the TRICARE Regional Office (if enrolled to a civilian PCM). You should contact your local MTF or TRICARE Regional Office travel representative if you think you may qualify for this travel reimbursement benefit. Figure 2.1 lists TRICARE Regional Office contact information for travel reimbursement.

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

Prior Authorization for Care

A prior authorization is a review of the requested health care service to determine if it is medically necessary at the requested level of care. Prior authorizations must be obtained before services are rendered or within 24 hours or on the business day following an emergency admission.

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

Services Requiring Prior Authorization

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

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

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

This list is not all-inclusive.

Each regional contractor has additional prior authorization requirements. Visit your regional contractor’s Web site or call the toll-free number to learn about your region’s requirements, as they may change periodically. See the Welcome to TRICARE Prime section for your regional contractor’s Web site and toll-free number.

Getting a Second Opinion

You have the right to request a consultation with another provider for a second medical opinion when you or the initial provider is uncertain about a contemplated course of action. Your PCM or
gettinG care

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

**Point-of-Service Option**

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

The POS option does not apply to the following:

- ADSMs
- Newborns or newly adopted children in the first 60 days after birth or adoption
- Emergency care
- Clinical preventive care received from a network provider
- First eight behavioral health care outpatient visits per FY (*October 1–September 30*) to a network provider
- Beneficiaries with other health insurance

The POS cost-share is applied when:

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

Using the POS option results in higher out-of-pocket costs and higher deductibles. POS costs do not apply to your annual catastrophic cap. **Note:** Prior authorization requirements still apply when using the POS option.
TRICARE Prime covers most care that is medically necessary and considered proven. Some types of care are not covered at all, and there are special rules and limits for certain types of care. This chapter is not 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 your program options. It is in your best interest to take an active role in verifying coverage. Visit your regional contractor’s Web site for additional information about covered services and benefits.

**Outpatient Services**

Figure 3.1 provides coverage details for outpatient services. Note: This chart is not all-inclusive.

### Outpatient Services: Coverage Details

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| Ambulance Services | The following ambulance services are covered:  
  • 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)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Services</strong></td>
<td>TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a “prudent layperson” <em>(someone with average knowledge of health and medicine)</em> 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</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Covers part-time or intermittent skilled nursing services and home health care services <em>(All care must be provided by a participating home health care agency and be authorized in advance by the regional contractor.)</em></td>
</tr>
<tr>
<td><strong>Individual Provider Services</strong></td>
<td>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 <em>(e.g., physical and occupational therapy and speech pathology services)</em>; and medical supplies used within the office</td>
</tr>
<tr>
<td><strong>Laboratory and X-ray Services</strong></td>
<td>Generally covered if prescribed by a physician <em>(Some exceptions apply, e.g., chemosensitivity assays and bone density X-ray studies for routine osteoporosis screening.)</em></td>
</tr>
<tr>
<td><strong>Active Duty Service Member (ADSM) Respite Care</strong></td>
<td>Covers respite care for active duty service members (ADSMs) who are homebound as a result of a serious injury or illness incurred while serving on active duty; available if the ADSM’s plan of care includes frequent* interventions by the primary caregiver&lt;br&gt;The following respite care limits apply:&lt;br&gt;• 40 hours per calendar week&lt;br&gt;• Five days per calendar week&lt;br&gt;• Eight hours per calendar day&lt;br&gt;Note: Respite care must be provided by a TRICARE-authorized home health care agency and requires prior authorization from your regional contractor and the ADSM’s approving authority <em>(i.e., Military Medical Support Office or referring military treatment facility). The ADSM is not required to be enrolled in the TRICARE Extended Care Health Option program to receive the respite benefit.</em></td>
</tr>
</tbody>
</table>

*p More than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.

### Inpatient Services

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalization</strong> <em>(semi-private room/ special care units when medically necessary)</em></td>
<td>Covers general nursing; hospital, physician, and surgical services; meals <em>(including special diets)</em>; 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&lt;br&gt;Note: Surgical procedures designated “inpatient only” may only be covered when performed in an inpatient setting.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong> <em>(semi-private room)</em></td>
<td>Covers regular nursing services; meals <em>(including special diets)</em>; physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances <em>(TRICARE covers an unlimited number of days as medically necessary.)</em></td>
</tr>
</tbody>
</table>
Figure 3.3 provides coverage details for clinical preventive services. Note: This chart is not all-inclusive.

**Clinical Preventive Services: Coverage Details**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Health Promotion and Disease Prevention Examinations</strong></td>
<td>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. Beneficiaries in each of the following age groups may receive one comprehensive clinical preventive exam without receiving an immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening (one exam per age group): 2–4, 5–11, 12–17, 18–39, and 40–64.</td>
</tr>
<tr>
<td><strong>Targeted Health Promotion and Disease Prevention Services</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **Cancer Screenings** | • **Colonoscopy:**  
  • Average Risk: Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50.  
  • Increased Risk: Once every five years for individuals with a first degree relative diagnosed with colorectal cancer or an adenomatous polyp before the age of 60, or in two or more first degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives.  
  • High Risk: Once every one to two years for individuals with a genetic or clinical diagnosis of Hereditary Non-Polyposis Colorectal Cancer or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. For individuals diagnosed with Inflammatory Bowel Disease, Chronic Ulcerative Colitis, or Crohn’s disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.  
  • **Fecal occult blood testing:** Conduct testing annually starting at age 50.  
  • **Mammograms:** Perform a mammography annually beginning at age 40. 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 TRICARE Prime beneficiaries age 30 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  
  • **Proctosigmoidoscopy or sigmoidoscopy:**  
    • Average Risk: Once every three to five years beginning at age 50.  
    • Increased Risk: Once every five years, beginning at age 40, for individuals with a first degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or two second degree relatives diagnosed with colorectal cancer.  
    • High Risk: Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected Familial Adenomatous Polyposis.  
  • **Prostate cancer:** Perform a digital rectal exam and prostate-specific antigen screening annually for high-risk men ages 40–49 and all men over age 50. |
## Clinical Preventive Services: Coverage Details (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Pap smears</strong>:</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Skin cancer</strong>:</td>
<td>Exams are covered at any age for a beneficiary who is at high risk due to family history or increased sun exposure.</td>
</tr>
<tr>
<td><strong>Cardiovascular Diseases</strong>:</td>
<td></td>
</tr>
<tr>
<td><em>Cholesterol test (non-fasting)</em>:</td>
<td>Testing is covered for a lipid panel at least once every five years, beginning at age 18.</td>
</tr>
<tr>
<td><em>Blood pressure screening</em>:</td>
<td>Screening is covered annually for children (ages 3–6) and a minimum of every two years after age 6 (children and adults).</td>
</tr>
<tr>
<td><strong>Eye Examinations</strong>:</td>
<td></td>
</tr>
<tr>
<td><em>Well-child care coverage (infants and children up to age 6)</em>:</td>
<td></td>
</tr>
<tr>
<td><em>Infants</em>:</td>
<td>Conduct one eye and vision screening at birth and at 6 months.</td>
</tr>
<tr>
<td><em>Children (ages 3–6)</em>:</td>
<td>Conduct a routine eye exam every two years. Active duty family member (ADFM) children are covered for one routine eye exam annually.</td>
</tr>
<tr>
<td><em>Adults and children (over age 6)</em>:</td>
<td>Conduct a routine eye exam every two years. Active duty service members (ADSMs) and ADFMs receive one eye exam each year.</td>
</tr>
<tr>
<td><em>Diabetic patients (any age)</em>:</td>
<td>Eye exams are not limited. One eye exam per year is recommended.</td>
</tr>
<tr>
<td><strong>Note</strong>:</td>
<td>ADSMs enrolled in TRICARE Prime must receive all vision care at a military treatment facility unless specifically referred by their primary care manager to a civilian network provider, or to a non-network provider if a network provider is not available.</td>
</tr>
<tr>
<td><strong>Hearing</strong>:</td>
<td>Preventive hearing examinations are only allowed under the well-child care benefit. A newborn audiology screening should be performed on newborns before hospital discharge or within the first month after birth. Evaluative hearing tests may be performed at other ages during routine exams.</td>
</tr>
<tr>
<td><strong>Immunizations</strong>:</td>
<td>Age-appropriate doses of vaccines, including annual influenza vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). The HPV vaccine is 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 <a href="http://www.cdc.gov">www.cdc.gov</a> for a current schedule of recommended vaccines.</td>
</tr>
<tr>
<td><strong>Note</strong>:</td>
<td>Immunizations for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered.</td>
</tr>
<tr>
<td><strong>Infectious Disease Screening</strong>:</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Patient and Parent Education Counseling</strong>:</td>
<td>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.</td>
</tr>
<tr>
<td><strong>School Physicals</strong>:</td>
<td>Covered for children ages 5–11 if required in connection with school enrollment.</td>
</tr>
<tr>
<td><strong>Note</strong>:</td>
<td>Annual sports physicals are not covered.</td>
</tr>
<tr>
<td><strong>Well-Child Care (birth to age 6)</strong>:</td>
<td>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.</td>
</tr>
</tbody>
</table>
Behavioral Health Care Services

Active Duty Service Members

Active duty service members (ADSMs) must have prior authorization before seeking behavioral health care. We do not want to discourage you from getting help, but we want to make sure that your condition does not adversely affect your health and your ability to perform worldwide duty. Your primary care manager (PCM) will coordinate all your behavioral health care referrals and authorizations. Note: In the event of a behavioral health emergency, go immediately to the nearest emergency room or call 911.

All Others Enrolled in TRICARE Prime

You may see a network provider for the first eight outpatient behavioral health care services per fiscal year (FY) (October 1–September 30) without a referral or authorization. After the first eight visits, your behavioral health care provider must obtain prior authorization from your regional contractor. If you obtain care from a non-network provider without a referral from your PCM and regional contractor, point-of-service fees will apply.

Authorized Behavioral Health Care Providers

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

- **Certified psychiatric nurse specialists** are licensed, master’s-level psychiatric nurses with additional American Nurses Association certification in behavioral health. 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. Their licensure is limited, so these providers require written physician referral 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 have questions about which type of provider would best meet your needs, contact your PCM or TRICARE regional contractor for assistance. ADSMs and active duty family members (ADFMs) may also call the Behavioral Health Care Provider Locator and Appointment Assistance Line (see Figure 3.4 on the following page). This service helps eligible ADSMs and ADFMs find behavioral health care providers and schedule timely appointments for urgent and routine outpatient behavioral health care. Before calling the appointment assistance line, ADSMs must have a referral from their military treatment facility (MTF) PCM, service point of contact, or their MTF behavioral health care clinic for civilian behavioral health care. Note: ADSMs calling this service without an appropriate referral or authorization will only be provided with MTF points of contact.

TRICARE Prime access standards for urgent and routine medical care apply to behavioral health care services, including appointments made through the appointment assistance line. The wait time for
Figure 3.5 provides coverage details for outpatient behavioral health care services. **Note:** This chart is not all-inclusive.

### Behavioral Health Care Services: Outpatient Coverage Details

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Psychotherapy</strong></td>
<td>The following outpatient psychotherapy limits apply:</td>
</tr>
</tbody>
</table>
| (physician referral and supervision required when seeing licensed or certified mental health counselors and pastoral counselors) | - **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 are taking prescription medications for a behavioral health condition, you must be under the care of a provider who is authorized to prescribe those medications. Your provider will manage the dosage and duration of your prescription to ensure you are receiving the best care possible.         |
Figure 3.6 provides coverage details for inpatient behavioral health care services. **Note:** This chart is not all-inclusive.

### Behavioral Health Care Services: Inpatient Coverage Details

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| **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) or in any single admission  
• **Patients age 18 and under:** 45 days per FY 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 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 or for a single admission. (*Limitations may be waived if determined to be medically or psychologically necessary.*)  
• RTC care is only covered for patients age 21 or younger. |

1. October 1–September 30
Figure 3.7 provides coverage details for substance use disorder services (up to three benefit periods per beneficiary, per lifetime). 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.

**Note:** This chart is not all-inclusive.

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

### TRICARE Assistance Program

The TRICARE Assistance Program (TRIAP) is a Web-based program available to eligible beneficiaries, including U.S. TRICARE Prime enrollees. 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. Call your regional contractor to request TRIAP services.

### Telemental Health Program

The Telemental Health program uses secure audio-visual conferencing to connect eligible beneficiaries, including U.S. TRICARE Prime enrollees, 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.

TRICARE Prime enrollees will not be charged for Telemental Health services, but behavioral health care limitations and referral and authorization requirements apply. For more information, visit the Mental Health and Behavior Web page at www.tricare.mil or contact your regional contractor.

TRICARE Smoking Quitline

TRICARE beneficiaries can receive smoking-cessation assistance through TRICARE’s Smoking Quitline, 24 hours a day, seven days a week. Current smokers who want to quit or former smokers concerned about relapsing may call the Smoking Quitline to speak with a trained smoking-cessation coach who will recommend appropriate treatment and resources. Call the toll-free number for your region for assistance.

Note: The Smoking Quitline is available to all TRICARE beneficiaries who are not eligible for Medicare.

The Smoking Quitline is part of the Department of Defense and TRICARE-sponsored tobacco-cessation program, which offers a variety of online tools and resources to help beneficiaries quit. The program includes live chats and step-by-step quit plans. Visit www.ucanquit2.org for more information.

TRICARE Pharmacy Program

TRICARE offers comprehensive prescription drug coverage and several options for filling prescriptions. To fill a prescription, you will 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 Pharmacies

An MTF pharmacy is the least expensive option for filling prescriptions. At an MTF pharmacy, you may receive up to a 90-day supply of most medications at no cost. Most MTF pharmacies accept prescriptions written by both civilian and military providers, regardless of whether you are enrolled at the MTF.

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

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 the MTF. With the Mail Order Pharmacy, there is only one copayment for each prescription (up to a 90-day supply). In addition,
prescriptions are delivered to you with free standard shipping, and refills can be ordered easily online, by phone, or by mail. The Mail Order Pharmacy also provides you with convenient notifications about your order status, refill reminders, and assistance in renewing expired prescriptions. If you have questions about your prescriptions, pharmacists are available 24 hours a day, seven days a week, to speak confidentially with you.

You may register for the Mail Order Pharmacy using any of the options in Figure 3.9.

**Mail Order Pharmacy Registration Methods**

<table>
<thead>
<tr>
<th>Online</th>
<th>Phone</th>
<th>Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <a href="http://www.express-scripts.com/TRICARE">www.express-scripts.com/TRICARE</a></td>
<td>• 1-877-363-1303</td>
<td>• Download the registration form from <a href="http://www.express-scripts.com/TRICARE">www.express-scripts.com/TRICARE</a>, and mail it to:</td>
</tr>
<tr>
<td></td>
<td>• 1-877-540-6261 (TDD/TTY)</td>
<td>Express Scripts, Inc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO. Box 52150</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phoenix, AZ 85072-9954</td>
</tr>
</tbody>
</table>

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.

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

**Member Choice Center**

The Member Choice Center makes it easy to reduce your out-of-pocket costs by moving your current retail pharmacy maintenance medication prescriptions to the Mail Order Pharmacy. Additionally, you may contact the Member Choice Center to convert your current MTF prescriptions to the Mail Order Pharmacy if you prefer the convenience of home delivery. (*Mail Order Pharmacy copayments will apply.*)

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

**TRICARE Retail Network Pharmacies**

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

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

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

**Non-Network Pharmacies**

At non-network pharmacies, you will pay full price for your medication and file a claim later for reimbursement. Reimbursements are subject to deductibles or out-of-network cost-shares and TRICARE-required copayments. All deductibles must be met before any reimbursement can be made. Log on to [www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE) or contact Express Scripts at 1-877-363-1303 for assistance with locating a network pharmacy. For details about filing a claim, see the Claims section.

**Quantity Limits**

TRICARE has established quantity limits on certain medications, which means that 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 used safely and appropriately. Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity.

**Prior Authorization**

Some drugs require prior authorization from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics Committee, brand-name medications with a generic equivalent, medications with age limitations, and medications prescribed for a quantity exceeding normal limits. For a general list of prescription drugs that are covered under TRICARE, drugs that require prior authorization or that have quantity limits, visit [www.tricareformularysearch.org](http://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](http://www.pec.ha.osd.mil/forms_criteria.php) or by calling Express Scripts at 1-877-363-1303.

**Note:** If medical necessity is approved, ADSMs may receive non-formulary medications through the Mail Order Pharmacy or at retail network pharmacies at no cost. ADSMs may not fill a prescription for a non-formulary medication unless medical necessity is established.

To learn more about medications and common drug interactions, check for generic equivalents, or determine if a drug is classified as non-formulary, visit the TRICARE Formulary Search Tool at [www.tricareformularysearch.org](http://www.tricareformularysearch.org).

For information on how to save money and make the most of your pharmacy benefit, visit [www.tricare.mil/pharmacy](http://www.tricare.mil/pharmacy) or [www.express-scripts.com/TRICARE](http://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,
assessments of educational needs, and management of medication use. This program provides:

- Access to proactive, clinically based services for specific diseases designed to help you get the most benefit from your medicine
- 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.

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**Dental Options**

ADSMs receive dental care from military dental treatment facilities (DTFs) and civilian providers through the TRICARE Active Duty Dental Program (ADDP), if necessary. 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 Active Duty Dental Program**

The ADDP is administered by United Concordia Companies, Inc. (United Concordia) and provides civilian dental care to ADSMs through military DTFs located on base or sometimes co-located at an MTF. ADDP benefits are available to ADSMs who are either referred for care by a DTF to the civilian dental community or who serve duty and reside greater than 50 miles from a DTF. For more information about the ADDP, visit www.addp-ucci.com or www.tricare.mil/dental.

**TRICARE Dental Program**

The TDP is a voluntary dental insurance program administered by United Concordia that is 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 before their report date) are not eligible for the TDP. They receive dental care through the ADDP.

For information about the TDP, visit the TDP website 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 Prime covers all necessary maternity care, from your first obstetric visit through six weeks after your child is born, including:

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

Newborns are covered separately. To ensure your newborn is covered by TRICARE, 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 approved for that use by the FDA (i.e., off-label use)
- Home uterine activity monitoring and related services
- Unproven procedures (e.g., lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent miscarriages, or salivary estriol test for preterm labor)
- Umbilical cord blood collection and storage, except when stem cells are collected for subsequent use in the treatment of tumor, blood, or lymphoid disease
- Private hospital rooms

**Note:** TRICARE does not generally cover private rooms; however, some MTFs may have private postpartum rooms.

**Maternity Ultrasounds**

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

- Estimate gestational age due to unknown date of last menstrual period, irregular periods, size/date different by greater than two weeks, or pregnancy while on oral contraceptive pills

**Note:** 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, oligo/ polyhydramnios, preeclampsia, decreased fetal movement, isoimmunization)

- Evaluate a suspected ectopic pregnancy
- Determine the cause of vaginal bleeding
- Diagnose or evaluate multiple births
- Confirm cardiac activity (e.g., when heart rate is not detectable by Doppler and/or suspected fetal demise)
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
• Evaluate the condition of the fetus in late registrants for prenatal care

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

Some providers offer patients routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation. TRICARE does not cover routine ultrasound screening. Only maternity ultrasounds with a valid medical indication that constitutes medical necessity are covered by TRICARE. Refer to your regional contractor’s Web site for additional details on maternity ultrasound coverage.

**Getting Maternity Care**

As soon as you think you may be pregnant, visit your PCM. If your PCM is not an obstetrician, he or she will refer you to one. You may see the same provider throughout your pregnancy or request a change at any time. If you relocate to a new region during your pregnancy, you must transfer your TRICARE Prime enrollment to your new region and select a new PCM by completing a TRICARE Prime Enrollment Application and PCM Change Form (DD Form 2876). Once you have moved, submit the form to your new regional contractor. Your PCM and regional contractor will coordinate with your new provider to ensure continuity of care. You are encouraged to obtain copies of your health care records from your PCM before relocating.

Maternity care services require prior authorizations and referrals. For more information, contact your regional contractor.

If your PCM is at an MTF, you should receive maternity care from the MTF. If you are not located near an MTF or MTF care is unavailable, your PCM will refer you to a civilian network provider. All beneficiaries except ADSMs may use the point-of-service option to self-refer to an obstetrician; however, higher out-of-pocket costs will apply. ADSMs who are pregnant at the time of release from active duty should contact their local Beneficiary Counseling and Assistance Coordinator to determine if maternity care is available through the MTF.

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

- Work through their service (unit personnel and MTF administrative channels) to establish ongoing eligibility for care within the MTF
- Receive transitional TRICARE coverage for health care services through the Transitional Assistance Management Program (TAMP), if they are eligible
- Enroll in the Continued Health Care Benefit Program (CHCBP), if they qualify

CHCBP is administered by Humana Military Healthcare Services, Inc. For CHCBP details, visit [www.humana-military.com](http://www.humana-military.com). To learn more about TAMP, visit [www.tricare.mil](http://www.tricare.mil).

To ensure your newborn is covered by TRICARE, see “Having a Baby or Adopting a Child” in the Changes to Your TRICARE Coverage section.

**Hospice Care**

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

**Hospice Benefit Coverage**

Four levels of care are covered by the hospice benefit: routine home care, continuous home care, inpatient respite care, and general hospice inpatient care. **Note:** Respite care is covered when necessary and is limited to no more than five days at a time. General inpatient care is limited to varying short-term stays.

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

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

Care is managed by the hospice care team and the PCM or primary care provider, always in consultation with the patient and his or her family. Changes in the levels of care are evaluated and approved by the hospice care team.

**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](http://www.tricare.mil/mybenefit) or contact your regional contractor.

**TRICARE Extended Care Health Option**

TRICARE Extended Care Health Option (ECHO) provides financial assistance to ADFMs who qualify based on specific mental or physical disabilities and 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
- Serious physical disability
- Extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (under age 3) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability
- Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems

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

**ECHO Benefits**

ECHO provides coverage for the following products and services:

- Applied Behavioral Analysis Therapy (which includes the Autism Services Demonstration, discussed below) 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, Guam, Puerto Rico, and the U.S. Virgin Islands)
  - 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 to use special education and assistive technology devices
• Institutional care when a residential environment is required
• Transportation to and from institutions or facilities in certain limited circumstances

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

**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 these services is meeting the appropriate standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board

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. Visit the ECHO Web site at www.tricare.mil/echo for details.

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 3.10 is a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist. **Note:** This list is not all-inclusive. Check your regional contractor’s Web site for more information.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions</td>
<td>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.</td>
</tr>
<tr>
<td>Breast Pumps</td>
<td>Heavy-duty, hospital-grade electric breast pumps <em>(including services and supplies related to the use of the pump)</em> 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.</td>
</tr>
<tr>
<td>Cardiac and Pulmonary Rehabilitation</td>
<td>Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.</td>
</tr>
</tbody>
</table>
### Services or Procedures with Significant Limitations (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cosmetic, Plastic, or Reconstructive Surgery</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Cranial Orthotic Device or Molding Helmet</strong></td>
<td>Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly.</td>
</tr>
<tr>
<td><strong>Dental Care and Dental X-rays</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Education and Training</strong></td>
<td>Education and training are only covered under the TRICARE Extended Care Health Option (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®. The provider’s “Certificate of Recognition” from the American Diabetes Association must accompany the claim for reimbursement.</td>
</tr>
<tr>
<td><strong>Eyeglasses or Contact Lenses</strong></td>
<td>Active duty service members (ADSMs) may receive eyeglasses at an MTF at no cost. For all other beneficiaries, the following are covered:</td>
</tr>
<tr>
<td></td>
<td>• Contact lenses and/or eyeglasses for treatment of infantile glaucoma</td>
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<td></td>
<td>• Corneal or scleral lenses for treatment of keratoconus</td>
</tr>
<tr>
<td></td>
<td>• Scleral lenses to retain moisture when normal tearing is not present or is inadequate</td>
</tr>
<tr>
<td></td>
<td>• Corneal or scleral lenses to reduce corneal irregularities other than astigmatism</td>
</tr>
<tr>
<td></td>
<td>• Intraocular lenses, contact lenses, or eyeglasses for loss of human lens function resulting from intraocular surgery, ocular injury, or congenital absence</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Adjustments, cleaning, and repairs for eyeglasses are not covered.</td>
</tr>
<tr>
<td><strong>Facility Charges for Non-Adjunctive Dental Services</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Food, Food Substitutes and Supplements, or Vitamins</strong></td>
<td>Food, food substitutes and supplements are covered when used as the primary source of nutrition for enteral, parenteral, or oral nutritional therapy. Intraperitoneal nutrition therapy is covered for malnutrition as a result of end-stage renal disease. Vitamins may be cost-shared only when used as a specific treatment of a medical condition. In addition, prenatal vitamins that require a prescription may be cost-shared, but are covered for prenatal care only.</td>
</tr>
<tr>
<td><strong>Gastric Bypass</strong></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown).</td>
</tr>
<tr>
<td></td>
<td><strong>Note for ADSMs:</strong> Receiving bariatric surgery while on active duty may be grounds for separation. For more information, please contact your regional contractor.</td>
</tr>
<tr>
<td><strong>Genetic Testing</strong></td>
<td>Testing is covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient. Routine genetic testing is not covered.</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Hearing aids are covered only for active duty family members (ADFMs) who meet specific hearing loss requirements.</td>
</tr>
<tr>
<td><strong>Intelligence Testing</strong></td>
<td>Testing is covered only when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders.</td>
</tr>
</tbody>
</table>
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 all-inclusive. Check your regional contractor’s Web site 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; or lifestyle modification)
- Custodial care
- Diagnostic admissions
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chair lifts
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships, or other such charges or items
- Experimental or unproven procedures
- 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

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laser/LASIK/Refractive Corneal Surgery</td>
<td>Surgery is covered only to relieve astigmatism following a corneal transplant.</td>
</tr>
<tr>
<td>Private Hospital Rooms</td>
<td>Private rooms are not covered unless ordered for medical reasons or because a semi-private room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room but will receive only the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.</td>
</tr>
<tr>
<td>Shoes, Shoe Inserts, Shoe Modifications, and Arch Supports</td>
<td>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.</td>
</tr>
</tbody>
</table>
• 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 (See “Services or Procedures with Significant Limitations” earlier in this section.)
• Inpatient stays directed or agreed to by a court or other governmental agency (unless medically necessary)
• Required as a result of occupational disease or injury for which any benefits are payable under a worker’s compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted
• That are (or are eligible to be) fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (In such instances, TRICARE is the 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
Health Care Claims

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

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

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

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

Note: Providers submit inpatient facility claims.

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

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

Pharmacy Claims

You will not need to file pharmacy claims if you have prescriptions filled 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 and its territories, you must pay the full price of your prescription and file a claim for reimbursement.

Regional Health Care Claims Processing Information

<table>
<thead>
<tr>
<th>TRICARE North Region</th>
<th>TRICARE South Region</th>
<th>TRICARE West Region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Send claims to:</strong></td>
<td><strong>Send claims to:</strong></td>
<td><strong>Send claims to:</strong></td>
</tr>
<tr>
<td>Health Net Federal Services, LLC</td>
<td>TRICARE South Region</td>
<td>West Region Claims</td>
</tr>
<tr>
<td>c/o PGBA, LLC/TRICARE</td>
<td>Claims Department</td>
<td>P.O. Box 77028</td>
</tr>
<tr>
<td>P.O. Box 870140</td>
<td>P.O. Box 7031</td>
<td>Madison, WI 53707-1028</td>
</tr>
<tr>
<td>Surfside Beach, SC 29587-9740</td>
<td>Camden, SC 29020-7031</td>
<td>Check the status of your claim at</td>
</tr>
<tr>
<td>Check the status of your claim at</td>
<td>Check the status of your claim at</td>
<td><a href="http://www.triwest.com">www.triwest.com</a>.</td>
</tr>
<tr>
<td><a href="http://www.myTRICARE.com">www.myTRICARE.com</a> or</td>
<td><a href="http://www.myTRICARE.com">www.myTRICARE.com</a> or</td>
<td></td>
</tr>
</tbody>
</table>
To file a pharmacy claim:

1. Download DD Form 2642 at www.tricare.mil/claims.
2. Complete the form and attach the required paperwork as described on the form.
3. Mail the form and paperwork to:
   
   Express Scripts, Inc.
   TRICARE Claims
   P.O. Box 66518
   St. Louis, MO 63166-6518

Prescription claims require the following information for each drug:

- Name of the patient
- 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

See “Coordinating Benefits with Other Health Insurance” later in this section, or call Express Scripts, Inc. (Express Scripts) at 1-877-363-1303 with questions about filing pharmacy claims.

Note: Non-active duty beneficiaries who fill prescriptions at a non-network pharmacy will use the point-of-service (POS) option. Active duty service members (ADSMs) may be required to pay for prescriptions in full and will receive a full reimbursement when the claim is filed.

Coordinating Benefits with Other Health Insurance

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

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

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

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

   TRICARE Program Integrity
   16401 East Centretech Parkway
   Aurora, CO 80011

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

Pharmacy Claims and Other Health Insurance

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

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 pharmacy claims with OHI.

**Appealing a Claim or Authorization Denial**

TRICARE has a multilevel appeals process to address claim and authorization denials. You may appeal the denial of a requested authorization of services, as well as TRICARE decisions regarding the payment of claims. Submit appeals to your regional contractor. For more detailed information on the appeals process, see “Appealing a Decision” in the For Information and Assistance section, visit [www.tricare.mil/claims](http://www.tricare.mil/claims), or contact your regional contractor.

**Pharmacy Claim Appeals**

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

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

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

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

**Third-Party Liability**

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

**Explanation of Benefits**

A TRICARE explanation of benefits (EOB) is not a bill. It is an itemized statement that shows what action TRICARE has taken on your claims. An EOB is for your information and files.

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

For a sample EOB in your region and instructions for reading an EOB, see the following figures 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 assist you in resolving health care collection-related issues. Contact a DCAO if you have received a negative credit rating or have been sent to a collection agency due to an issue related to TRICARE services.

When you visit a DCAO for assistance, you must bring or submit documentation associated with a collection action or adverse credit rating, including debt collection letters, EOB statements, and medical/dental bills from providers. The more information you can provide, the faster the cause of the problem 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 Prime continues to provide health coverage for you and your family as you experience major life events. You will, however, need to take specific actions to make sure you remain eligible for TRICARE. 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 Welcome to TRICARE Prime section of this handbook for details.

The following sections 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 your 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.

Registration in DEERS is not the same as enrolling in TRICARE Prime. Once your spouse is registered in DEERS, he or she will need to enroll in TRICARE Prime; otherwise, he or she will be covered by TRICARE Standard and TRICARE Extra. To enroll in TRICARE Prime, complete the TRICARE Prime Enrollment and PCM Change Form (DD Form 2876) and submit the form to your regional contractor. You can download the form from your regional contractor’s Web site, visit a local TRICARE Service Center, or call your regional contractor to request an enrollment application. You may also enroll your spouse in TRICARE Prime through the Beneficiary Web Enrollment (BWE) Web site at www.dmdc.osd.mil/appj/bwe/ after your spouse is enrolled into DEERS. For more information on the BWE Web site, see “Beneficiary Web Enrollment” in the Getting Started section of this handbook.

Your new spouse’s TRICARE Prime enrollment is effective based on the “20th of the month” rule. Applications received by your regional contractor by the 20th of the month will be effective at the beginning of the following month (e.g., an enrollment received by December 20 would become effective January 1). If your application is received after the 20th of the month, your coverage will not become effective until the first day of the month following the next month (e.g., an enrollment received on December 27 would become effective February 1).

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

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

**Divorce**

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

**Children**

After a divorce, any children who retain eligibility under the sponsor remain TRICARE-eligible up to age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides at least 50 percent of the financial support), as long as his or her DEERS information is current. To extend benefits for your college student beyond his or her 21st birthday,
contact DEERS to verify what documentation is needed. See “Keep Your DEERS Information Current!” in the Welcome to TRICARE Prime section of this handbook for contact information.

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 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. Contact your regional contractor for assistance. **Note:** Children with a disability may remain TRICARE-eligible beyond the normal age limits. Check with DEERS for eligibility criteria.

If children are living with a sponsor’s former spouse in a different TRICARE region than the one in which the sponsor resides, they may continue TRICARE Prime coverage using the split enrollment feature. See “Split Enrollment” later in this section for a description of TRICARE Prime’s split enrollment feature.

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**Former Spouses**

Certain former spouses are TRICARE-eligible, as long as they:

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

When a former spouse is eligible for TRICARE coverage, he or she must change his or her personal information in DEERS so his or her name and Social Security number (SSN) are listed as the primary contact. The former spouse’s TRICARE eligibility will be shown in DEERS under his or her SSN and not the sponsor’s. Completing a new *DD Form 2876* is required to enroll in TRICARE Prime under the former spouse’s SSN. Otherwise, the former spouse will be covered under TRICARE Standard and TRICARE Extra.

---

**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.
   - 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.

*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

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

To ensure your new child’s coverage continues after the first 60 days, there are two things you must do:

• Register your child in DEERS at a uniformed services ID card-issuing facility. A birth certificate or certificate of live birth from the hospital is required. If your child is not registered in DEERS within one year after the date of birth or adoption, DEERS will show “loss of eligibility,” and he or she will no longer be able to receive TRICARE benefits until registered in DEERS.

• Enroll your child in TRICARE Prime within 60 days after birth or adoption by submitting 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.

Going to College

Eligibility

Any children who retain eligibility under the sponsor remain TRICARE-eligible up to age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides at least 50 percent of the financial support), as long as their DEERS information is current. Your college student’s TRICARE Prime coverage ends if his or her DEERS record is not updated before age 21. To extend benefits for your college student beyond his or her 21st birthday, contact DEERS to verify what documentation is needed. See “Keep Your DEERS Information Current!” in the Welcome to TRICARE Prime section of this handbook for contact information.

To reenroll a student in TRICARE Prime, you must update DEERS and document that the student is continuing his or her college education to age 23. Then you must submit DD Form 2876 to reenroll in TRICARE Prime after the DEERS record is updated. Both steps must be taken to reenroll in TRICARE Prime, as updating DEERS does not update TRICARE Prime enrollment. Note: In most cases, children going overseas to attend college on their own are eligible only for TRICARE Standard in the overseas area.

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

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

Health Care Options

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

If the school is in a different TRICARE region, your child may remain enrolled in TRICARE Prime using the split enrollment feature (if TRICARE Prime is available in that area). You will need to submit a new DD Form 2876 and select a PCM for your child at the new location. Additionally, some colleges and universities offer student health plans. These are considered other health insurance (OHI). TRICARE pays second to OHI coverage.
Split Enrollment

Split enrollment allows families living in different TRICARE regions to enroll in TRICARE Prime together. To use split enrollment, you must notify each family member’s regional contractor of the split enrollment status and establish one family enrollment fee (where applicable). Student enrollment in TRICARE Prime is automatically renewed after one year, unless the renewal offer is declined. Note: If your child enrolls separately in TRICARE Prime after arriving at college, and no other family members are enrolled in TRICARE Prime, it is considered a single enrollment. However, if the child enrolls and there are two or more family members enrolled elsewhere, your TRICARE Prime family enrollment fee remains the same. The regional contractors will coordinate enrollment fees and send the statements to the designated payer. An enrollment fee left unpaid will cause the entire family to be disenrolled.

Key points to remember with split enrollment:

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

If your child does not enroll in TRICARE Prime, he or she will be automatically covered by TRICARE Standard and TRICARE Extra, as long as his or her DEERS information is current. Any children who retain eligibility under the sponsor remain TRICARE-eligible up to age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides at least 50 percent of the financial support). Visit your regional contractor’s Web site or call the toll-free number if you have questions about using TRICARE Standard and TRICARE Extra.

Traveling

Active Duty Service Members

If an emergency occurs, call 911 or go to the nearest hospital emergency room and notify your PCM within 24 hours or on the next business day. Note: Prior authorization is not required for emergency care (including overseas care) before receiving treatment. If possible, active duty service members’ (ADSMs) traveling overseas should contact the local TRICARE Overseas Program (TOP) Regional Call Center before seeking care or before making a payment. Figure 5.2 lists contact information for the TOP Regional Call Center in each overseas area.

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

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

All Other TRICARE Prime Enrollees

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

If urgent treatment cannot wait until you return home to see your PCM, you must contact your PCM for a referral or call your regional contractor for assistance before receiving care. Failure to obtain
Section 5
Changes to Your TRICARE Coverage

A referral may cause your care to be covered under the POS option,* and you will incur higher costs.

When traveling overseas, plan for health care contingencies in advance of the trip. If you need emergency care, go to the nearest emergency care facility or call the TOP Medical Assistance number for the overseas area where you are traveling. If you are admitted, you must call your PCM and the TOP Regional Call Center before leaving the facility, preferably within 24 hours or the next business day to coordinate authorization, continued care, and payment if applicable. Contact your PCM and the TOP Regional Call Center for urgent care. See Figure 5.2 for overseas contact information.

TRICARE Overseas Program Contact Information

<table>
<thead>
<tr>
<th>TRICARE Eurasia-Africa</th>
<th>TRICARE Latin America and Canada</th>
<th>TRICARE Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa, Europe, and the Middle East</td>
<td>Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands</td>
<td>Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries</td>
</tr>
</tbody>
</table>

TRICARE Overseas Program (TOP) Regional Call Center
011-44-20-8762-8384
tricarelon@internationalsos.com

Medical Assistance
011-44-20-8762-8133

TRICARE Area Office
011-49-6302-67-6314
314-496-6314 (DSN)
1-888-777-8343, option 1 (toll-free)
toeweb@europe.tricare.osd.mil
www.tricare.mil/eurasiafrica

TRICARE Area Office
1-703-588-1848
312-425-1848
1-888-777-8343, option 3 (toll-free)
toalac@tma.osd.mil
www.tricare.mil/tlac

TRICARE Area Office
011-81-6117-43-2036
315-643-2036 (DSN)
1-888-777-8343, option 4 (toll-free)
tpao.csc@med.navy.mil
www.tricare.mil/pacific

* For toll-free contact numbers, visit www.tricare-overseas.com. Only call Medical Assistance numbers to coordinate overseas emergency care.

Filling Prescriptions on the Road

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

TRICARE Retail Network Pharmacy

You can fill prescriptions at any TRICARE retail network pharmacy in the United States and U.S. territories (American Samoa,* Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

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

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

Military Treatment Facility Pharmacy

If you are traveling, you can fill a new prescription at any MTF pharmacy free of charge if the medication is on the MTF formulary and in stock. All you will need is the written prescription and your uniformed services ID card or Common Access Card (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 a non-network pharmacy. If you fill a prescription at a non-network pharmacy, you will be using the POS option. You may be required to pay for prescriptions up front and then file a claim with Express Scripts for reimbursement. See the Claims section for details about filing pharmacy claims.

Filling Prescriptions Overseas

Your pharmacy coverage is limited overseas. TRICARE recommends that you fill all your prescriptions before you travel overseas. TRICARE retail network pharmacies are only located in the United States and U.S. territories (American Samoa*, 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 with WPS for reimbursement for host nation pharmacy services when traveling overseas.

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

Moving

TRICARE Prime coverage is portable—you can easily transfer your TRICARE Prime enrollment when you move within your TRICARE region or to a new TRICARE region. Follow these simple steps to ensure continuous coverage when you move:

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

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

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

- **ADSMs:** Transfer your enrollment to TRICARE Prime Remote (TPR) by submitting a new DD Form 2876. The enrollment transfer is effective when your regional contractor receives your form.
- **Active duty family members (ADFM):** If you live with your TPR-enrolled sponsor, your enrollment will transfer to TRICARE Prime Remote for Active Duty Family Members (TPRADFM). Your sponsor can include you on his or her enrollment form. If you choose to disenroll from TRICARE Prime, you will be automatically covered by TRICARE Standard and TRICARE Extra, as long as your DEERS information is current.
- **Retired service members and their families and all other TRICARE Prime enrollees:** You must disenroll from TRICARE Prime. You will be covered automatically by TRICARE Standard and TRICARE Extra, as long as your DEERS information is current. If you do not disenroll, you will be using the POS option.

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

Contact the appropriate TOP Regional Call Center before you move to determine overseas TOP Prime option eligibility requirements if you are moving overseas. Retirees and their family members are not eligible for any TOP Prime options. See Figure 5.2 for Call Center contact information.

**Separating from the Service**

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

**Transitional Assistance Management Program**

TAMP provides 180 days of transitional health care benefits to help certain 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 was more than 30 consecutive days in support of a contingency operation
- Separating from active duty following involuntary retention (stop-loss) in support of a contingency operation
- Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation
- Separating from active duty with an agreement to become a member of the Selected Reserve of the Ready Reserve of a reserve component
- Separating from active duty due to sole survivorship discharge

You are not eligible for TAMP while on terminal leave. During terminal leave, you continue to receive the ADSM benefit, and your family members remain covered under TRICARE Prime. Please note that an ADSM is not eligible to change his or her PCM while on terminal leave. All care must be coordinated through his or her current PCM. If you have an injury, illness, or disease that was incurred while on active duty, contact your unit or service branch for eligibility determination or authorizations for follow-up medical or dental care. If you qualify, the 180-day TAMP period begins the day after your date of separation from active duty. When you become eligible for TAMP, you and your family members are covered under TRICARE Standard and TRICARE Extra. If you live in a PSA, you and your family members may choose to enroll in TRICARE Prime. You may also enroll or reenroll in TRICARE Prime under the following conditions:

- If you were enrolled in TRICARE Prime immediately prior to your change in status, you may continue your enrollment in TRICARE Prime with no break in coverage. A reenrollment application must be completed prior to the TAMP expiration period in order to continue with TRICARE Prime. The effective date will be the date the sponsor separated from active duty.
- If you were not enrolled in TRICARE Prime (including TPR and TPRADFM) immediately prior to your change in status, you may choose to enroll in TRICARE Prime while receiving TAMP coverage. However, such enrollment is subject to the “20th of the month rule.” Applications received by your regional contractor by the 20th of the month will become effective at the beginning of the following month (e.g., an enrollment received by December 20 would become effective January 1). If your application is received after the 20th of the month, your coverage will become effective on the first day of the month following the next month (e.g., an enrollment received on December 27 would become effective February 1).
Note: TPR and TPRADFM are not available during TAMP. If you were enrolled in one of these programs, you will be disenrolled and covered by TRICARE Standard and TRICARE Extra.

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

**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 coverage within 60 days of loss of eligibility for either regular TRICARE or TAMP coverage.

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

Contact your regional contractor or a BCAC to discuss your family’s eligibility for this program. You also can visit www.tricare.mil 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, and a monthly premium is charged. You will receive comprehensive coverage and can obtain care from any TRICARE-authorized providers. Annual deductibles and cost-shares apply. Visit www.tricare.mil/reserve/reserveselect for more information about TRS coverage.

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**Retiring from Active Duty**

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

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

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

- If you reenroll in TRICARE Prime, you will:
  - Pay an annual enrollment fee *(Network copayments apply.)*
  - Be responsible for copayments for certain medical services
  - See an increase in your catastrophic cap
  - Experience minor differences in covered services *(e.g., eye exams are now only covered every two years and hearing aids are no longer covered)*
  - Experience changes in your dental coverage *(See “Dental Options” in the Covered Services, Limitations, and Exclusions section to see dental coverage options)*
  - Your family members who use TRICARE Standard and TRICARE Extra will see a cost-share increase of five percent
  - TPR will not be available to you or your family members

You and your family members should look at your health care options together and determine which option best meets your needs after you retire. If you decide to reenroll in TRICARE Prime, you must submit your DD Form 2876 to your regional contractor prior to your retirement date; otherwise, the “20th of the month” rule may apply *(see “Transitional Assistance Management Program” earlier in this section for details)*. Visit www.tricare.mil/costs for additional information regarding program costs.
Becoming Entitled to Medicare

**Active Duty Status**

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 continue enrollment 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 have the option to continue enrollment 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.

**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 current and you are:

- A surviving spouse who has not remarried
  *(Eligibility cannot be regained later, even if you divorce or your new spouse dies.)*

- An unmarried child younger than age 21 (or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides 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 eligible as a “survivor” and pay retiree rates under TRICARE Prime. You will need to reenroll at that time and pay retiree enrollment fees and copayments.

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

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

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

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

**Dependent Parent Coverage**

If your parents or parents-in-law are dependent on you for support, your local MTF may be able to help with the cost of their health care. Although dependent parents are not eligible for most TRICARE benefits, they may be eligible to receive health care at the MTF. Dependent parents can also fill prescriptions at MTF pharmacies and through the TRICARE Pharmacy Program once they become entitled to Medicare Part A and purchase Medicare Part B.
Your branch of service will determine MTF care eligibility for your parents or parents-in-law, register them as dependents in DEERS, and issue their ID cards.

Health care for eligible dependent parents or parents-in-law is available on a space-available basis at certain MTFs. Access to care is subject to change based on the MTF’s capacity and capabilities. Also, enrollment at one MTF does not guarantee enrollment at another MTF. When moving, you should check with the MTF at your new location to determine whether care is available.

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

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

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

Loss of Eligibility

Upon loss of TRICARE eligibility, each family member will automatically receive a certificate of creditable coverage. The certificate of creditable coverage is a document that serves as evidence of prior health care coverage under TRICARE so that you cannot be excluded from a new health care plan for 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 a full-time course of study at an approved institution of higher learning, 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 which the certificate should be sent
- Requester’s signature

Certificates cannot be requested by phone. If there is an urgent need for a certificate of creditable coverage, fax your request to 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 at the 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 the payment of your claims.

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

When services are denied based on a medical necessity or a benefit decision, you 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 Appeals Requirements

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>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.</td>
</tr>
<tr>
<td>2</td>
<td>The appeal must be submitted in writing. See Figure 6.2 for the appeals submission address for your region.</td>
</tr>
<tr>
<td>3</td>
<td>The issue in dispute must be an appealable issue. The following are not appealable issues: • Allowable charges • Eligibility • Denial of services from an unauthorized provider • Denial of a treatment plan when an alternative treatment plan is selected • Refusal by a primary care manager to provide services or refer a beneficiary to a specialist • Point-of-service issues, except when services were related to an emergency</td>
</tr>
<tr>
<td>4</td>
<td>The appeal must be filed in a timely manner. An appeal must be filed within 90 days after the date on the explanation of benefits or denial notification letter.</td>
</tr>
<tr>
<td>5</td>
<td>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.</td>
</tr>
</tbody>
</table>
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, contact your regional contractor.

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

Appeals should contain the following:

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

A description of the issue or concern must include:

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

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

Filing a Grievance

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

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

Grievances may include such issues as:

- The quality of health care or services (i.e., accessibility, appropriateness, level of care, continuity, timeliness of care)
The demeanor or behavior of providers and their staff
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
- A description of the issue or concern must include:
  - Date and time of the event
  - Name(s) of the provider(s) and/or person(s) involved
  - Location of the event (address)
  - The nature of the concern or complaint
  - Details describing the event or issue
  - Any appropriate supporting documents

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

**Reporting Suspected Fraud and Abuse**

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

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 are billed fraudulently. You can also visit the TRICARE Fraud & Abuse Web site at [www.tricare.mil/fraud](http://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. Report suspected fraud and abuse to your regional contractor. See Figure 6.4 on the following page for details.

To report fraud or abuse regarding the pharmacy program, contact Express Scripts, Inc., by phone at **1-800-332-5455, ext. 367079**, or by e-mail at fraudtip@express-scripts.com.

You also can report fraud or abuse issues directly to TRICARE at fraudline@tma.osd.mil.
### Regional Grievance Filing Information

<table>
<thead>
<tr>
<th>TRICARE North Region</th>
<th>TRICARE South Region</th>
<th>TRICARE West Region</th>
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</table>
| **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

<table>
<thead>
<tr>
<th>TRICARE North Region</th>
<th>TRICARE South Region</th>
<th>TRICARE West Region</th>
</tr>
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</table>
| **Phone:** 1-800-977-6761  
**Fax:** 1-888-881-3644  
**Online:** www.healthnetfederalservices.com  
**E-mail:** program_integrity@healthnet.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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
<th>Acronym</th>
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<tbody>
<tr>
<td>ADDP</td>
<td>TRICARE Active Duty Dental Program</td>
<td>USFHP</td>
<td>US Family Health Plan</td>
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<td>ADFM</td>
<td>Active duty family member</td>
<td>VA</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>ADSM</td>
<td>Active duty service member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCAC</td>
<td>Beneficiary Counseling and Assistance Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BWE</td>
<td>Beneficiary Web Enrollment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAC</td>
<td>Common Access Card</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHCBP</td>
<td>Continued Health Care Benefit Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DCAO</td>
<td>Debt Collection Assistance Officer</td>
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<td></td>
</tr>
<tr>
<td>DEERS</td>
<td>Defense Enrollment Eligibility Reporting System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DMEPOS</td>
<td>Durable medical equipment, prosthetics, orthotics, and supplies</td>
<td></td>
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</tr>
<tr>
<td>DoD</td>
<td>Department of Defense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis-related group</td>
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<tr>
<td>DTF</td>
<td>Dental treatment facility</td>
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<tr>
<td>ECHO</td>
<td>TRICARE Extended Care Health Option</td>
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<td>EHHC</td>
<td>ECHO Home Health Care</td>
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<tr>
<td>EOB</td>
<td>Explanation of benefits</td>
<td></td>
<td></td>
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<tr>
<td>FY</td>
<td>Fiscal year</td>
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<tr>
<td>MTF</td>
<td>Military treatment facility</td>
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<tr>
<td>NMA</td>
<td>Non-medical attendant</td>
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</tr>
<tr>
<td>OHI</td>
<td>Other health insurance</td>
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<tr>
<td>PCM</td>
<td>Primary care manager</td>
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<td>PHP</td>
<td>Partial hospitalization program</td>
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<tr>
<td>POS</td>
<td>Point of service</td>
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<tr>
<td>PSA</td>
<td>Prime Service Area</td>
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<tr>
<td>RTC</td>
<td>Residential treatment center</td>
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<tr>
<td>SNF</td>
<td>Skilled nursing facility</td>
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<tr>
<td>SSN</td>
<td>Social Security number</td>
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<td>TAMP</td>
<td>Transitional Assistance Management Program</td>
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<td>TRICARE Overseas Program</td>
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<td>TRICARE Prime Remote</td>
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<td>TRICARE Prime Remote for Active Duty Family Members</td>
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<td>TRICARE Reserve Select</td>
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<td>TSC</td>
<td>TRICARE Service Center</td>
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**Glossary**

**20th of the Month Rule**
Under the “20th of the month rule,” applications for benefits received by your regional contractor by the 20th of the month will become effective at the beginning of the following month (e.g., an enrollment received by December 20 would become effective January 1). If your application is received after the 20th of the month, your coverage will become effective on the first day of the month following the next month (e.g., an enrollment received on December 27 would become effective February 1).

**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. BCACs were previously known as Health Benefits Advisors. 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). Point-of-service (POS) cost-shares and the POS deductible are not applied to the catastrophic cap.

**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.

**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 have received a negative credit rating or have been sent to a collection agency due to an issue related to TRICARE services.

**Defense Enrollment Eligibility Reporting System (DEERS)**
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.

**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 types 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, to accept payment directly from TRICARE, and to accept the amount of the TRICARE-allowable charge, less any applicable patient cost-share paid by you, as payment in full for their 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.

**Point-of-Service (POS) Option**

The POS option allows a TRICARE Prime beneficiary to obtain medically necessary services—inside or outside the TRICARE network—from someone other than his or her primary care manager without first obtaining a referral or authorization. Using the POS option results in a deductible and greater out-of-pocket expenses for the beneficiary. The POS option is not available to active duty service members.

**Primary Care Manager (PCM)**

A PCM is a TRICARE civilian network provider or military treatment facility provider who provides routine (primary) care to TRICARE beneficiaries. A PCM is either selected by the beneficiary or assigned by an MTF commander or his or her designated appointee.

**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 a 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 your TRICARE regional contractor’s Web site 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 their 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 TRICARE-authorized providers: network and non-network.

TRICARE Supplement

A TRICARE supplement is a health care plan you may purchase specifically to supplement your TRICARE Prime coverage. It pays after TRICARE pays. 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) statements.

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

Date of Notice: October 22, 2009
Sponsor SSN: ***-**-9898
Sponsor Name: TRICARE SPONSOR
Beneficiary Name: TRICARE BENE

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

Claim Number: 999999999-00-00

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<th>Services Provided By:</th>
<th>Services Provided</th>
<th>Amount Billed</th>
<th>TRICARE Approved</th>
<th>APC#</th>
<th>See Remarks</th>
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<td>PATHOLOGY LABDOE</td>
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<td>09/02/2009</td>
<td>001 Emergency dept visit (99282)</td>
<td>32.84</td>
<td>11111</td>
<td>1, 2, 3</td>
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<td>09/02/2009</td>
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Claim Summary

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Beneficiary Liability Summary

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<td>0.00</td>
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<th>Paid to Provider:</th>
<th>Paid by Beneficiary:</th>
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<tr>
<td>161.84</td>
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Check Number: 6990666666

Remarks:

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 WEBSITE TODAY.

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.
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.


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

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<th>1</th>
<th>TRICARE SOUTHERN REGION</th>
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<tr>
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<td>HUMANA MILITARY HEALTHCARE SERVICES</td>
</tr>
<tr>
<td>3</td>
<td>Date of Notice: October 11, 2009</td>
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<tr>
<td>4</td>
<td>Sponsor SSN: *<strong>.</strong>.6789</td>
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<tr>
<td>5</td>
<td>Sponsor Name: NAME OF SPONSOR</td>
</tr>
<tr>
<td>6</td>
<td>Patient, Parent/Guardian Address</td>
</tr>
<tr>
<td>7</td>
<td>Benefits were payable to:</td>
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<td>8</td>
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</table>

#### Section 9

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<td>PROVIDER OF MEDICAL CARE</td>
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<td>10/06/2009</td>
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#### Summary

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#### Remarks:

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.

---

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.
# 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 only appears here only if a check accompanies your EOB.

7. **Toll-Free Number/Web Address:** This is how you can reach us (TriWest Healthcare Alliance Corp.) if you have questions.

8. **Service 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 Services:** This is the date you received the care.

10. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.

11. **TRICARE Allowed:** This is the amount TRICARE approves for the services you received.

12. **Remarks:** If you see a code or a number here, look at the “Remark Codes” section (16) for more information about your claim.

13. **Claim Summary:** 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.
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.

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

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.

| Date of Notice | 08/14/2009 |
| Sponsor SSN    | 234567890 |
| Sponsor Name   | John B. Nice |
| Patient Name   | John B. Nice |
| Claim Number   | 2002212 053 0017930 |
| Check Number   | C0001545337 |
| Provider Number| 752906887 76550 0001 |
| Provider Name  | ABC Valley Clinic |

THIS IS NOT A BILL

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Total: $000,000.00

CLAIM SUMMARY

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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.

PAID TO

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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.

Patient Bill of Rights and Responsibilities

“TRICARE” is a registered trademark of the TRICARE Management Activity. All rights reserved.