DEPARTMENT OF DEFENSE

TRICARE Handbook

TRICARE
www.tricare.osd.mil

For Your Records

Emergency Numbers _____

Ambulance Number _____

Poison Control Number 1-800-222-1222 _____

Beneficiary Counseling and Assistance Coordinator's/Health Benefits Adviser's Name _____

Phone _____

Health Care Finder _____

Phone _____

Primary Care Manager's Name _____

Phone _____

Your Uniformed Service Sponsor's SSN _____

Phone _____

Military Treatment Facility (MTF) _____

Appointments/Phone _____

Emergencies/Phone _____

TRICARE/Managed Care Support Contractor's Name _____

Address _____

Toll-free Phone _____

Claims Processor and Toll-free Phone _____

Nurse Advice Line _____

Primary/Supplemental Insurance Company _____

Policy No. _____

Address _____

Phone _____

TRICARE Web Site	***www.tricare.osd.mil***
TRICARE Questions	***questions@tma.osd.mil***
TRICARE Questions	**1-888-363-2273**
Hearing- or Speech-Impaired	**1-877-535-6778 (TTY/TDD)**
National Mail Order Pharmacy	**1-800-903-4680**
DEERS	**1-800-538-9552**

WELCOME to the Military Health System… TRICARE.

This handbook is a guide for you to learn about the TRICARE program. We know you will find it useful. This handbook is for the new user, the experienced user checking on a benefit, and the civilian provider office manager helping patients.

If you would like to make comments to improve this handbook, please contact TRICARE Management Activity, Office of Communications and Customer Service, Skyline Five, Suite 622, 5111 Leesburg Pike, Falls Church, Virginia 22041-3206 or call (703)-681-1770. We want to make it work for you.

If you are new to TRICARE or it's been a while since you have had to work with the program, please contact one of the following:

- Beneficiary Counseling and Assistance Coordinator (BCAC)/ Health Benefits Adviser (HBA) at the nearest Military Treatment Facility (MTF). We will use MTF throughout the handbook. The acronym will include all uniformed and military service hospitals and clinics.
- Nearest TRICARE Service Center (TSC).
- Primary Care Manager (PCM).
- Regional Managed Care Support Contractor (MCSC).

These terms will be discussed in the handbook and are listed in the glossary.

*Use these resources **before** seeking care from either a military or civilian source. They are there to help you use your benefit wisely.*

Please remember this handbook is only a guide; public law and 32 CFR (Code of Federal Regulations) Part 199 govern the TRICARE policy and benefit. These documents are the final word on TRICARE regulations, policies, and benefits. If a difference exists among this handbook and these authorities, federal laws and 32 CFR 199 are the guiding force.

Another important fact to understand is your entitlement to benefits, or your *eligibility*. This eligibility information is kept in a computer database called DEERS (Defense Enrollment Eligibility Reporting System). *If you are not in DEERS, you are not eligible to use your military health care system benefit (a mechanism exists to establish retroactive eligibility if required in individual circumstances).* You or your sponsor's uniformed service determines your eligibility (not TRICARE), so you must ensure that your DEERS information is correct and current in this database. Read the DEERS section to understand this important piece of the system.

One last thing before we begin. We have a great web site that has this handbook in electronic format, a TRICARE University course for the adventurous, the TRICARE policy manual, plus the latest changes about TRICARE at *www.tricare.osd.mil/*. The handbook is on a multi-year production cycle, so changes might occur between publication and now.

Thank you for taking the time to read this handbook to better understand TRICARE.

Before You Go Any Further...

- If you are planning to get civilian health care under TRICARE, talk to your Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA) at the nearest MTF, your nearest Beneficiary Service Office, your TRICARE Service Center (TSC), or your Primary Care Manager (PCM) *before* you seek care.
- If you're planning to get civilian inpatient health care under TRICARE, you may need a *nonavailability statement (NAS).* (See the handbook section on "Where to Get Care" for details.)
- TRICARE offers a choice of three health care options:
  - TRICARE Prime where MTFs are normally the principal source of health care
  - TRICARE Extra is a network of providers that you may use on a case-by-case basis at a discounted cost share
  - TRICARE Standard (formerly CHAMPUS), in which you see the authorized civilian health care provider of your choice, then file a claim—or the provider does it for you—for reimbursement by the regional TRICARE contractor.
- TRICARE For Life is available for those who are 65 years of age and over, are Medicare Part A eligible, and have enrolled in Medicare Part B.

How to Use This Handbook

- Check the Contents page first. It directs you to the specific sections to help you find information about various aspects of the TRICARE programs.
- Check the Glossary in the back of the book if you don't understand the meaning of a particular word or term. Terms and words that have a special meaning under TRICARE are explained there.
- Check the Index in the back of the book for specific entries or topics.
- Check with your local or overseas Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA), TRICARE Service Center (TSC), Health Care Finder (HCF), or Beneficiary Service Office if you have questions.

Remember, **this handbook does not cover all details and special rules of TRICARE.** Certain rules may change over time. That's why your BCAC/HBA, HCF, and TSC are so important. Their job is to help you use your health benefits. To get in touch with your nearest BCAC/HBA, HCF, or TSC, call the information number at the nearest military base or hospital. If you don't know what hospitals or clinics are located near you, check our web site at *www.tricare.osd.mil* (see the section on TRICARE Regions) or call your regional TRICARE contractor.

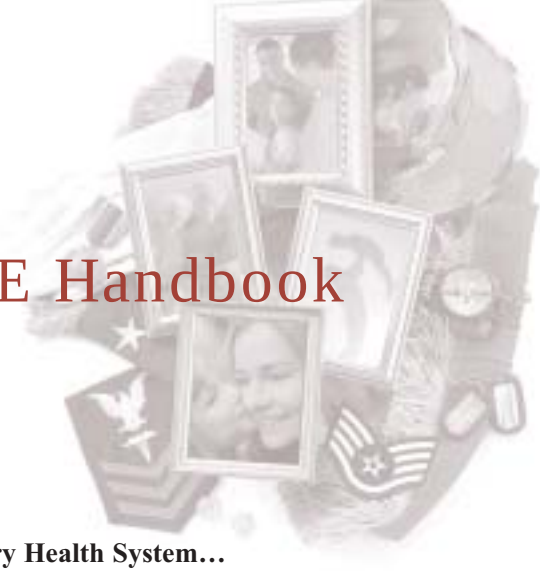
Some Words of Advice

If you aren't sure whether TRICARE covers a service or supply, contact your BCAC/HBA/TSC, HCF, or your TRICARE contractor. *They can advise you about covered services, but they can't guarantee payment by TRICARE.* That determination comes later, after a claim has been submitted. If you're enrolled in TRICARE Prime, **be sure to see your PCM for a referral before getting any type of civilian specialized medical care**. After the PCM makes a referral, the HCF issues an authorization for the care. Your PCM usually contacts the HCF for the authorization, but you should ask the HCF for help in locating a provider and making an appointment.

Since you are the recipient of health care, you are a partner in ensuring payment is made for service(s) provided.

And don't forget—if you have other health insurance, you or your health care provider must first file a claim with that insurance plan (unless it's a policy that's designated as a TRICARE supplement) and receive a payment determination before filing with TRICARE.

Keep in mind that the applicable Federal laws and **32 CFR Part 199** are the final word on any TRICARE issue. If any difference exists among this handbook, what anybody tells you, and the law and regulation, it's the law and regulation that apply (32 CFR 199 is on the Military Health System/TRICARE web site at *www.tricare.osd.mil*. Click on "TRICARE Beneficiaries," then on "TRICARE Manuals").



TRICARE Handbook

Contents

A Look at TRICARE

TRICARE: What Is It?

TRICARE is the name of the Department of Defense's managed health care program for active duty military, active duty service families, retirees and their families, and other beneficiaries. Under TRICARE, you'll generally have three options for health care:

- TRICARE Prime
- TRICARE Extra
- TRICARE Standard (formerly called CHAMPUS)

Here's a look at each of the three options:

TRICARE Prime

This is a voluntary health maintenance organization (HMO)-type option. If you decide to get your health care through TRICARE Prime, active duty members and their dependents have no enrollment fee. Retirees pay an annual enrollment fee and normally enroll for one year at a time. *You should receive a TRICARE Prime handbook specific to your region when you enroll.* This TRICARE handbook does not go into regional details on TRICARE Prime.

Also, you can "split" your family's enrollment—that is, you can have different family members enrolled in TRICARE Prime in different TRICARE regions, at no additional cost. Or you can have some of your family in TRICARE Prime and other family members in the other programs.

Your TRICARE Prime enrollment is "portable"—you can take it with you if you move from one TRICARE region to another, without having to disenroll in one region and reenroll in another, except when moving to and from an overseas assignment. You will need to notify your new TRICARE Managed Care Support Contractor (MCSC) upon arriving at your new location. Your new TRICARE MCSC will contact your former MCSC to ensure that your enrollment is properly transferred.

Normally, you'll receive your care from military providers in an MTF or from the TRICARE Prime network of civilian providers. An advantage of being enrolled in TRICARE Prime is the policy directed access standards for TRICARE appointments. They are as follows:

- Urgent care — 24 hours
- Routine appointment — 7 days
- Routine specialty care — 30 days
- Wellness, health promotion — 30 days

Point-of-Service

If you're a TRICARE Prime enrollee, you also have what's called a point-of-service (POS) option. This means that you can choose to get TRICARE-covered non-emergency services outside the TRICARE Prime network of providers without a referral from your Primary Care Manager (PCM) and without authorization from a Health Care Finder (HCF). However, if you choose to get care under the POS option, *there's an annual deductible* (for both inpatient and outpatient care) of **$300** for an individual and **$600** for a family. After the deductible is satisfied, your cost share will be **50 percent** of the TRICARE allowable charge. Any additional charges by non-network providers are also your responsibility: up to 15 percent above the allowable charge, as permitted by law. POS cost sharing may also apply to services you receive from a TRICARE Prime network provider if you don't get a required pre-authorization for the care.

Because of the increased costs associated with point-of-service care, you should always contact your PCM and HCF to ***get authorization before getting care.*** *Be sure to get (and keep for your records) an authorization number, documenting the fact that you received the authorization to get the care. Ask your PCM or HCF to provide you a written copy of the authorization via mail, fax, or e-mail, also.*

The POS option does not apply to TRICARE Extra or TRICARE Standard.

Is TRICARE Prime the Right Plan For You?

It depends. TRICARE Prime may be the least costly of the three TRICARE options for you. You'll be able to predict your health care costs more exactly. As noted earlier, there's no enrollment fee for active duty members and their families—and no copayments when you get health care within the TRICARE Prime network of civilian providers. For retirees and other TRICARE Prime eligible beneficiaries, there is a small enrollment fee and minimal copayments when getting health care through the TRICARE Prime network.

TRICARE Prime is **easy to use.** You'll have a PCM at your Military Treatment Facility (MTF) or in the TRICARE Prime provider network, from whom you'll get most of your care, and who will refer you to specialists within the network when necessary. Your local HCF at the TRICARE Service Center (TSC) will make the arrangements for you to get the specialized care after you receive a referral from your PCM.

A recent change in Federal law allows you to be reimbursed for reasonable travel expenses when your HCF authorizes your referral to a specialist who's more than 100 miles away from your PCM's office. Check with your PCM, or Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA) for details.

The services of HCFs are available to you 24 hours a day, 7 days a week. The various TSCs in the region served by your contractor will have representatives available during regular business hours to provide information about all aspects of your health benefits.

There's **less paperwork** with TRICARE Prime. When you get care from a provider who is part of the TRICARE Prime network,

you don't have to file claims (but if you should seek care from a non-network provider, you or the provider may have to file a claim with the regional TRICARE contractor).

TRICARE Prime might not be your best choice if you have other health insurance (OHI) as your primary coverage (this is especially true if the OHI is an HMO, since the OHI and TRICARE Prime might require that you use different providers). In such a case, TRICARE will pay only after your other insurance has paid whatever it's going to pay for your civilian care. **If you discontinue your OHI when you enroll in TRICARE Prime, and later choose to disenroll or become ineligible for TRICARE Prime, you might have difficulty getting your other insurance back, or you might experience some waiting periods, especially if you have any pre-existing medical conditions.**

If you frequently travel out of your TRICARE Prime service area, TRICARE Prime might not be your best choice. The reason: when you get civilian care outside your TRICARE Prime service area, TRICARE Prime will pay only for emergency services—and for urgent care when it has been authorized in advance by the Health Care Finder in your home service area.

You might not want to enroll in TRICARE Prime if you don't want to be restricted to using providers who are members of the TRICARE Prime network only. A better choice might be either the TRICARE Extra or TRICARE Standard options, which are described later in this chapter.

When you enroll in TRICARE Prime, your enrollment is continuous. During the period of your enrollment, you're "locked in" to using only TRICARE Prime (with the expensive exception of getting care under the "point-of-service" option). You can become ineligible for TRICARE Prime while enrolled due to a move to a non-TRICARE Prime area, a move out of your service area, or if you are disenrolled for non-payment.

Note: *There are no pre-existing condition limitations for TRICARE.*

TRICARE Extra

With this option, you don't have to enroll or pay an annual fee. You do have to satisfy an annual deductible for outpatient care, just as you do under TRICARE Standard. (See the section on TRICARE Standard below, and also see the chapter titled "How Much Will It Cost?"(page 113) for more information about the deductible under TRICARE Standard.) The deductible and cost sharing work the same way for TRICARE Extra.

In the TRICARE Extra program, when you receive care from a TRICARE Extra network provider, you get a *discount* on cost sharing, and you don't have to file your own claims. You don't enroll and may use TRICARE Extra on a case-by-case basis just by using the network providers. TRICARE Extra is not available overseas or to active duty service members.

The annual outpatient deductibles for TRICARE Extra are the same as for TRICARE Standard: for the families of active duty E-4s and below, $50 for one person or $100 for a family per fiscal year. For all others, the deductible is $150 for one person or $300 for a family.

In general, after the annual outpatient deductible has been satisfied, the cost share for care under TRICARE Extra for an active duty family member will be 15 percent of the fee for which the TRICARE Extra network provider has contracted to provide the medical service or supply. All other eligible persons will pay a 20 percent cost share of the contracted fee. You can get a list of TRICARE Extra providers by contacting one of the TSCs located in your region, by calling the toll-free numbers established by the MCSC, or by checking the MCSC's web site.

There are a few exceptions to the TRICARE Extra cost sharing percentages. (See the cost charts section beginning on page 22.)

In addition to what's on the charts, the *ambulatory surgery* cost is $25 for active duty families and 20 percent of the contracted fee for all others.

There's an annual "catastrophic cap" on how much a family will have to pay for their *covered* care under TRICARE Extra. It's the same as for TRICARE Standard. (See the "How Much Will It Cost?" chapter for details.)

TRICARE Standard

TRICARE Standard is what once was called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The name has been changed to TRICARE Standard—one of the three TRICARE options that are available to TRICARE-eligible people.

TRICARE Standard shares most of the costs of care from civilian hospitals and doctors when you don't get care through a uniformed services hospital or clinic. But there are certain important things you need to know about TRICARE Standard before using it.

- The lowest cost medical care is available from MTFs.
- Benefits and costs vary for different categories of eligible persons.
- While you might be eligible to use MTFs, your access may be restricted based on the MTF's capacity to see patients.
- Some people are not eligible for TRICARE Standard, such as active duty service members, dependent parents, and parents-in-law. (See the section called "Who's Eligible For TRICARE?" on page 28 for details.)
- TRICARE Standard **is not free.** You must pay part of your medical costs, as well as everything TRICARE Standard doesn't cover. (See the section on page 113 called "How Much Will It Cost?" for cost information.)
- TRICARE Standard **does not cover all health care.** There are special rules or limits on certain care, and some care is not covered at all. (See the sections on "What's Covered?" on page 63 and "What's Not Covered?" beginning on page 97 for information.)
- TRICARE Standard **pays for only medically necessary care** and services that are provided at an "appropriate level of care." Claims for services that don't meet this definition will be denied.
- Your **provider must be certified by the regional contractor as an authorized provider of care** under TRICARE Standard for the Government to share the cost of care you receive. Being "authorized" or "certified" is not the same as being a "participating" or "non-participating" provider of care under TRICARE Standard. (See the chapter titled "Where to Get Care" beginning on page 93 for discussions of authorized providers as well as participation and non-participation.)

- You or your provider **must file claims before TRICARE Standard can pay its share of the bills.** It is important to fill out the claim form correctly and to include any necessary paperwork. (See the section on "How to File a Claim" for more information.)
- Equally important, all TRICARE eligible persons **must be enrolled in the DEERS** computerized eligibility database before TRICARE claims can be paid. (See the DEERS section on page 25 for more information about DEERS.)

The section called "Tips on Using TRICARE Standard" has information that will help you use your health benefits. The most important person to get to know is your BCAC/HBA, HCF, Beneficiary Services Representative (BSR) and others at your nearest MTF or TSC. Their job is to help you locate providers and get the medical care you need, at the best price and in the most convenient manner. There are BCAC/HBAs at many military hospitals and clinics, and TRICARE Service Centers are located throughout the regions served by the various TRICARE contractors.

TRICARE Standard Does Not Cover

- Active duty service members.
- Dependent parents and parents-in-law. (They are, however, eligible for care in military medical facilities on a space-available basis.)

Medicare and TRICARE (Also See TRICARE For Life Chapter)

In an important change to the law, Medicare-eligible uniformed-services retirees, their spouses, and survivors who are age 65 and over are now entitled to expanded health-care benefits, under the National Defense Authorization Act of 2001. The new benefits include coverage under TRICARE and pharmacy coverage.

The pharmacy benefits were effective April 1, 2001. TRICARE coverage was extended to the Medicare-eligible persons listed above, effective October 1, 2001.

TRICARE beneficiaries who turned 65 before April 1, 2001, may use the pharmacy benefit without being enrolled in Medicare Part B. Those who reached age 65 on or after April 1, 2001, must be enrolled in Medicare Part B to use the pharmacy benefit.

Effective October 1, 2001, under the new law, eligible beneficiaries who continue to receive medical care from their current Medicare providers will have TRICARE as their second payer. TRICARE will pay their out-of-pocket costs for services covered under Medicare and TRICARE. In addition, they have access to TRICARE benefits that may not be covered under Medicare. To continue using TRICARE after age 65, Medicare-eligible beneficiaries *must* be enrolled in Medicare Part B.

Medicare eligibility begins on the first day of the month in which you turn 65. However, if your 65th birthday falls on the first day of the month, then your Medicare eligibility begins on the first day of the *preceding* month.

If you are the widow or widower of a service member, and remarry someone outside the uniformed services, you are no longer covered by TRICARE (unless the marriage is annulled, in which case eligibility is reinstated after the annulment). If you remarry a member or former member of the uniformed services entitled to retired or retainer pay you will remain eligible.

Retired reservists, National Guard, and their families are covered by TRICARE after the reservist reaches age 60 and begins to receive retired pay. Check with your BCAC/HBA/TSC on this.

Families of veterans with 100 percent, permanent disability, or of veterans, who died from a service-connected disability, may be covered by CHAMPVA as long as they are not eligible for TRICARE. These veterans—who left active duty without qualifying for a regular military retirement—must receive their care from the Department of Veterans Affairs (VA).

Military retirees who need treatment of service-connected conditions may choose to be treated under TRICARE or to get civilian health care that's paid for by the VA—but not both.

Dual Eligibility

TRICARE beneficiaries under the age of 65 who become eligible for Medicare due to a disability are considered dual-eligible. They obtain Medicare coverage and keep their TRICARE benefit. This benefit is comparable to TRICARE For Life with some distinct differences:

Since 1991, dual-eligible beneficiaries have been able to use TRICARE as a second payer to Medicare. Dual-eligible beneficiaries are defined as those under 65, eligible for TRICARE and Medicare Part A, and are enrolled in Medicare Part B. Beginning October 1, 2001, the way claims are calculated will change. This change will eliminate most out-of-pocket expenses that are currently paid by our dual-eligible beneficiaries. Also, the way claims are calculated will be the same for both the dual-eligible and TFL beneficiaries.

Dual-eligible beneficiaries under age 65 currently file paper claim forms for reimbursement. Claim forms are available from any TRICARE BCAC/HBA/TSC or on the web at *www.tricare.osd.mil/claims/default.htm* (click on the CHAMPUS Claim Form). Medicare-eligible beneficiaries over age 65 generally will not need to file paper claims if they use a provider who participates in Medicare and the services provided are payable by Medicare and TRICARE.

An added benefit is dual-eligible beneficiaries under age 65 may enroll into TRICARE Prime. TFL beneficiaries cannot. Dual-eligible who enroll into TRICARE Prime have the annual TRICARE premium waived, although, like TFL beneficiaries, they are required to maintain Medicare Part B.

TRICARE Cost Comparison Charts

The tables on the next pages provide examples of cost-shares or copayments (up-to-date for Fiscal Year 2002) for families who use civilian providers and facilities under each of the three TRICARE options. The listed fees are subject to change.

Active Duty Family Members:

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductible	None	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 & below	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 & below
Annual Enrollment Fee	None	None	None
Civilian Outpatient Visit	No cost	15% of negotiated fee	20% of allowable charge
Civilian Inpatient Admission	No cost	Greater of $25 or $11.90/day	Greater of $25 or $11.90/day
Civilian Inpatient Mental Health	No cost	$20/day	$20/day

Retirees, Their Family Members, and Others:

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductible	None	$150/individual or $300/family	$150/individual or $300/family
Annual Enrollment Fees	$230/individual $460/family	None	None
Civilian Copays:		20% of negotiated fees	25% of allowed charges for covered services
Outpatient Visit	$12		
Emergency Care	$30		
Mental Health Visit	$25 ($17 for group visit)		
Civilian Inpatient Cost Share	$11/day ($25 minimum) charge per admission	Lesser of $250/day or 25% of negotiated charges plus 20% of negotiated professional fees	Lesser of $414/day* or 25% of billed charges plus 25% of allowed professional fees
Civilian Inpatient Mental Health	$40/day	20% of institutional & negotiated professional fees	Lesser of $154/day* or 25% of allowable fees

* Rates are subject to change every fiscal year.

TRICARE Regions

The TRICARE program is worldwide. However, TRICARE Prime and TRICARE Extra might not be available in overseas and in all parts of the country, if a TRICARE contractor does not have a network of providers in a particular area. If that's the case where you live, you can still use TRICARE Standard.

Listed below are the various Department of Defense Health TRICARE Service Regions. (Note: You can reach the web site for a particular TRICARE region's contractor—and for the military lead agent for each region—through links that are available by going to the Department of Defense's Military Health System/TRICARE web site at: *www.tricare.osd.mil.)*

You can also find a TRICARE region map that allows you to find individual MTFs by state and region at *www.tricare.osd.mil/tricare/trimap2.htn*.

Region 1 (Northeast) (Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Delaware, Maryland, New Jersey, New York, Pennsylvania, the District of Columbia, certain northern Virginia ZIP codes located near the Washington, DC area, and a few ZIP codes in eastern West Virginia).

– Contractor: Sierra Military Health Services, Inc. Toll-free phone: 1-888-999-5195 (Beneficiary Services); 1-888-333-4522 (Health Care Finder); 1-800-578-1294 (Routine Claims).

Region 2 (Mid-Atlantic) (North Carolina and most of Virginia, ***except*** a small part of northern Virginia).

– Contractor: Humana Military Healthcare Services. Toll-free phone: 1-800-931-9501.

Regions 3 (Southeast) and 4 (Gulf South)—(Florida, Georgia, South Carolina, Alabama, Tennessee, Mississippi, the eastern third of Louisiana, which includes New Orleans and Baton Rouge, and a small part of northeastern Arkansas that's in the Naval Hospital, Millington, Tennessee, service area).

– Contractor: Humana Military Healthcare Services. Toll-free phone: 1-800-444-5445 (Beneficiary Services); 1-800-333-4040 (Health Care Finder); 1-800-403-3950 (Routine Claims).

Region 5 (Heartland) (Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, a small part of Tennessee, the St. Louis area in Missouri, and most of West Virginia, ***except*** for a small section of the eastern part of the state that's included in Region 1).

– Contractor: Humana Military Healthcare Services. Toll-free phone: 1-800-941-4501.

Region 6 (Southwest)—(Oklahoma, Arkansas—***except*** for a small piece of northeastern Arkansas that's in the Naval Hospital, Millington, Tennessee service area—most of Texas ***except*** for a triangular piece of the southwestern part of the state that includes El Paso, and approximately the western two-thirds of Louisiana, generally west of Baton Rouge.

– Contractor: Health Net Federal Services. Toll-free phone: 1-800-406-2832.

Central Region (formerly known as Regions 7 and 8)— (Arizona, Nevada, New Mexico, Colorado, Wyoming, Utah, most of Idaho, Montana, North and South Dakota, Kansas, Nebraska, Minnesota, Iowa, that piece of southwestern Texas which includes El Paso, and Missouri. There are carved out areas: the St. Louis area and Rock Island, Illinois (Region 5), Yuma, Arizona (Region 9).

– Contractor: TriWest Healthcare Alliance. Toll-free phone: 1-888-874-9378 (Beneficiary Services and Health Care Finder); 1-877-225-4816 (Routine Claims).

Regions 9 (Southern California) and 10 (Golden Gate)— (California and the Yuma, Arizona area).

– Contractor: Health Net Federal Services. Toll-free phone: 1-800-242-6788 (Beneficiary Services and Health Care Finder); 1-800-930-2929 (Routine Claims).

Region 11 (Northwest)—(Alaska, Washington, Oregon, plus the following six counties in northern Idaho: Benewah, Bonner, Boundary, Kootenai, Latah, and Shoshone).

– Contractor: Health Net Federal Services. Toll-free phone: 1-800-404-2042.

– For Alaska only, toll-free phone: 1-800-242-6788 (Beneficiary Services and Health Care Finder); 1-800-378-7568 (Routine Claims).

TRICARE Overseas (includes areas outside the United States, as listed previously). TRICARE Prime and TRICARE Standard are offered to service families overseas. Networks of providers for the TRICARE Prime health care option are developed by local MTFs in overseas areas. (See details on page 49 about TRICARE Overseas in the Special Programs chapter.)

TRICARE Pacific (Hawaii, Western Pacific).

– Toll-free phone: 1-800-242-6788.

TRICARE Europe (Europe, Africa, Middle East, Azores and Iceland).

– Toll-free phone: 1-888-777-8343.

TRICARE Latin America/Canada (Panama, Central and South America, Puerto Rico, Virgin Islands, Canada, and West Indies.)

– Toll-free phone: 1-888-777-8343.

TRICARE For Life

On October 1, 2001, Medicare-eligible uniformed services retirees and their eligible family members and survivors gained access to expanded medical coverage known as TRICARE For Life (TFL). Under the law health care for Medicare-eligible military beneficiaries became a permanent entitlement program, so it will not require annual renewals by the Congress. It is now truly TFL.

Summary highlights of TFL are as follows:

- TRICARE pays second to Medicare.
- You will incur no monthly premiums (except for Medicare Part B).

Benefits

TFL is an enhanced health care benefit for Medicare-eligible uniformed services beneficiaries, their eligible family members and survivors. For additional information about TFL, go on line to the TRICARE web site (*www.tricare.osd.mil*), or call the toll-free number at 1-888-DOD-LIFE (1-888-363-5433).

How TRICARE For Life Works With Medicare

When services are covered by both Medicare and TFL, and you use a Medicare provider, no claims forms are necessary. Both Medicare and TRICARE will pay your health care provider. You will receive an Explanation of Benefits (EOB) from TRICARE indicating the amount they paid. TFL provides the following benefits:

- Services covered by Medicare and TRICARE. Medicare and TRICARE pay for the same benefits in most cases. When Medicare and TRICARE both pay, Medicare will pay first. The remaining out-of-pocket expenses will be paid by TRICARE.
- Services covered by TRICARE and not Medicare. For example, health care you receive while traveling outside the United States, TRICARE will pay, and you will be responsible for an annual TRICARE deductible and cost share. You must file the claim with TRICARE. A copy of the Medicare denial should accompany the claim.
- Services covered by Medicare but not TRICARE. These are limited circumstances, for example, for chiropractic services, Medicare pays as usual, but TRICARE pays nothing.
- TRICARE pays second to Medicare in absence of other health insurance or a Medicare supplement.
- Services neither covered by Medicare nor TRICARE. The beneficiary is responsible for the cost of non-covered services, such as, custodial care, routine dental care, hearing aids, and eyeglasses.
- Prescription drugs. See section on TRICARE Pharmacy Benefit beginning on page 55.

Eligibility

TRICARE For Life is provided to the following:

- Medicare-eligible retirees, including retired National Guard and reservists
- Eligible qualifying family members and survivors
- Certain former spouses if they were eligible for TRICARE before age 65, and who have not remarried and do not have employer-sponsored other health insurance

To take advantage of this benefit, eligible beneficiaries and their eligible family members must be eligible for Medicare Part A and purchase Medicare Part B and have up-to-date information in DEERS. As a retiree, you are registered in DEERS through the Defense Finance and Accounting Service (DFAS), so any information updates are made through DFAS. Your family members with valid military identification (ID) cards are registered in DEERS, so updates must be made through DEERS (see below).

Medicare automatically enrolls the vast majority of eligible beneficiaries within 90 days prior to their attaining the age of 65. When you received your initial information from Medicare, you received a Medicare card indicating both Medicare Part A and Part B coverage. If you did not decline the Part B coverage, you are generally enrolled. If you decline the Part B coverage or if for some other reason you were not automatically enrolled in Medicare Part B, you can enroll in Medicare Part B during the annual General Open Enrollment Period, which runs from January 1 to March 31 every year. Medicare Part B coverage will then begin on July 1 of the year in which you enroll.

For more information on enrolling in Medicare Part B, beneficiaries should visit the Social Security Administration on-line at *www.medicare.gov* or call toll free 1-800-772-1213, TTY/TDD: 1-800-325-0778 for the hearing impaired. Note: Medicare-eligible family members and survivors 65 years of age and over who do not possess a valid military ID card will need to register in DEERS. To obtain a military ID card, contact your local *military personnel office.* Only the Services' personnel experts can make eligibility determinations. You can also contact the Defense Manpower Data Center (DMDC) Support Office (DSO) at 1-800-538-9552 to review your DEERS records. Mail the address change (COA) to DSO: COA, 400 Gigling Road, Seaside, CA 93955-6771. You can fax address changes to COA at 1-831-655-8317. To update only your address and telephone number in DEERS: *www.tricare.osd.mil/DEERSAddress/.*

Cost

There are no enrollment fees or premiums for TFL. Retirees and their eligible beneficiaries who wish to use TFL must be enrolled in Medicare Part B and pay the Part B monthly premium.

Using TRICARE For Life Overseas

Eligible beneficiaries and their eligible family members, who are receiving health care overseas and are enrolled in Medicare Part B, can take advantage of TFL. Because Medicare typically does not provide benefits for medical care received overseas, TRICARE becomes the primary source of health benefits. TFL will provide the same level of coverage afforded retirees under the age of 65, and beneficiaries will be responsible for the same cost shares and deductibles as under-65 retirees. See the sections on TRICARE Standard for a full explanation on how TRICARE Standard works.

Other Health Insurance and Medicare/TRICARE Supplemental Policies

Many TFL beneficiaries have other health insurance. This is health care insurance provided by an employer, former employer, or privately purchased coverage to supplement Medicare, for example. If you have other health insurance, by law, TRICARE will process your claim only after all other insurance has processed the claim. In these cases, you will need to complete a TRICARE claim form, attach the doctor's or hospital bill and the EOB from both your other health insurance and Medicare, and mail the claim to the TRICARE claims processor in your area. Keep copies of the paperwork for your records.

Frequently Asked Questions

Is there an annual fee?
There is no fee for TRICARE For Life, however, retirees must be enrolled in Medicare Part B and pay the Part B monthly premium.

Is TRICARE For Life a permanent program, or must Congress renew it each year?
TRICARE For Life is a permanent program.

Should I cancel my current Medigap coverage?
This is a personal decision. We suggest you carefully evaluate your health insurance needs to determine if you should continue purchasing Medigap coverage. An example could be pre-existing conditions that might prevent you from returning to the Medigap coverage.

I'm enrolled in the Uniformed Services Family Health Plan. Am I eligible for TRICARE For Life?
No. As long as you are enrolled in the Uniformed Services Family Health Plan (USFHP), you are prohibited from using other TRICARE benefits. However, effective October 1, 2001, your USFHP enrollment fee will be waived if you purchase Medicare Part B. You can only use USFHP or TRICARE For Life, but not both.

Can I continue to use the military treatment facilities under TRICARE For Life?
Yes. To the extent appointments are available to see patients and facilities permit, you can continue to use military treatment facilities. In addition, military treatment facilities may offer opportunities for affiliation with military providers for primary care. See section on TRICARE Plus on page 48 for additional details.

My doctor is a "non-participating Medicare provider" and does not "accept Medicare." His charges, which I pay upon service, are 115 percent of Medicare authorized charges. Medicare pays 80 percent of authorized charges, and my supplement pays the balance. Both pay me directly. Will TRICARE For Life work the same way?
TRICARE For Life will work the same way.

I will turn 65 this year. I am older than my sponsor/ husband, who is 57 and a military retiree. Currently we are enrolled in TRICARE Prime. I have not worked outside the home, so I don't know if or when I am eligible for Medicare Part A or TRICARE For Life. If I'm not eligible for Part A, may I continue to use TRICARE Prime?

If you are not eligible for Medicare Part A, premium free, when you turn 65, you will remain TRICARE eligible (and may remain in TRICARE Prime) until you become eligible for Medicare Part A, premium free. When your spouse turns 62, you will need to apply for Medicare Part A under his Social Security Number. If there is a chance that you will be eligible for Medicare Part A premium free when he turns 62, you will need to purchase Medicare Part B, to avoid paying penalties. If you are not eligible for Medicare Part A premium free when he turns 62; you will receive a Formal Determination (letter of disallowance) from the Social Security Administration. You must take the Formal Determination (letter of disallowance) to a military ID card issuing

activity and ask that your ID card be reissued to ensure that you may remain in TRICARE Prime until you become eligible for Medicare Part A. When your husband turns 65, if you are not already eligible for Medicare Part A, you will become eligible for Medicare Part A under his Social Security Number. At this time you will both be eligible for TRICARE For Life. Three months before your 65th birthday, you will receive a Department of Defense letter that explains these major benefit changes in detail.

Do I need a beneficiary card to receive health benefits under TRICARE For Life?
A separate TRICARE beneficiary card is not required for you to receive benefits under this program. Your Uniformed Services ID card and your Medicare card are all you need for Medicare to pay first and TRICARE to pay second on your claims.

If I have to file a claim for reimbursement of copays, etc., where can I get a claim form, and where do I file it?
Please see the "How to File a Claim" section on page 129 in the handbook.

I am a military retiree over 65 years old who lives outside the United States without access to Medicare. How will TRICARE For Life help me? Can it help me?
TRICARE payments for eligible beneficiaries age 65 and over in foreign countries will work much like for under-65 retirees, survivors, and their dependents. By statute, to be eligible for TRICARE, Medicare-eligible beneficiaries must be enrolled in Medicare Part B. The Part B requirement applies regardless of whether the beneficiary lives in the United States or abroad. Medicare does not pay for services outside the United States. The Medicare regulations define the United States as the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and for purposes of services rendered onboard ship, the territorial waters adjoining the land areas of the United States. Where Medicare does not pay for services, TRICARE Standard rules will apply—typically the Government will pay 75 percent, and the beneficiary will pay 25 percent of the TRICARE Standard covered charge. TRICARE would be secondary to other coverage the beneficiary may have.

What Healthcare Services are Covered, and Who Pays?

		Medicare PAYS[1]	TRICARE PAYS[2]	WHAT YOU PAY[3]
INPATIENT SERVICES (MEDICARE PART A)				
Inpatient Hospitalization (Medical-Surgical)	Days 1-60	100% (after $812 deductible)[4]	$812 deductible[4]	Nothing for Medicare covered services
	Days 61-90	All but $203/day[4]	$203/day[4]	Nothing for Medicare covered services
	Days 91-150[5]	All but $406/day[4]	$406/day[4]	Nothing for Medicare covered services
	Days 151+	Not Covered	80% if network hospital[6] 75% if Non-network hospital	$250/day or 20% of the institutional charges (whichever is less) if care is delivered in a TRICARE network hospital $414[7]/day or 25% of the institutional charges (whichever is less) if care is delivered in a Non-network hospital
Inpatient Mental Health (Psychiatric Facility) – Inpatient mental healthcare requires preauthorization. Care in excess of 30 days requires a waiver for secondary TRICARE coverage. If authorized, TRICARE pays cost share or deductible. *A new benefit period must begin before Medicare covers days 151 to 190.*	Days 1-60	100% (after $812 deductible)[4]	$812 deductible[4]	Nothing for services payable by Medicare and TRICARE
	Days 61-90	All but $203/day[4]	$203/day[4]	Nothing for services payable by Medicare and TRICARE
	Days 91-150	All but $406/day[4]	$406/day[4]	Nothing for services payable by Medicare and TRICARE
	Days 151-190	100% (after $812 deductible)[4]	$812 deductible[4]	Nothing for services payable by Medicare and TRICARE
	Days 191+	Not Covered	80% if network hospital 75% if Non-network hospital	20% of TRICARE allowable charges if care delivered In a network hospital 25% of TRICARE allowable charges if care delivered In a Non-etwork hospital

Skilled Nursing Facility: . A beneficiary must be admitted to an inpatient hospital during a benefit period for at least three days prior to receiving Medicare authorization to receive this benefit.	Days 1-20	100%	Remaining Beneficiary Liability (if any)	Nothing for Medicare covered services
	Days 20-100	All but $101.50/day[4]	$101.50/day[4]	Nothing for Medicare covered services
	Days 101+	Not Covered	80% if network hospital[6] 75% if Non-network hospital	20% of TRICARE allowable charges if care delivered In a network hospital 25% of TRICARE allowable charges if care delivered In a Non-network hospital
Hospice Care	95%		Remaining Beneficiary Liability 5%	Nothing for services payable by Medicare and TRICARE
OUTPATIENT SERVICES (MEDICARE PART B)				
Doctors Visits (Outside MTF)	80%		20%	Nothing for Medicare covered services
Emergency Room Visit	80%		20%	Nothing for Medicare covered services
Mental Health Visit	50%		50%	Nothing for Medicare covered services
Laboratory Services	100%		Remaining Beneficiary Liability (if any)	Nothing for Medicare covered services
Radiology (X-Rays)	80%		20%	Nothing for Medicare covered services
Home Health Care	100% for approved services		Remaining Beneficiary Liability (if any)	Nothing for Medicare covered services
Durable Medical Equipment	80%		20%	Nothing for Medicare covered services
Outpatient Hospital Services	80%		20%	Nothing for Medicare covered services

[1] All percentages paid by Medicare are for the Medicare approved amounts for services received from Medicare providers who accept Medicare assignment.

[2] TRICARE will pay the difference between Medicare's paid amount and Medicare's limiting charge (up to 115 percent of the allowable amount) for non-participating provider claims.

[3] TRICARE has a $3,000.00 per fiscal year (Oct 1- Sept 30) catastrophic cap (your maximum out of pocket expense).

[4] Medicare amount that will change every calendar year.

[5] Lifetime Reserve days (91-150) are sixty additional days that Medicare will pay for, minus $406/day (in 2002) deductible, when you are in a hospital for more than 90 consecutive days. These 60 reserve days can be used only once.

[6] A network hospital is one that has a contractual agreement with TRICARE.

[7] DRG per diem rate that will change every fiscal year.

Can I switch from FEHBP to TRICARE For Life?
Yes, the Office of Personnel Management (OPM) has issued further guidance on considerations for FEHBP-covered annuitants and former spouses who qualify for the newly launched TRICARE For Life (TFL) program for uniformed services Medicare eligible retirees, spouses, and survivors. OPM indicates that eligible annuitants can suspend FEHBP coverage to use TRICARE at any time by calling OPM's Retirement Information Office at 1-888-767-6738 (within the Washington, DC calling area, 202-606-0500) to obtain a suspension form. For Further Information Contact OPM, Room 3425, 1900 E Street NW, Washington, DC 20415-0001.

Can I Get Back into FEHBP?
If you suspended FEHBP coverage to use TFL, you can reenroll in the FEHBP for any reason during the next open season. If you are involuntarily disenrolled from the TRICARE program, you will be eligible to immediately enroll in FEHBP. You must request reenrollment within 31 days before and ending 60 days after your TFL coverage ends. Otherwise, you must wait until the next FEHBP open season.

DEERS, ID Cards, and Eligibility

DEERS

You must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) to receive care in MTFs or to have claims for civilian health care processed by TRICARE. Both active and retired military sponsors and all family members must be entered in the DEERS computer data banks and shown as eligible for TRICARE benefits. Newborns should be enrolled in DEERS as soon as possible after birth, in order not to risk denial of a claim because of non-enrollment. ***It's the sponsor's responsibility to make sure that his or her family members are enrolled in DEERS through the nearest military personnel office.*** All military sponsors should ensure that the status of their families (marriage, divorce, new child, etc.) and residential address and telephone numbers are current in the DEERS files, so TRICARE claims can be processed quickly and accurately. In addition, residential address and telephone number changes should be provided in a timely manner to the MCSC if you are enrolled in TRICARE Prime.

Note: *The military sponsor is responsible for disenrolling his or her family members from DEERS when they are no longer eligible for TRICARE (because of the marriage of a minor child, divorce of a spouse who isn't eligible for continued TRICARE benefits, enlistment of a child in the military, etc.). If the sponsor doesn't do this, and an ineligible family member improperly continues to receive care under TRICARE, the Government is required by law to get back the amount it paid for such care from whomever received the money. Improperly receiving care may also be considered fraud. For more information about this, read the section on recoupment of funds incorrectly paid in the chapter titled "How Much Will It Cost?" found on page 127.*

Remember: *TRICARE doesn't make DEERS entries. That's done through the local military installation's personnel office.*

However, you can send address changes to DEERS yourself. Here are the ways to do it:

- If you have access to the Internet, you may send the address changes by e-mail to DEERS. The DEERS e-mail address is *addrinfo@osd.pentagon.mil*. DEERS recommends that you use all lower-case letters when typing the e-mail address. Your e-mail should include the following: (1) sponsor's name and Social Security Number; (2) the address change you want to make; (3) names of other family members affected by the address change; (4) effective date of the address change; and (5) your area code and telephone number. Other information, such as the addresses for geographically separated family members, will be processed if you provide it.

Note: *All personal information communicated to DEERS in this manner is deemed "non-secure," and could be observed by a third party in transit. If you wish to keep your personal information secure, please DO NOT use this e-mail address.*

- Initiate a request through your nearest uniformed-service upersonnel office (this is how you'll have to make any change other than an address change). To locate the nearest military ID card facility, visit *www.dmdc.osd.mil/rsl/*.
- Call the DSO at the toll-free number 1-800-538-9552.
- Fax address changes to DEERS at 1-408-655-8317.
- Mail the address change to the DSO, ATTN: COA, 400 Gigling Road, Seaside, CA 93955-6771.
- Go on-line at *www.tricare.osd.mil/DEERSAddress/*.

Identification Cards

To use TRICARE benefits, you must have a valid identification (ID) card issued by the uniformed services and be in the DEERS database. The ID card says on the back, in the "Medical" block, whether you are eligible for medical care from military or civilian sources. Children under 10 can normally use either parent's or guardian's ID card, but must be enrolled in DEERS. After the age of 10, the child's sponsor should obtain an ID card for the child. Children under 10 should also have an ID card of their own when in the custody of a parent who is not eligible for benefits.

Newborns over 120 days old who need a *nonavailability statement* (see the glossary in the back of this book for a definition of this term) must be listed in the DEERS computer files even though they don't have an ID card.

Who's Eligible For TRICARE?

TRICARE is a health benefit program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. To use TRICARE, you must be listed in DEERS as being eligible for military health care benefits. If you don't find answers to your eligibility questions in this section, check with your military service personnel office for specific information.

TRICARE-eligible persons include the following:

- Active duty service members
- Spouses and unmarried children of active duty service members
- Uniformed service retirees, their spouses, and unmarried children
- Un-remarried former spouse and unmarried children of active duty or retired service members who have died

  Note: *Family members of active duty service members who died while on active duty, and who were on active duty for at least 31 days before death, will continue to be treated as active duty family members for TRICARE cost-sharing purposes for 3 years after their active duty sponsor dies.*
- Spouses and unmarried children of reservists and National Guard who are ordered to active duty for more than 30 consecutive days (they are covered only during the reservist's active duty tour) or of reservists and National Guard who die on active duty.
- Spouses and unmarried children of reservists and National Guard who die as a result of a line of duty condition may be eligible for health care.
- Persons who have received the Congressional Medal of Honor, and their family members, who are not otherwise TRICARE-eligible. These persons will be able to obtain health care benefits under TRICARE in the same manner as if they were entitled to retired pay.

- Unmarried children up to age 21 (including stepchildren ***who are adopted by the sponsor***) are still covered by TRICARE even if the spouse gets divorced or remarried. But in the case of a stepchild who was not adopted by the sponsor and the marriage ends in divorce, the stepchild loses eligibility on the date the divorce decree is final. It should be emphasized that stepchildren don't have to be adopted by the sponsor to be covered by TRICARE while the sponsor and the mother or father of the stepchildren remains married. A child aged 21 or over may be covered if he or she is severely disabled and the condition existed prior to the child's 21st birthday—*or*, if the condition occurred between the ages of 21 and 23 while the child was enrolled in a full-time course of study in an approved institution of higher learning and is, or was at the time of the sponsor's death, dependent on the sponsor for more than one-half of his or her support. A child may also be covered up to the 23rd birthday if he or she is in school full-time.
- Children placed in the custody of a service member or former member, by a court of law; or by a recognized adoption agency in anticipation of legal adoption by the member. TRICARE eligibility is effective July 1, 1994, if a court of law places the child. A child placed by a recognized adoption agency is eligible effective October 5, 1994.
- Children of current or former service members or their spouses born out of wedlock may be eligible for TRICARE benefits under certain conditions. Check with your Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA), or TRICARE Service Center (TSC).
- Certain family members of active duty service members who were court-martialed and separated for spouse or child abuse. The victims of the abuse within the family are eligible for health benefits for the period that the abused family member is receiving "transitional compensation" under Section 1059 of Title 10, U.S. Code. Cost sharing will be the same as for other active duty families.
- Certain abused spouses, former spouses, and dependent children of service members who were eligible for retirement, but had that eligibility taken away as a result of abuse of the spouse or child. This benefit is effective for medically necessary services and supplies provided under TRICARE Standard (CHAMPUS) on or after October 23, 1992.

- Spouses and children of North Atlantic Treaty Organization (NATO) and "Partners for Peace" (PFP) nation representatives who are officially accompanying the NATO or PFP nation representatives while stationed in, or passing through, the United States on official business. These family members are eligible for outpatient benefits only (including ambulatory surgery). They are not listed in the DEERS files, and should check with a BCAC/HBA/TSC for assistance before getting care or filing claims. (NATO and PFP family members cannot enroll in TRICARE Prime.)
- Former spouses of active or retired military who were married to a service member or former member who had performed at least 20 years of creditable service for retirement purposes at the time the divorce or annulment occurred. The former spouse must also meet the following requirements:

  1. Must not have remarried.
  2. Must not be covered by an employer-sponsored health plan.
  3. Must not be the former spouse of a NATO (or "Partners for Peace" nation) member. And—
  4. Must meet the requirements of one (not all) of the following three situations:

Situation 1:

Must have been married to the *same* member or former member for at least 20 years, and at least 20 of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment was on or after February 1, 1983, the former spouse is eligible for TRICARE coverage of health care that is received after that date. If the date of the final decree is before February 1, 1983, the former spouse is eligible for TRICARE coverage of health care received on or after January 1, 1985.

Situation 2:

Must have been married to the *same* military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment is ***before April 1, 1985***, the former spouse is eligible only for care received on or after January 1, 1985, or the date of the decree, whichever is later.

Situation 3:

Must have been married to the *same* military member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. If the date of the final decree of divorce or annulment is ***on or after September 29, 1988***, the former spouse is eligible for care received for only one year from the date of the decree.

Upon completion of the period of eligibility for TRICARE, explained in Situation 3 above, a former spouse is eligible for the ***Continued Health Care Benefit Program (CHCBP)***.

Check with your BCAC/HBA/TSC for details.

Who's *Not* Eligible For TRICARE?

- Those individuals not enrolled in DEERS. (There is a method to retroactively be registered in DEERS under certain situations. See your uniformed service personnel office.)
- Those individuals 65 years of age or over who qualify for Medicare Part A, but who are **not** enrolled in Medicare Part B. (There is an exception for certain active duty uniformed service family members.)
- Those individuals under age 65 who are Medicare-eligible because of disability or end-stage renal disease, but not enrolled in Medicare Part B. These individuals may retain TRICARE eligibility after they reach age 65, but they must enroll in Medicare Part B.
- Persons who are eligible for benefits under Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

What Are the Priorities for Care in Military Treatment Facilities?

1. Active duty service members.
2. Active duty family members *who are enrolled in TRICARE Prime* (survivors of military sponsors who died on active duty *who are enrolled in TRICARE Prime* are included in this priority group during the time period they are eligible). Active duty family members who are enrolled in TRICARE Plus fall into this category for primary care appointments only.
3. Retirees, their family members, and survivors *who are enrolled in TRICARE Prime.*
4. Active duty family members *who are NOT enrolled in TRICARE Prime* (survivors of military sponsors who died on active duty who are ***not*** enrolled in TRICARE Prime are in this priority group). These beneficiaries may enroll in the TRICARE Plus Program to receive primary care within an MTF (see that section on page 48 for additional details).

5. Retirees, their family members and survivors *who are not enrolled in TRICARE Prime.* These beneficiaries may enroll in TRICARE Plus Program (see that section for additional details).

6. All other eligible persons.

Note: *There are certain special provisions in the military treatment facilities access policy, as follows:*

- Military members who are not on active duty, but who are entitled to care in a service hospital, are in Priority Group 1. This includes members of reserve components entitled to medical care relating to conditions incurred in the line of duty and members on the Temporary Disability Retired List for required periodic medical examinations.
- NATO and other foreign military members who are entitled to care in an MTF, pursuant to an applicable international agreement are in Priority Group 1, for the scope of the services specified in the agreement.
- NATO and other foreign military members' family members who are entitled to care, pursuant to an applicable international agreement, are in Priority Group 2, for the scope of services specified in the agreement.
- As indicated in the priority list above, survivors of sponsors who die on active duty, as provided in the law—10 U.S. Code 1076(a)—are, for purposes of access to military hospitals, considered to be together with active duty family members. They would, therefore, be in Priority Group 2 or 4, depending on whether they were enrolled in TRICARE Prime.
- Persons other than those in any of the beneficiary groups identified in Priority Groups 1 through 5 don't have priority access.
- Priority access rules are not applicable to bona fide medical emergencies, or cases in which the providing of certain medical care is required by law, or applicable Department of Defense Directive or Instruction. This includes care for civilian employees who are exposed to health hazards in the workplace or are injured on the job.

In certain situations, MTF commanders may grant exceptions to the priority access rules. For example,

- A higher priority may be given to an active duty family that's in Priority Group 4 because TRICARE Prime isn't available where the sponsor is assigned, when the family member is temporarily in a location where TRICARE Prime is available, and needs medical care.
- A particular patient might be given a higher priority, if necessary, for the military hospital to maintain an adequate mix of cases for its graduate medical education programs, or to help maintain the readiness-related medical skills of its medical staff.
- A higher priority might be given to a patient in other unexpected or extraordinary cases, as determined by the hospital commander, in coordination with the military lead agent (a military office that oversees contractor operations in a particular region) for the TRICARE region.
- And, in overseas locations, other exceptions may be established to the extent necessary to support mission objectives.

Eligible beneficiaries can get outpatient care from an MTF for free. For inpatient care, you may pay only a small amount for each day. This daily fee is usually much less than the daily costs in a civilian hospital. Furthermore, you don't need a nonavailability statement for care at an MTF, and you don't have to file any claims.

Will TRICARE Exclude Retirees from Military Hospitals?

Eligible retirees, their family members, and survivors *who are enrolled in TRICARE Prime* will have improved access to military hospitals. Those who decide not to enroll in TRICARE Prime, TRICARE Plus, or those who are not eligible for TRICARE, may find their access to care reduced, because most of the capacity at military hospitals and clinics may be devoted to TRICARE Prime and TRICARE Plus enrollees. (See section on TRICARE Plus on page 48.)

Special Programs

Under TRICARE there are special programs that have been established to meet the needs of certain eligible beneficiaries, to meet congressionally mandated legislation, or to improve the benefit for all beneficiaries. These programs are addressed in the following sections.

Debt Collection Assistance Officer Program

Beginning July 26, 2000, the position of Debt Collection Assistance Officer (DCAO) was established at all Lead Agent offices and MTFs, worldwide, to help you understand and get assistance with health care related debt collection problems. If you receive a notice from a collection agency or a negative credit report because of a medical or dental bill, you should call or visit the nearest DCAO.

You must bring or submit documentation associated with a collection action or adverse credit rating to the DCAO. This includes debt collection letters, TRICARE Explanation of Benefits (EOBs), and medical/dental bills from providers. The more information you can provide, the faster it will be to determine the cause of the problem. The DCAO will research your claim with the appropriate claims processor or other agency points of contact and provide you with a written explanation of how to resolve your collection problem. The collection agency will be notified by the DCAO that action is being taken to resolve the issue. The DCAO cannot provide you with legal advice or fix your credit rating, but can help you through the debt collection process by providing you with documentation for your use with the collection or credit reporting agency in explaining the circumstances relating to the debt. You may locate the nearest DCAO by contacting your TRICARE contractor or online at *www.tricare.osd.mil*.

Other resources are in place at Lead Agent offices and MTF to help beneficiaries who are having problems with TRICARE claims, but have not been sent to collection agencies or who have questions about the TRICARE program. These resources include BCAC/HBA/TSCs who can assist you with your concerns.

Federal Employees Health Benefits Program Demonstration Program for Retirees

In 2000, the Department of Defense began a 3-year demonstration program in which up to 66,000 uniformed services retirees and their families in selected areas are eligible to enroll, and get their health care through—the Federal Employees Health Benefits Program (FEHBP). The same health plan that Federal civil service employees use.

To enroll in one of the participating FEHBP health plans, retired sponsors and their families must live within the designated ZIP code areas that encompass one of the test sites. The sites are Dover Air Force Base, Delaware; Fort Knox, Kentucky; Greensboro/Winston-Salem/High Point, North Carolina; Dallas, Texas; New Orleans, Louisiana; Naval Hospital, Camp Pendleton, California; the Humboldt County area (and surrounding counties), California; Coffee County, Georgia; Adair County, Iowa; and Puerto Rico.

The following people are eligible to participate in the demonstration:

- Medicare-eligible military retirees and their family members
- Family members of deceased active or retired military members
- Certain un-remarried former spouses of military service members or former members

Coverage under the demonstration began January 1, 2000. The demonstration is expected to run through December 31, 2002.

Please Note: *Persons who enroll in the FEHBP demonstration may not use military treatment facilities, TRICARE benefits, or pharmacy services during the period of their enrollment.*

For more details about the FEHBP test program (eligibility, enrollment, participating plans, etc.), call the Defense Department's Information Processing Center toll free at 1-877-363-3342. Or, go to the Military Health System/ TRICARE web site at: *www.tricare.osd.mil/fehbp/*.

TRICARE Prime Remote

TRICARE Prime Remote (TPR) is the program for active duty service members assigned to locations that are more than 50 miles, or approximately 1-hour drive, from an MTF. This is a special version of the TRICARE Prime benefit for active duty men and women in uniform who live and work away from military installations. Under this program, TRICARE provides you with health care when and where you need it—with less hassle and paperwork. The goal is to ensure that the local health care provider meets our standards for health care coverage.

Active duty service members must fill out an enrollment application to become eligible for this program. Contact the TRICARE contractor for your region to have one sent to you or go to the web site *www.tricare.osd.mil/remote/* to get the form or find out more information about this benefit.

Reservists and National Guard Members are also eligible for TPR if they are on orders for over 30 consecutive days and work and reside more than 50 miles from an MTF.

TRICARE Prime Remote for Active Duty Family Members

It is anticipated that TRICARE Prime Remote for Active Duty Family Members (TPRADFM) will be implemented beginning September 2002. Active duty family members who reside with their TPR-eligible sponsors in remote locations will be eligible to enroll in TPRADFM . Reservists or National Guard family members are also eligible for TPRADFM if they reside with an eligible member who is on active duty orders for 179 days or more.

Enrollment in TPRADFM will be optional for active duty family members who reside with their sponsors in designated remote locations. You can verify your sponsor's TPR eligibility on the TPR web site at *www.tricare.osd.mil/remote* or call 1-888-DOD-CARE (1-888-363-2273). For overseas beneficiaries, contact your BCAC/HBA for information on TRICARE Prime Remote Overseas.

When TPRADFM is implemented, eligible active duty family members choosing to enroll will enjoy a TRICARE Prime-like benefit. The TRICARE Prime access standards and other benefits will apply.

Network providers are available in many TPR locations, and TPR family members who are enrolled must use these providers to avoid costly point-of-service (POS) charges. In TPR locations where network providers are not available, POS will not apply. However, family members will be required to use TRICARE-authorized providers.

When TPRADFM is implemented, active duty family members residing with their TPR-eligible sponsors in remote locations who choose not to enroll, can continue using the TRICARE Standard benefit. Family members choosing to use TRICARE Standard will be responsible for TRICARE Standard deductibles and cost shares.

Active duty sponsors are encouraged to contact the Defense Enrollment Eligibility Reporting System (DEERS) to verify that information for themselves and their family members is correct. Eligibility for TPRADFM will be based on DEERS data. Sponsors may call DEERS personnel at the Defense Manpower Data Center (DMDC) Support Office (DSO) toll-free at 1-800-538-9552. Sponsors and family members can also update their addresses for DEERS on the Military Health System/ TRICARE web site at *www.tricare.osd.mil/DEERSAddress/*.

Another excellent source of information on TPRADFM is the Military Health System/TRICARE web site at *www.tricare.osd.mil*.

Uniformed Services Family Health Plan

There is a TRICARE Prime option called the Uniformed Services Family Health Plan (USFHP) available to eligible persons—including those who are age 65 and over—who live near selected civilian medical facilities around the country. These facilities are called "designated providers" (DPs)—formerly known as Uniformed Services Treatment Facilities.

At these hospitals named as DPs, the USFHP provides TRICARE Prime benefits and cost shares for eligible persons who enroll—including those who are Medicare eligible.

USFHP's TRICARE-like benefits do not include the POS option, under which TRICARE Prime enrollees can get non-emergency

care outside their TRICARE Prime network without their PCM's authorization, but pay higher cost shares and deductibles for the privilege. All care for a USFHP enrollee that's going to be cost-shared by the Government must be received from the DP, unless the enrollee is traveling (see more about transferring your enrollment to a second DP or TRICARE region below).

Enrollees must live in specific ZIP code catchment areas around one of the designated hospitals. They may not seek care at military hospitals, or under TRICARE at other civilian medical facilities, during the period of enrollment. Medicare-eligible enrollees must also agree not to use their Medicare benefits for services covered under TRICARE Prime.

Enrollment is easy. All you have to do is complete an application and submit it to the USFHP program of your choice. Enrollment is contingent on available space, and you must reside in the service area of a USFHP program to enroll. All eligible beneficiaries may enroll at anytime throughout the year. When you enroll in the USFHP, you make a 1-year commitment to receive your care from the plan, unless you move out of the area or your eligibility status changes.

As in TRICARE Prime, non-active duty USFHP enrollees must pay an annual enrollment fee of $230 for one person or $460 for a family. There's no enrollment fee for active duty family members. The enrollment fee is waived for persons who are Medicare eligible and are enrolled in Medicare Part B.

USFHP enrollments are "portable." You can transfer your enrollment to another area twice during your enrollment year—as long as the second transfer is back to the DP at the site of your original enrollment. Non-Medicare enrollees may transfer from their home DP to another DP—or to an area where TRICARE Prime is offered, and become TRICARE Prime enrollees for the duration of their stay at the new location. Medicare-eligible USFHP enrollees may transfer from only one DP to another, and back again.

The DP hospitals and clinics where you can enroll in the USFHP managed-care option are:

- **Saint Vincent Catholic Medical Centers,** 75 Vanderbilt Avenue, Staten Island, NY 10304. Telephone: 1-800-241-4848.
- **Johns Hopkins Medical Services Corporation,** 3100 Wyman Park Drive, Baltimore, MD 21211. Telephone: 1-800-808-7347.
- **Brighton Marine Health Center** (in conjunction with St. Elizabeth's Medical Center in Boston), 77 Warren Street, Brighton, MA 02139. Telephone: 1-800-818-8589.
- **Martin's Point Health Care Center**, P.O. Box 9746, Portland, ME 04104-5040. Telephone: 1-888-674-8734.
- **Fairview Health System,** 18101 Lorain Avenue, Cleveland, OH 44111. Telephone: 1-800-662-1810 (Ohio only); or (216) 476-2534.
- **PacMed Clinics,** 1200 12th Avenue South, Seattle, WA 98144. Telephone: 1-800-585-5883.
- **Sisters of Charity Health Care System,** St. Mary Hospital in Port Arthur, Texas, with additional service to eligible persons in the Galveston area; St. John Hospital in Nassau Bay, Texas; and St. Joseph Hospital in Houston, Texas. Address: P.O. Box 924708, Houston, TX 77292-4708. Telephone: 1-800-678-7347.

You can find out more information about each of these designated providers on the Internet, at the USFHP web site, at *www.usfhp.com*.

TRICARE Senior Supplement Demonstration

This test program is for military Medicare-eligible persons who are age 65 and over, and who live within designated ZIP codes in areas around Santa Clara County, California, and Cherokee County, Texas. It began April 1, 2000, and is scheduled to end December 31, 2002.

The TRICARE Senior Supplement Demonstration (TSSD) offers affordable coverage that's secondary to Medicare, and includes a pharmacy benefit for those who enroll.

Eligible persons include retired members of the uniformed services, their family members, and surviving family members of deceased uniformed-service members who died while on active duty for a period of more than 30 consecutive days. Enrollees must also be age 65 or over, eligible for Medicare Part A, enrolled in Medicare Part B, and must live within one of the demonstration sites.

TSSD offers enrollees benefits similar to TRICARE Extra and TRICARE Standard. Benefits include access to the National Mail Order Pharmacy (NMOP), use of TRICARE civilian network pharmacies, coverage for certain diagnostic and preventive services, extended mental health coverage, and coverage for health care services delivered outside the continental United States.

The enrollment cost is $576 per person, per year. You may make four quarterly payments of $144 each. Your initial payment must be sent in with your enrollment. You must also satisfy an annual deductible and pay cost-shares for your care.

For more information about the TSSD, call toll free, 1-877-363-8773, Monday through Friday, from 8 a.m. to 5 p.m., Central Standard Time. Or, go to the Military Health System/ TRICARE web site at *www.tricare.osd.mil/tssd/*.

Program for Persons with Disabilities

The Program for Persons with Disabilities (PFPWD) provides financial assistance to reduce the effects of mental retardation or a serious physical disability. It is not a stand-alone program; subject to certain restrictions, it may be used concurrently with other TRICARE medical programs. The PFPWD is not an enrollment program.

Remember: *The person must be a family member of an active duty sponsor.*

Who Qualifies?

The PFPWD serves persons with two kinds of serious disabilities: persons who have moderate or severe mental retardation and those who have a significant physical disability. If the qualifying condition existed prior to reaching age 21, the beneficiary retains eligibility as long as the sponsor remains on active duty.

Public Funds and Facilities Must Be Either Unavailable or Insufficient to Meet the Patient's Disability-Related Needs

In many communities, public funds are available for persons with disabilities. If so, you must get assistance from community sources first. Your BCAC/HBA/TSC might be able to help you find out about help available in your community.

If public help isn't available or isn't enough, TRICARE Standard helps pay for covered services. But you must include with your request for PFPWD benefits a letter from the proper public official saying why public help is unavailable or insufficient. If you don't know who the right public official is, contact your BCAC/HBA/TSC.

Note: *As with the rest of the TRICARE program, all providers of services, supplies, and equipment must be authorized. See the section titled "Where and From Whom Can You Get Care Under TRICARE" on page 107 in the "Where to Get Care" chapter.*

You Must Apply

Active duty family members, or persons acting on their behalf, who apply for benefits under the TRICARE PFPWD must show that the medical condition qualifies them for the program and that the requested benefits are necessary and appropriate. If your PFPWD-eligible family member is diagnosed with a medical condition requiring care beyond the scope of your nearest uniformed services hospital, talk with the BCAC/HBA/TSC to determine whether the family member might be eligible for care under the PFPWD.

All program benefits must be authorized in advance. Contact your BCAC/HBA/TSC for guidelines on the type of information required to establish the existence of a qualifying medical condition and to establish the need for the benefits required.

Claims for Pre-Authorized Benefits

All benefits under the program must be authorized in writing by TRICARE before any services, supplies, or equipment are received. A copy of the authorization must be attached to the claim form.

For all services and supplies under the PFPWD, individual providers of care must send in the HCFA 1500 claim form; institutional providers will use the UB-92 form. The claims should be sent to the TRICARE contractor for the region where the patient lives.

For general medical care of the disabled person, patients or their family members who must file claims will use the DD Form 2642 ("Patient's Request for Medical Payment"). Providers will use the forms listed in the preceding paragraph. Anyone under the PFPWD—no matter what age—is covered for general medical care as described in the rest of this handbook.

If the Active Duty Member is Transferred

You must get new benefit authorizations after you move. Contact the BCAC/HBA/TSC at the new location to help with this.

Changing Health Care Providers

If you need to change the provider listed on the benefit authorization form, you must ask for a new benefit authorization.

How Much Will It Cost?

You must pay part of the monthly expenses for the person's care before TRICARE Standard can help. How much you must pay depends on the sponsor's pay grade. The monthly costs are shown in the following chart.

Pay Grade	Member Pays
E-1 to E-5	$25
E-6	$30
E-7, O-1	$35
E-8, O-2	$40
E-9, W-1, W-2, O-3	$45
W-3, W-4, O-4	$50
W-5, O-5	$65
O-6	$75
O-7	$100
O-8	$150
O-9	$200
O-10	$250

Costs for One Eligible Person with a Qualifying Disability

After you have paid your share, TRICARE will pay as much as $1,000 a month for PFPWD benefits. If the costs are more than $1,000 in any month, you must pay the extra amount.

Costs for Two or More Eligible Persons with Qualifying Disabilities

If there are two or more persons with the same sponsor who receive services under the PFPWD, TRICARE will make sure you won't have to pay any more than you pay for one. TRICARE covers all allowable costs for the second person, as long as you pay your full monthly share for the other disabled person. Check with your BCAC/HBA/TSC for more information.

Be Aware of These Important Points

- The PFPWD is only for persons who are moderately or severely mentally retarded, or who have a serious physical disability, and who are the **dependents of active duty members.**
- Although the PFPWD does not require enrollment (as does TRICARE Prime, for example), you must **apply and get approval** before receiving services for TRICARE to help pay the costs of care.
- You should check with your nearest BCAC/HBA/TSC before requesting benefits under the program.
- The PFPWD benefit is limited to $1,000 per month, except for a sponsor who has more than one family member receiving benefits through the PFPWD. Sometimes, **not** using PFPWD benefits for diagnostic and treatment services can save you money. You may be able to get these services under the basic TRICARE programs (Prime, Extra, or Standard), where you may have to pay only a maximum of $1,000 in a fiscal year (this is the "catastrophic cap" on expenses for active duty families).
- But if you decide to use PFPWD for the needed services, and your costs exceed the $1,000 monthly limit, those amounts in excess of the limit under PFPWD may not be cost shared by TRICARE Standard under the basic program. Because of this, it is very important to work closely with your BCAC/HBA/TSC when considering using these benefits. (See the beginning of the chapter titled "How Much Will It Cost?" for details on the catastrophic cap.)
- Enrollment in TRICARE Prime does not affect a person's eligibility to receive services through the PFPWD; however, all requirements of TRICARE Prime, such as using the PCM for specialty care referral, must also be met.

TRICARE Plus

Where available at MTFs, TRICARE Plus is a primary care enrollment option for Military Health System beneficiaries not enrolled in TRICARE Prime, a civilian health maintenance organization (HMO), or Medicare HMO. For care from civilian providers not available in the MTF, TRICARE Standard or TRICARE Extra rules will apply. For services payable by Medicare, Medicare rules will apply, with TRICARE as second payer for TRICARE covered services and supplies if eligible for this benefit. Your PCM will refer you to an MTF specialist when space is available. Other points to note are:

- There is no enrollment fee for TRICARE Plus.
- If enrolled in TRICARE Prime, you cannot enroll in TRICARE Plus.
- Enrollment availability in this program will be based on each individual MTF's capacity to see patients as determined locally by the facility's commander.
- TRICARE Plus is not a comprehensive health plan and is not portable to other MTFs.
- TRICARE Plus enrollees are to receive primary care appointments within the TRICARE Prime access standards. See TRICARE Prime beginning on page 1.
- Priority for enrollment in TRICARE Plus will be given to persons with existing relationships with MTF providers.
- Enrollment for others will be made available through a fair process that will be determined by the MTF commander.
- TRICARE Plus enrollment will be annotated in DEERS.

TRICARE Overseas

Active duty military families who live overseas can choose how to get their health care under TRICARE. They have **two options: TRICARE Prime** and **TRICARE Standard.** Military retirees and their families who live overseas can't enroll in TRICARE Prime, but they can use TRICARE Standard.

Remember: *Medicare-eligible uniformed-services retirees and their eligible family members* ***must be enrolled in Medicare Part B*** *to receive TRICARE benefits. This also applies to overseas residents, even though Medicare doesn't pay for services received outside the U.S and its territories.*

Under **TRICARE Prime,** active duty eligible families who live overseas must enroll as they would stateside. Enrollment in TRICARE Prime for active duty families overseas is not automatic. Military sponsors must take action to enroll their families in TRICARE Prime. Active duty families will pay no enrollment fees, cost shares, or deductibles while overseas.

TRICARE Prime enrollees will have access to both military medical facilities and to networks of local civilian providers established by the commanders of military medical facilities. Wherever possible or available, most of their care will be provided by their Primary Care Manager (PCM) to whom they will be assigned. When referred by their PCM, they will have access to necessary and appropriate specialty care. Regional TSCs will provide TRICARE Prime beneficiaries with the necessary authorizations for specialty care when referred by their PCM.

The extent of provider networks will depend on the area—but even if a network is not available in a given location, enrolled active duty families will still have their cost shares and deductibles waived when authorized by the regional military service center upon a PCM's referral. However, if an overseas family member who's enrolled in **TRICARE Prime uses a non-network provider of care without getting a pre-authorization from the regional military service center, point-of-service** cost shares and deductibles will apply.

Overseas TRICARE Prime enrollees won't need pre-authorization for urgent or emergency care when receiving care in the United States.

Overseas TRICARE Prime enrollees traveling in the United States will have the same priority for available appointments at MTFs as TRICARE Prime enrollees who live near these facilities.

Persons who are enrolled in TRICARE Prime overseas may call toll free 1-888-777-8343 for assistance during normal business hours.

Note: *If you do decide to enroll in TRICARE Prime, your regional TRICARE contractor should provide you a TRICARE Prime handbook that's specific to the region in which you live. Among your contractor's publications will be a booklet containing information about TRICARE Prime and TRICARE Extra network providers*

TRICARE Standard is available to overseas families who choose not to enroll in TRICARE Prime. Benefits and procedures are the same as in the United States. (See the chapter titled "How to File a Claim" (page 129) for instructions on claim filing and claims mailing addresses.) Information about TRICARE Standard in overseas areas is also available from the BCAC/HBAs at military medical facilities.

- Retired TRICARE eligible beneficiaries overseas age 65 and over may now use the TRICARE pharmacy benefit. See the TRICARE Senior Pharmacy program on page 61 for eligibility requirements. Overseas retirees should submit claims to TRICARE for their prescription drugs. They may also use the NMOP benefit (see page 55) if they have an APO/FPO address.

Chiropractic Care Program

Chiropractic care is a health care discipline that focuses on the relationship between the structure (primarily the spine) and the function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. Chiropractic care emphasizes healing without the use of drugs or surgery, however, the chiropractic providers do work in cooperation with other health care providers for the best interest of the patient.

Eligibility for the Chiropractic Care Program

The Chiropractic Care Program is available only to **active duty service members** at designated military treatment facilities (MTFs). Family members may be referred to the traditional health care services in the Military Health System (physical therapy, family practice, or orthopedics) or may seek chiropractic care in the local community at their own expense.

Access to the Chiropractic Care Program

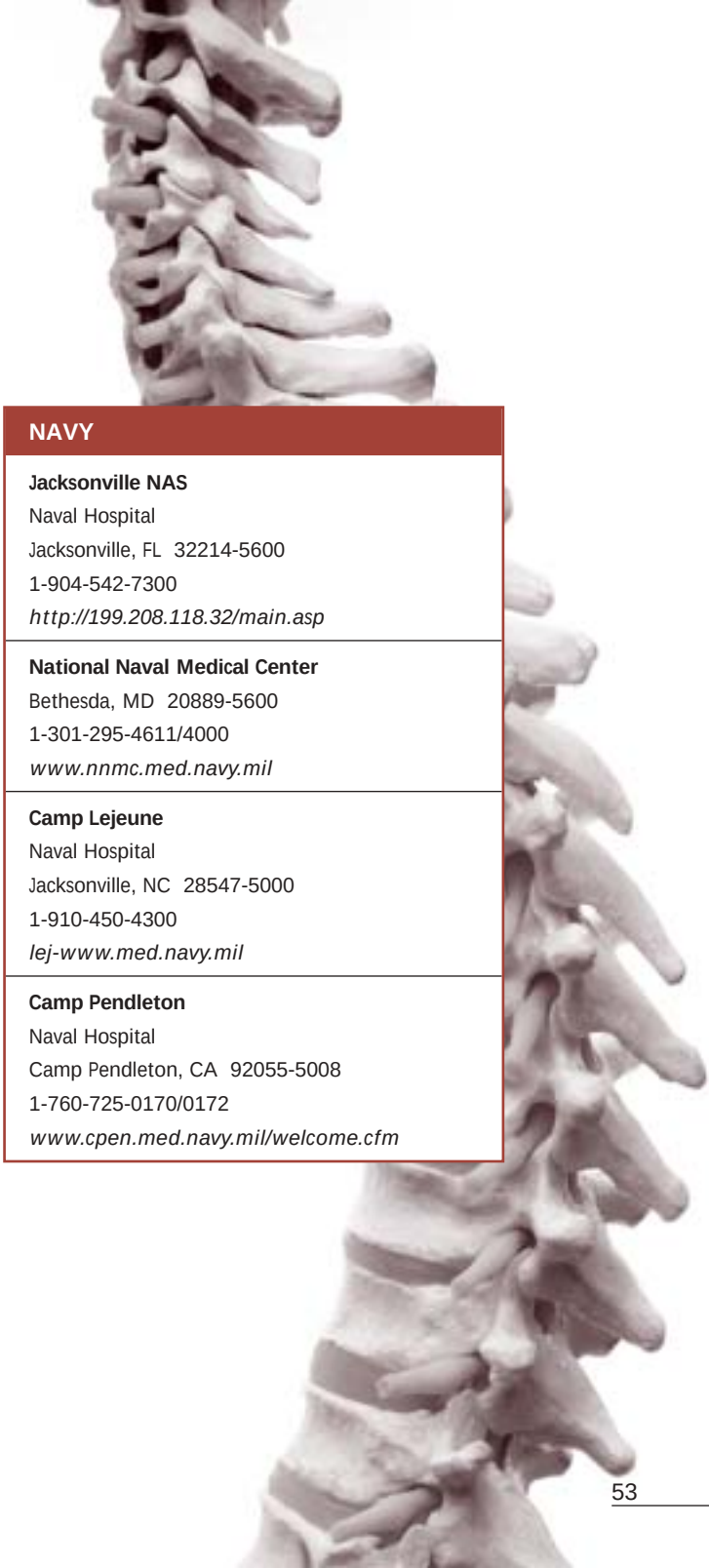
A chiropractic provider for neuromusculoskeletal conditions may treat active duty service members if referred by their PCM at one of the designated MTFs. During the course of treatment, the PCM will determine if specialty care (traditional or chiropractic) is required. If chiropractic care is considered an option, the patient will undergo a screening process to rule out any medical conditions that would prohibit chiropractic care. At this point, the patient can either continue treatment with the PCM or be referred to a chiropractic provider for treatment.

These procedures must be followed to receive chiropractic care under the Chiropractic Care Program. Chiropractic care received outside of the designated locations may not be covered under the Chiropractic Care Program.

Locations Where the Chiropractic Care Program Is Available

The charts below lists the sites where the program is available. Please contact the facility or visit the web site for more information.

ARMY
Fort Carson Evans Army Community Hospital Colorado Springs, CO 80913-5020 1-719-526-7000 *www.evans.amedd.army.mil*
Walter Reed Army Medical Center Washington, DC 20307-5001 1-202-782-3501 *www.wramc.amedd.army.mil*
Fort Benning Martin Army Hospital Columbus, GA 31905-5060 1-706-544-3461 *www.martin.amedd.army.mil/index.html*
Fort Jackson Moncrief Army Hospital Columbia, SC 29207-5758 1-803-751-2160 *www.moncrief.amedd.army.mil*
Fort Sill Reynolds Army Hospital Lawton, OK 73521-5300 1-580-458-2500 *www.tricaresw.af.mil/mtfs/ftsill.html*



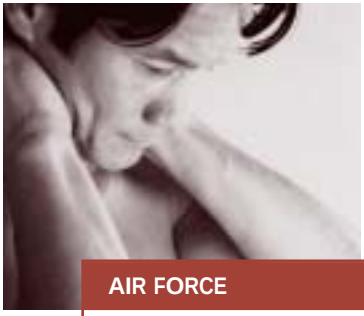
NAVY

Jacksonville NAS
Naval Hospital
Jacksonville, FL 32214-5600
1-904-542-7300
http://199.208.118.32/main.asp

National Naval Medical Center
Bethesda, MD 20889-5600
1-301-295-4611/4000
www.nnmc.med.navy.mil

Camp Lejeune
Naval Hospital
Jacksonville, NC 28547-5000
1-910-450-4300
lej-www.med.navy.mil

Camp Pendleton
Naval Hospital
Camp Pendleton, CA 92055-5008
1-760-725-0170/0172
www.cpen.med.navy.mil/welcome.cfm



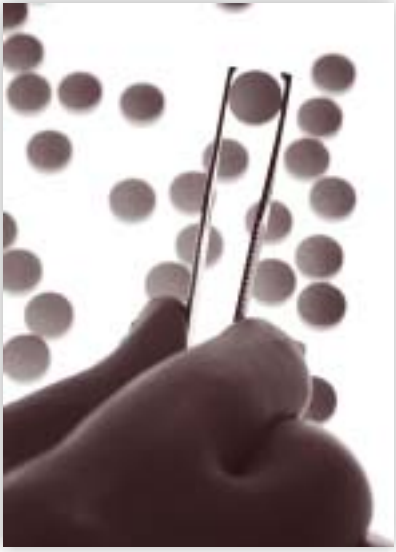
AIR FORCE

Scott AFB
USAF Medical Center
375th Medical Group
Belleville, IL 62225-5300
(618) 256-7364
https://hospital.scott.af.mil

Wilford Hall Medical Center
San Antonio, TX 78236
(210) 292-7412
www.whmc.af.mil/

Offutt AFB
Ehrling Bergquist Hospital
55th Medical Group
Omaha, NE 68113-5300
(402) 294-9760
www.offutt.af.mil/55thWing/55MDG/Medical/default.asp

For more information about the Chiropractic Care Program, please visit the TRICARE web site at *www.tricare.osd.mil/* or visit your local BCAC/HBA/TSC.



TRICARE Pharmacy Benefit

The TRICARE pharmacy benefit offers multiple ways to have your prescription filled. The most cost-effective way for you to receive prescription drugs is through the nearest uniformed service MTF. Your out-of-pocket cost for the prescription is zero. If you cannot visit a uniformed service MTF pharmacy, there are three other options: the National Mail Order Pharmacy (NMOP), TRICARE network pharmacies, and non-network pharmacies which are explained in the following sections. The TRICARE Senior Pharmacy Program is also explained.

National Mail Order Pharmacy

For prescriptions you take regularly—such as medication to reduce blood pressure or to treat asthma or diabetes—the most convenient TRICARE pharmacy option is the NMOP. You will save money by filling your prescriptions through the mail instead of going to a retail pharmacy.

To use the Department of Defense NMOP, you simply mail your health care provider's written prescription along with your copay to the NMOP, and your medications will be sent to you. Refills are available via mail, phone or Internet—whichever method you prefer through the NMOP. You may obtain up to a 90-day supply of a medication at a cost of $9 per prescription for a brand-name medication and $3 per prescription for a generic drug.

Before beneficiaries living overseas can use NMOP, the following requirements must be met:

- Have an APO/FPO address.
- The prescription must be written by a U.S. licensed provider.

How to Get Your Prescription Filled

Tell your health care provider you are using a mail order prescription filling service, and request a written prescription for a 90-day supply with refills, if possible. There are certain types of medications that may have a limit of 30 days for the supply amount, some drugs have quantity limits, and some drugs require evidence of medical necessity from a provider.

If you need to begin taking a prescription medication right away, ask your provider to write two separate prescriptions—a one-month supply for you to have filled immediately at a local retail pharmacy and a longer-term supply to be filled through the NMOP. While you wait for your shipment in the mail, you can begin taking the medication you purchased locally.

You can obtain mail order forms and pre-addressed envelopes by calling Member Services toll free at 1-800-903-4680 (outside of the United States, contact your local, long-distance carrier for access to this toll-free number, or call 1-614-421-8211). The first time you order, you also should request, complete, and return a Patient Health Registration Form, which covers issues such as drug allergies. Or download the forms and envelopes from *www.medcohealth.com*.

When you send in your form, you will also need to enclose your copayment. You may pay by check or money order payable to Medco Health Rx. You can also authorize billing to your credit card: VISA, MasterCard, Discover/NOVUS, American Express, or Diners Club.

For each prescription you are having filled, enclose a copay. For example, if you are an active-duty family member having two separate prescriptions filled for generic medications, your total cost would be $6 (two $3 copays) There are no shipping or handling charges.

You can mail your order using a pre-addressed envelope or your own envelope addressed to:

Medco Health of New Jersey, LLC
P.O. Box 1014
Summit, NJ 07902-9895

Contacting the NMOP

You can contact the NMOP:

- Within the United States: 1-800-903-4680.
- Outside of the United States: Contact your long distance carrier for access to the toll-free number above, 1-800-903-4680, or call 1-614-421-8211.
- The TTY/TDD number for the hearing impaired is 1-800-759-1089. For the vision impaired, upon special request with your order, the pharmacist will provide Braille labels for your prescription containers.
- Web site: *www.medcohealth.com*.

NMOP hours of operation are as follows:

- Weekdays, 8 a.m. to 12 midnight, Eastern Time
- Saturdays, 8 a.m. to 6 p.m., Eastern Time
- Sunday, 9:40 a.m. to 6:30 p.m., Eastern Time

A registered pharmacist is available for emergency consultations 24 hours a day, 7 days a week at the toll-free Member Services number above.

EasyRx

You can have your prescription faxed directly to Medco Health that will save yourself the trouble of sending the written prescription to Medco Health Rx Services. See if your health care provider will fax the prescription directly. Your health care provider will need to call Medco Health's Easy Rx toll-free number to obtain the appropriate form: 1-888-EASY RX 1, or 1-888-327-9791. The form will be faxed to the provider, who then fills it out and faxes it back to the number indicated. (Note that this line is set up for provider use only; he or she must request the form by calling that line.)

You may either wait to be billed the copay, or you may call Medco Health to authorize billing on your credit card. Be sure to wait 48 hours after the provider faxes the prescription to ensure your order is in Medco Health's system when you call.

TRICARE Network Pharmacies

The TRICARE network pharmacies are retail pharmacies that have contracted with TRICARE to serve its beneficiaries. If you need a prescription filled immediately, such as an antibiotic or a pain medication, visit one of these approved network pharmacies. You can receive up to a 30-day supply of medication at a time for each prescription. You pay only $9 for a 30-day supply of brand-name prescription drugs, and $3 for a 30-day supply of generic prescription drugs. Simply present the pharmacist with your written prescription and military ID card.

For a list of TRICARE network pharmacies in your area, contact the nearest TRICARE Service Center or visit the web site at *www.tricare.osd.mil/pharmacy/retail_network.htm*.

Non-Network Pharmacies

Non-network retail pharmacies are the most expensive option. Eligible beneficiaries usually receive reimbursement of 80 percent of the full retail price for medications, after they have met the TRICARE annual deductible amount ($150 per individual, $300 per family). Non-active duty TRICARE Prime beneficiaries will have to meet point-of-service (POS) deductibles. In most cases, you must pay the full retail price at the pharmacy and then file a claim for appropriate reimbursement. The reimbursement form is called the Patient's Request for Medical Payment (DD Form 2642). The form is available from a BCAC/HBA at an MTF; by mail from TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9043; or on the web. For additional information on filing claims, visit *www.tricare.osd.mil/claims*.

Also, beneficiaries can call the toll-free telephone number 1-877-DOD-MEDS or (877-363-6337), between 7 a.m. and 11 p.m. EST, Monday through Friday, 9 a.m. and 8 p.m. EST on Saturday, and 10 a.m. and 5:30 p.m. on Sunday to find out more about their benefits.

Other Health Insurance

By law, 10 U.S.C. 1079(j)(l), when a Department of Defense (DoD) beneficiary has private health insurance, that insurer must be the first payer. TRICARE then becomes secondary payer, providing reimbursement of those expenses not covered by the other health insurance. Having other health insurance (OHI) complements the TRICARE Pharmacy Program, it does not prevent anyone from using it. Beneficiaries can use the TRICARE Pharmacy Program POS mentioned above when they require a medication that is not covered by their OHI. In this case, beneficiaries would need to obtain an Explanation of Benefits (EOB) from their insurer stating the medication is not covered and submit it with a prescription. However, for medications covered by their OHI, beneficiaries should use that plan's mail order or retail pharmacy benefit, pay any copay charged by that plan, and then submit a claim for reimbursement, along with medication receipts, to a TRICARE claim center.

Policies on Available Medications at MTFs

The DoD Basic Core Formulary (BCF) is a list of medications that must be made available to beneficiaries by MTFs. BCF medications are intended to meet the majority of primary care needs of Military Health System beneficiaries. MTFs may augment the BCF with their own formularies based on the scope of care of their medical staff. The DoD Pharmacy & Therapeutics (P&T) Committee updates the BCF quarterly. Civilian prescriptions for formulary items will be filled at MTFs. Civilian prescriptions for non-formulary items are not filled at MTFs. If a beneficiary is under the care of a military provider at an MTF, the provider may special order a non-formulary drug, if he or she thinks it is justified.

DoD mail order and retail pharmacy points of service make available most non-injectable prescription medications, some injectable medications that are administered at home, and a few over-the-counter (OTC) medications requiring prescriptions.

Covered drugs are subject to limitations. The DoD P&T Committee has listed some drugs as “preferred drugs” because they have a clinical and economic advantage over other medications used for the same disease. Some medications require prior authorization or clinical justification before they can be dispensed. Certain drugs have quantity limits.

TRICARE Senior Pharmacy Program

On April 1, 2001, uniformed services beneficiaries 65 years of age and over became eligible for one of the best pharmacy benefits available in the United States to older Americans. The TRICARE Senior Pharmacy Program authorizes eligible beneficiaries to obtain low-cost prescription medications from the NMOP and TRICARE network and non-network civilian pharmacies. Beneficiaries may also continue to use military hospital and clinic pharmacies to obtain medications at no cost. The TRICARE Senior Pharmacy Program replaces the Base Realignment and Closure (BRAC) pharmacy benefit and the Pharmacy Redesign Pilot Program with a very robust benefit.

Eligibility Requirements and Medicare Part B

This pharmacy program is open to uniformed services beneficiaries age 65 and over. However, you must be registered in the Defense Enrollment Eligibility Reporting System (DEERS). Beneficiaries, who turned 65 before April 1, 2001, do **not** have to enroll in Medicare Part B. Those who turned 65 on or after April 1, 2001, **must** be enrolled in Medicare Part B to use the mail order and retail pharmacy benefits. The DoD encourages everyone to carefully consider enrollment in Medicare Part B so they will have comprehensive health care and will be eligible to take advantage of other TRICARE For Life (TFL) health benefits that began October 1, 2001. If not eligible for Medicare Part A, you have always been eligible for TRICARE, even if you are age 65 or over.

Pharmacy Payment Matrix

	TRICARE PAYS	WHAT YOU PAY
MTF Pharmacy	100% (up to a 90-day supply)	Nothing
National Mail Order Pharmacy	All but a copay for generic and brand name drugs. (up to a 90-day supply)	Copay for generic prescriptions is $3 Copay for brand-name prescriptions is $9
TRICARE Retail Network Pharmacy	All but a copay for generic and brand-name drugs (up to a 30-day supply)	Copay for generic prescriptions is $3 Copay for brand-name prescriptions is $9
Non-network Retail Pharmacy	All but a copay and applicable deductibles for generic and brand-name drugs. (up to a 30-day supply)	Copay for all drugs is $9 or 20% whichever is greater (in most cases full cost of prescription must be paid in advance). A yearly deductible of $150/individual or $300/family of E-5s & above will apply. For E-4s & below there is a $50/individual or $100/family deductible.

What's Covered?

Generally, TRICARE covers most health care that is medically necessary. But there are special rules or limits on certain types of care. And some types of care are not covered at all.

Remember: *Just because your military or civilian provider tells you that you need certain care doesn't mean that TRICARE can help you pay for it. If you're not sure whether TRICARE covers a service or supply, contact your Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA) your TRICARE Service Center (TSC) or your regional TRICARE Managed Care Support Contractor (MCSC). They can advise you about covered services, but can't guarantee that TRICARE will share the cost. That determination comes later, after the claim has been submitted.*

Also, be sure to check ahead of time with your BCAC/HBA/TSC, or your MCSC, to determine whether you need authorization **in advance** ***from the contractor for the care you seek.***

In general, TRICARE helps pay most doctor bills for inpatient and outpatient care that's **medically necessary and is not considered unproven.**

TRICARE Standard helps pay most hospital bills for semi-private rooms, meals (including special diets), diagnostic tests, and treatment. It covers medical supplies such as bandages and syringes. And, it helps pay for covered care at some health care centers other than hospitals. For example, you might need to use a residential treatment center (RTC) for an emotionally disturbed child, or a drug detoxification and rehabilitation center. The types of other health care centers covered by TRICARE Standard are listed in the chapter titled "Where to Get Care," beginning on page 103.

Much of the rest of this chapter contains the following alphabetical listing and brief explanation of various types of care that are covered by TRICARE.

Remember: *You may need pre-authorization from the contractor for the care you receive. Always check before getting the care.*

Note: *While the term TRICARE Standard is used throughout this chapter and the next, the same benefits apply to TRICARE Extra and TRICARE Prime. Any differences among the programs are noted.*

Alcoholism (and Other Substance Use Disorders)

Treatment for alcoholism or the abuse of other substances is considered mental health treatment by TRICARE Standard and is subject to the same pre-authorization requirements as mental health care. Alcoholism (or other substance use disorder) treatment includes the following:

- ***Hospital Care***

  TRICARE Standard helps pay for up to 7 days of detoxification in a TRICARE-certified substance use disorder rehabilitation facility. This may be needed when the patient suffers from delirium, confusion, trauma, unconsciousness, or malnutrition. The 7 days are included in the maximum of 30 or 45 days (depending on the patient's age) of inpatient mental health care allowed per fiscal year, but don't count toward the 21 days of rehabilitation mentioned below.

- ***Rehabilitation Stays***

  In addition to the 7-day detoxification period mentioned above, TRICARE Standard helps pay for up to 21 days of rehabilitation (this is included in the 30 or 45 days of inpatient mental health care allowed per fiscal year). But it is limited to 21 days per 365-day period and only three inpatient admissions during the person's life. And it's covered only in a hospital or special treatment center whose alcohol or other substance use disorder rehabilitation facility has entered into a participation agreement with TRICARE and identified as a TRICARE certified facility. Before getting care, check with the TRICARE claims processor to make sure the hospital or center is approved by TRICARE.

  Treatment for alcoholism or other substance use disorders includes "partial hospitalization" in a TRICARE-certified substance use disorder rehabilitation facility. Partial hospitalization is when the patient spends at least 3 hours a day at the facility, 5 days a week (the treatment may also occur on weekends or in the evening), then goes home at night. TRICARE Standard shares the cost of this treatment up to 21 days at a predetermined, all-inclusive per diem rate.

- ***Outpatient Care for Alcoholism or Other Substance Use Disorders***

  Coverage is for up to 60 visits over the course of a "benefit year," beginning the day the person starts receiving the rehabilitation phase of treatment.

  Family therapy is covered for up to 15 visits per year, beginning the day the therapy starts.

  Waivers to the limits on care can be granted if the continued care meets certain requirements. This is true of both inpatient care and partial hospitalization.

Ambulances

TRICARE Standard cost shares ambulances only when medically necessary. It must be needed for a medical condition that is covered by TRICARE Standard.

TRICARE Standard shares the cost of an ambulance for transfers between any two points determined to be medically necessary for the covered medical condition, such as from home to hospital, or between hospitals. If the ambulance is ordered from a military hospital, TRICARE Standard can't pay for it—the military hospital must pay. Ambulance transfers between hospitals are currently cost shared on an inpatient basis. Ambulance service to or from a hospital (for example, between the hospital and your home) is still cost shared on an outpatient basis. Check with your BCAC/HBA/TSC if you have questions about this.

Any Care that Lasts a Long Time

Any type of care that goes on for a long time (over a period of days or weeks, etc.), such as physical therapy, regular medication or mental health services, may need certain reviews and paperwork to be completed before, during, and after the course of treatment. Be sure to check with your BCAC/HBA/TSC.

Biofeedback

Only certain types of therapy (electrothermal, electromyography and electrodermal) are covered and only when the patient's condition is documented as not having responded to other forms of conventional treatment. There are other limits as well. Check with your BCAC/HBA/TSC before beginning biofeedback therapy.

Cancer Test Project Expansion

A DoD/National Cancer Institute (NCI) demonstration project that has allowed TRICARE patients access to promising cancer treatments has been expanded to include cancer prevention strategies, as well.

The expansion of the test permits eligible patients who meet clinical criteria to participate in NCI-sponsored Phase II and Phase III clinical trials in cancer prevention, in addition to cancer treatment.

The original demonstration, which began in 1994, allowed CHAMPUS to reimburse the costs for eligible patients who requested treatment for breast cancer under NCI-sponsored clinical trials. Effective January 1, 1996, the demonstration was expanded to include treatment for other cancers. Effective June 10, 1999, it was expanded to include prevention strategies.

Patients who want to participate in an NCI-sponsored clinical trial must first have their physician confirm with the proper TRICARE contractor for the demonstration (currently Palmetto Government Benefits Administrators—or "PGBA") that the proposed trial falls under the terms of the demonstration project. The physician must then receive authorization from PGBA for the patient to be evaluated at the institution conducting the study. If the patient is eligible for the study and agrees to participate, the physician must contact PGBA for treatment authorization.

PGBA staff members are available to answer questions from patients about the demonstration project and to provide treatment authorization for providers of care. PGBA's toll-free telephone number is 1-800-779-3060.

Participating institutions include a nationwide network of 2,000 facilities, including comprehensive and clinical cancer centers, community hospitals and practices, and military medical facilities.

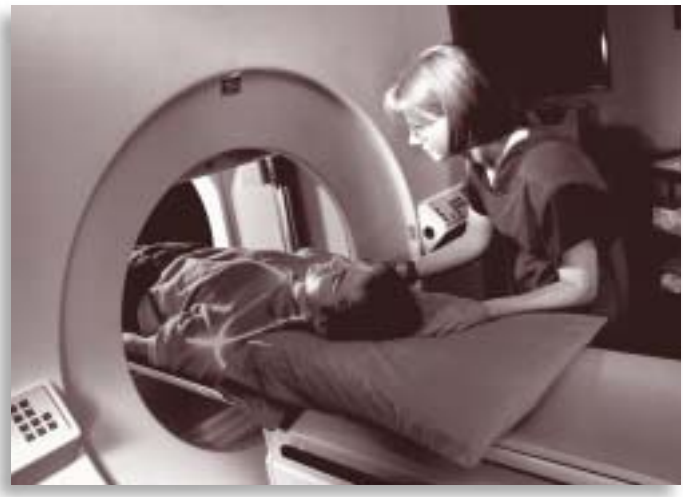
Normal TRICARE cost shares and deductibles, and other rules, policies, and regulations, will apply for demonstration participants. Transportation costs are borne by the patient.

Cardiac Rehabilitation

Certain cardiac rehabilitation programs are covered for inpatient or outpatient care. Services and supplies must be provided by TRICARE-authorized hospitals and ordered by physicians as treatment for patients who have experienced any of the following conditions or events during the preceding 12 months:

- Myocardial infarction (heart attack)
- Coronary artery bypass graft
- Coronary angioplasty (surgical reconstruction of coronary blood vessels)
- Heart-valve surgery
- Heart transplants, including heart-lung transplants
- Percutaneous transluminal coronary angioplasty (use of balloon catheter inserted into a coronary blood vessel to flatten plaque against the artery wall)
- Chronic stable angina (chest pain)—subject to certain limitations

Outpatient cardiac rehabilitation treatment is limited to 36 sessions per cardiac event, and in some cases, one series of treatments in a calendar year. There are other limits as well. TRICARE Standard won't cost share programs designed primarily for lifetime maintenance that are performed at home or in medically unsupervised settings, or for non-hospital-based cardiac rehab rehabilitation programs. Check with your BCAC/HBA/TSC for other restrictions.



CT Scans and Magnetic Resonance Imaging

Computerized tomography (CT) can be cost shared by TRICARE Standard. But the doctor must first try other diagnostic tests that can give the desired medical information and are less expensive and non-invasive (that is, involve no insertion of an instrument or foreign material into the body), unless the CT scan is considered the most appropriate diagnostic test.

Magnetic resonance imaging (MRI) is a way of producing high-quality images of cross-sections of the body in order to spot internal abnormalities or diseases. TRICARE Standard cost sharing of MRI is limited to medically necessary and appropriate use of the procedure on soft tissue areas within the body, using only MRI equipment approved by the Food and Drug Administration and used within its guidelines. TRICARE Standard won't cost share MRI's for certain kinds of patients, such as pregnant women or acutely ill patients on certain kinds of life-support systems. Contact your BCAC/HBA for more details on coverage limits and requirements for MRI, or check with the TRICARE contractor for the preauthorization requirements in your region.

Dental Care

IMPORTANT NOTE: *The dental coverage discussed below is not part of, and has nothing to do with, the uniformed services' TRICARE Dental Program, or with the TRICARE Retiree Dental Plan. (See the chapter later in the handbook for information on the TRICARE Dental Program.)*

For the most part, TRICARE Standard does not cover dental care. TRICARE Standard does cover FDA-approved prescriptions written by a dentist. The only time other dental charges are covered, is when it's a medically necessary part of medical treatment that is covered by TRICARE Standard. And in such cases, you must get approval from your TRICARE contractor before you get care from a dentist (oral surgery does not need preauthorization). (See "How to Get Approval for Dental Care" on page 96.) TRICARE covers dental care only as follows:

- When it is a necessary part of other medical care that is covered. For example, an oral surgeon may have to remove broken teeth as part of the medical treatment for an injury.
- Or, when a medical problem requires that you go into the hospital as an inpatient for dental work. For example, people with blood disorders such as hemophilia may be hospitalized for dental treatment so that any bleeding caused by the dental work can be stopped. In this case, TRICARE Standard pays for only the hospital part of the bill, not for the dental inpatient care, and for any care that is medical, not dental. For example, anesthesia used in conjunction with the dental work is not cost shared by TRICARE Standard.

TRICARE Retiree Dental Program

In early 1998, the Defense Department began offering the TRICARE Retiree Dental Program to retired uniformed service members, their eligible family members, and un-remarried surviving spouses of deceased military retirees (there are no age limits on eligibility). The program features a variety of diagnostic, preventive, restorative, endodontic, periodontal, and oral surgery services, at specified levels of cost sharing.

The program is paid for by premiums collected from retired enrollees through payroll deduction from those who receive retired pay. If you do not receive retired or retainer pay through payroll deduction, the dental program contractor bills you directly.

Initial enrollment in the program is for at least 24 months. Enrollees must submit a payment equal to two months' worth of premiums with their initial enrollment application. After the first 24-month period, enrollees may choose to stay enrolled on a month-to-month basis.

More information (including what services are not covered) is available on the contractor's web site, at *www.ddpdelta.org*. Or, check with your BCAC/HBA/TSC for details.

Combined Dental Plan for Reservists, National Guard, and Active Duty Family Members

Two TRICARE dental plans joined forces in February 2001, and now provide improved dental coverage for active duty family members, National Guard and Reserve members and their families in the process. The two plans were the TRICARE Selected Reserve Dental Plan and the TRICARE Family Member Dental Plan. The TRICARE Retiree Dental Plan (described above) remains separate from the new combined plan.

The new, single plan—which is known as the TRICARE Dental Program (TDP)—began operation February 1, 2001. It features improved benefits; easier, more efficient enrollment; and expanded eligibility. Check with your nearest BCAC/HBA/TSC for details. Also, read the section on the on page 159 in this handbook.

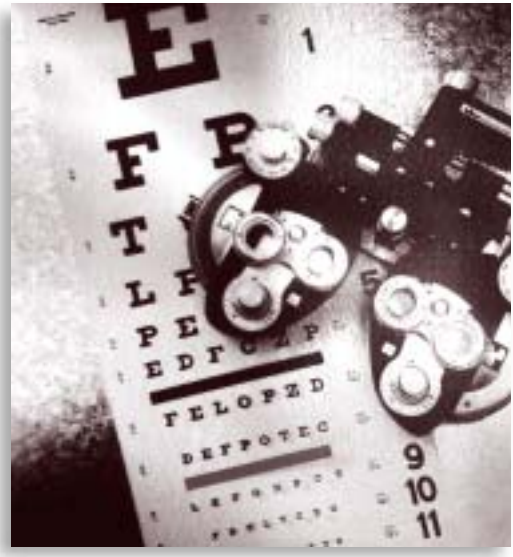
Drug Abuse

Treatment for drug abuse (substance use disorders) is covered on an inpatient or outpatient basis in a TRICARE certified treatment facility. Like treatment for alcoholism (see the "Alcoholism" section earlier in this chapter), it's covered under the general category of mental health treatment. (See the discussion of mental health coverage later in this chapter, and contact your nearest BCAC/HBA/TSC.

Durable Medical Equipment

Durable medical equipment, like wheelchairs, hospital beds, and respirators can be cost shared by TRICARE Standard. You can rent, sometimes "lease/purchase," or buy the equipment (whichever method is least expensive for the Government). A doctor's prescription specifying the particular type of equipment you need, why, and for how long you need it, must be sent in with your claim. Your BCAC/HBA/TSC can help you find a medical supply firm or pharmacy that accepts TRICARE Standard terms. Equipment that is for general use—such as air cleaners or whirlpool baths—is not cost shared by TRICARE Standard, even though a physician may have prescribed it. Because it can be complicated, be sure to check with the BCAC/HBA/TSC before getting any durable medical equipment.

Remember: *The BCAC/HBA/TSC can give you information, but can't guarantee payment by TRICARE Standard.* ***Make sure you get the exact equipment that you ordered****. If you don't get the proper equipment, notify your BCAC/HBA/TSC.*



Eye Examinations

If you are a dependent of an active duty member, you are authorized one screening eye examination per 12-month period. The exam may include a check of the internal and external structures of the eye for disease and signs of other disease and evaluation of the patient's vision and other health. An ophthalmologist or an optometrist may perform it.

Screening eye exams are not covered for any TRICARE Standard/Extra-eligible person unless the exam is related to a covered medical condition, such as cataracts or an eye injury.

Additional eye exams are authorized under the Well-Baby and Well-Child care benefit, see page 83.

If in TRICARE Prime, you are authorized eye examinations every 2 years as a clinical preventive service. Prime enrollees who are diabetic are allowed an annual comprehensive eye examination.

Family Planning

TRICARE Covers:

- Infertility diagnosis and treatment. (Remember, TRICARE Standard does not cover the active duty sponsor.)
- Intrauterine devices (IUDs).
- Measurement for, and purchase of, contraceptive diaphragms.
- Birth control pills (contraceptives) or injections your doctor prescribes.
- Norplant System long-term reversible contraceptive implants.
- Tests to find out if you're pregnant (not OTC self-tests).
- Sterilization—vasectomy or tubal ligation; check with your BCAC/HBA/TSC for limitations.

TRICARE Does Not Cover:

- Over-the-Counter contraceptives (birth control devices)—such as prophylactics (condoms) and spermicidal foams.
- Surgery to reverse sterilization.
- Artificial insemination—including sperm banks/donors, in vitro fertilization, and other artificial means of conception or the medications used to support artificial insemination.
- Abortions.

  Note: *In extremely limited circumstances, when the physician certifies that the life of the mother is endangered, TRICARE Standard can cover abortions; check with your BCAC/HBA/TSC.*

Having a Baby

Genetic Tests

Genetic tests to find out if your unborn child has genetic defects are covered. But TRICARE Standard helps pay **only** if:

- You are pregnant and age 35 years old or over, or
- You had rubella during your first 3 months of pregnancy, or
- You or your husband have had a child with a genetic (congenital) defect, or
- You or your husband comes from a family that has a history of genetic (congenital) defects.

TRICARE Standard cannot help pay for genetic tests:

- Not ordered by a doctor.
- To tell who is the father of the child.
- To tell if your unborn child will be a boy or a girl.

  Note: *Chromosome analysis in cases of infertility or where fetuses are repeatedly miscarried is considered a diagnostic service, and is not subject to genetic testing limitations.*

Maternity Care

If you become pregnant, TRICARE Standard helps pay for the maternity care you need. This is true during your pregnancy, delivery of the baby, and up to 6 weeks after the baby is born.

However, if an active duty member is discharged from the service while his wife is pregnant, TRICARE Standard does not cover any maternity care after the day of discharge, unless the family qualifies for the Transitional Assistance Management Program—or has enrolled in the Continued Health Care Benefits Program (CHCBP). (See the "Who's Eligible For TRICARE?" section on page 28 for details.)

Remember: *"Maternity care" is the care you need because you are pregnant or for complications from pregnancy. Furthermore, TRICARE Standard can share the cost only of maternity care that is covered. For example, vitamins purchased OTC during pregnancy are not covered. Prescription drugs related to the maternity care are covered.*

When you find out you're pregnant, decide where to have the baby. Do you plan to have the baby at a hospital or other health care center where you stay overnight? If so, you'll be an inpatient. Or, do you plan to have the baby at home or at a participating TRICARE Standard-authorized "freestanding" birthing center or hospital-based birthing room? If so, you'll be an outpatient.

Nonavailability Statements for Maternity Care

TRICARE requires that—except for emergencies—maternity patients who live in an MTF's ZIP code catchment area, and who are not enrolled in TRICARE Prime, generally must get all of their maternity care—***both inpatient*** **and** ***outpatient***—from that MTF. If the service hospital can't provide the needed maternity care, it will issue a nonavailability statement (NAS) to the patient, who may then seek care from a civilian source.

Patients who don't live within the ZIP code catchment area of an MTF will not have to get an NAS for their civilian maternity care.

The nonavailability statement (NAS) is a certification, issued by the MTF, that a specific medical service is not available to the patient, at the time the patient seeks the service.

Maternity patients will need one NAS for all of the maternity care associated with the pregnancy. The NAS is needed for the first prenatal visit after confirmation of the pregnancy, and will remain valid for 42 days (6 weeks) following the delivery.

Patients who have other health insurance (OHI) that pays before TRICARE are exempt from the NAS requirement (*but, check to see if your TRICARE contractor has established any other requirements for prior authorization for care*). The other health plan must be a medical-hospital-surgical plan that at least covers inpatient hospitalization of the patient.

Inpatient Deliveries

If you live in the designated ZIP code catchment area around an MTF, you must get all of your inpatient maternity care at that hospital. If the military hospital can't provide all of your inpatient maternity care, ask for an NAS. You must get the military hospital to file an NAS electronically in the Defense Enrollment Eligibility Reporting System (DEERS) computer data bank. You should also ask for a paper copy of the NAS from the MTF, and file it with the claim that's sent to the TRICARE claims processing contractor. Check with your BCAC/HBA at the MTF if you aren't sure whether your home address falls within the ZIP code catchment zone. (See additional details about NAS in the previous section, and in the "Where to Get Care" chapter, page 105.)

If you do need to go to a civilian hospital or doctor, it will save you money if you find one who participates in TRICARE Standard. (For a more complete discussion of providers who do or don't participate, see the "Where to Get Care" chapter.)

Getting Inpatient Maternity Care from Providers Who Participate in TRICARE Standard

Hospitals and doctors who participate in TRICARE Standard receive the TRICARE Standard "allowable charge" for their services. However, you must still share some of the costs as follows:

- If you're the wife of an active duty member, TRICARE Standard pays for all of the covered maternity care from your doctor. For the hospital's costs, you must pay a small amount for each day that you're in the civilian hospital. These daily rates are subject to change. In fiscal year 2002, it's $11.90 per day, with a minimum total charge of $25.
- For unmarried daughters of active duty members and retirees, TRICARE Standard will share covered maternity costs for the mother, but not medical care costs for the baby. After delivery, the baby is not eligible for TRICARE Standard, unless the father is an active duty member or a retiree and a court recognizes him as the father—or unless the military sponsor adopts the child, or has custody awarded by a court.
- If you are a retiree or the wife of a retiree, you'll pay the lesser of 25 percent of the hospital's billed charges or a fixed daily amount (currently $414, but subject to change) under the TRICARE Standard "diagnosis-related group" (DRG) payment system. TRICARE Standard pays the rest. Or, in the few areas or hospitals that don't have the DRG payment system, you'll pay 25 percent of the allowable maternity costs, and TRICARE Standard will pick up the other 75 percent.
- For claims purposes, newborns are treated as separate patients during their stay in a hospital that comes under the DRG payment system. After that, they will be charged a cost share, whether the mother continues to be hospitalized or not. Infants who are delivered in a hospital that does not come under the DRG system (such as hospitals in Maryland) will be charged a cost share for every day after the third day of their hospital stay. For NAS requirements, check with your BCAC/HBA/TSC.

Getting Inpatient Maternity Care from Providers Who Don't Participate in TRICARE Standard

If the hospitals or doctors don't participate in TRICARE Standard, you must make arrangements with them to pay your bills. They may charge more than the TRICARE Standard allowable charge.

Note*: They shouldn't charge more than the legal limit—15 percent above the TRICARE allowable charge. See the chapter titled "How Much Will It Cost?" for more details.*

If these providers charge ***more*** than the legal limit of 15 percent above the TRICARE allowable charge, **they cannot expect to receive any more reimbursement than the legal limit under Federal law,** as described above.

TRICARE Standard pays the Government's share of the allowable charge for covered care. You must pay the difference, and are responsible for paying the provider's full bill, up to the legal limits.

Hospital Birthing Rooms or Centers

If you plan to have your baby in a birthing center or a hospital outpatient birthing room, TRICARE Standard can cost share the delivery and all of your maternity care at inpatient rates if you're an active duty or North American Treaty Organization (NATO) family member (the care will be cost-shared at outpatient rates for all other TRICARE-eligible persons). That's true even if you don't stay in the hospital's outpatient birthing room for 24 hours. Check with your BCAC/HBA/TSC or claims processor to make sure the center is approved by TRICARE Standard. (See the "Outpatient Deliveries" section immediately following for information about freestanding birthing centers.)

Maternity Claims

Under the DRG payment system, separate claims must be filed for the mother and the newborn. Your hospital will take care of this for you.

Outpatient Deliveries

Do you plan to have the baby as an outpatient (that is, you won't be admitted to a hospital to give birth)? If you have your baby as an outpatient, TRICARE Standard helps pay for your maternity care on an outpatient basis, as follows:

The Outpatient Deductible

As with all outpatient care, you are responsible for the deductible for the fiscal year—October 1 through September 30. The claims processor subtracts your deductible from TRICARE Standard payments on your claims during the fiscal year and applies amounts to your deductible from claims being processed.

Getting Outpatient Maternity Care from Providers Who Participate in TRICARE Standard

Providers who participate in TRICARE Standard receive the TRICARE Standard allowable charge for their services. However, you still must share some of the costs, as follows:

- If you are the wife or unmarried daughter of an active duty member, TRICARE Standard pays generally 80 percent of your covered maternity costs. You must pay the other 20 percent, unless you use a freestanding birthing center. (See the upcoming section on freestanding birthing centers.) For unmarried daughters, TRICARE Standard pays none of the baby's bills, unless the father is an active duty, retired, or deceased service member, and a court recognizes him as the father—or unless the baby is adopted by the sponsor, or placed in the custody of a sponsor by a court.
- If you are a survivor, retiree, or the wife or unmarried daughter of a retiree, TRICARE Standard pays 75 percent of your covered maternity costs. You must pay the other 25 percent.

Getting Outpatient Maternity Care from Providers Who Don't Participate in TRICARE Standard

If the hospitals or doctors don't participate in TRICARE Standard, you must arrange with them to pay your bills. The law says they may charge up to 15 percent more than the TRICARE Standard allowable charge. TRICARE Standard pays the providers the Government's share of the cost of covered care. You must pay the difference, up to the legal limit. (See a discussion of the limits on medical bills in the chapter titled "How Much Will It Cost?")

If You Plan to Deliver at Home

Even though you plan to have your baby at home, if you live in the designated ZIP code zone around a military hospital, contact the BCAC/HBA/TSC to find out if the hospital can provide inpatient maternity care. If it can't, ask for a NAS right away!

Why? Suppose you plan to have your baby at home. But at the last minute, you decide to go to a hospital instead. Or, you might have problems with your pregnancy or delivery and need to go to a hospital. You must have the NAS before you go to the civilian hospital if TRICARE Standard is to share any of your maternity care costs.

Note: *While certified nurse midwives can be authorized TRICARE Standard providers of care, "lay" midwives (midwives who are not registered nurses) are not authorized under TRICARE Standard.*

Freestanding Birthing Centers

TRICARE Standard cost shares the use of approved "freestanding" birthing centers that agree to participate in TRICARE Standard. Birthing centers may be freestanding (separately located and not having any official connection with a "parent" institution), or they may be affiliated with, and even located at, another institution. They must be authorized as providers of care under TRICARE Standard and must have signed a participation agreement with TRICARE Standard. These birthing centers provide services for low-risk (normal) pregnancies and are limited to the use of natural childbirth procedures. Active duty family members pay $25 to use them and to use hospital-based birthing rooms for outpatient deliveries. For other TRICARE-eligible persons, cost sharing will be on a standard outpatient basis. For more information, contact your nearest BCAC/HBA/TSC.

Ambulance Costs for Maternity Care

No matter where you plan to have your baby, TRICARE Standard may share ambulance costs on an inpatient or outpatient basis. (See the section on "Ambulances" earlier in this chapter.)

Care for Your Baby

For routine newborn care, separate claims are filed, but the baby's care is paid as part of your maternity care for the first 3 days. After 3 days, the baby begins separate cost sharing as an individual at the normal rate, and may require an NAS. (See additional discussions of this in the sections on providers who participate in TRICARE Standard for maternity care, earlier in this chapter.)

Note: *TRICARE Standard cannot cost share the charges for grandchildren of active duty, retired, or deceased members, unless the child's father is an active duty member or retired service member—or unless the child is adopted by the sponsor, or placed in the sponsor's custody by a court.*

If your baby has to stay in the hospital more than 3 days, stays after you leave, or needs other than routine newborn care while you're both still in the hospital, the baby is considered a patient in his or her own right. For the first 120 days of life the baby is automatically cost shared as TRICARE Prime, if the family is enrolled in TRICARE Prime. The baby will convert to TRICARE Standard on the 121st day if not enrolled in TRICARE Prime. This means claims must be sent in separately for the baby's non-routine care. If you live in a military hospital's ZIP code catchment area, and your baby must stay in a civilian hospital after you leave the civilian facility, you may need to get a NAS for the baby from the military hospital, within 15 days of your own discharge from the civilian hospital. Or, the baby may have to be transferred to the military hospital if it can provide the care.

After you both leave the hospital, your baby becomes a TRICARE Standard beneficiary in his or her own right—the baby may have already become one if his or her hospital stay lasted more than three days. That means claims for the baby's care must be sent in and TRICARE Standard shares the costs on the same basis as for anybody covered by TRICARE Standard.

Note: *Be sure to enroll your baby in DEERS as soon as possible. TRICARE Standard will deny payment on claims for the baby unless he or she is listed in the DEERS files as being eligible for TRICARE benefits.*

Well-Baby and Well-Child Care

In an expansion of TRICARE Standard and TRICARE Extra health benefits, eligible children who haven't reached the age of 6 may now receive well-child care—like the services currently available to those who enroll in the TRICARE Prime option—from authorized civilian providers of care.

The benefit includes routine newborn care, health supervision examinations, routine immunizations, periodic health screening, and developmental assessment in accordance with American Academy of Pediatrics guidelines.

Well-child care is covered for children from birth to age 6 when services are provided by the attending pediatrician, family practice physician, certified nurse practitioner, or certified physician assistant.

For children whose health screening and immunizations aren't up-to-date, TRICARE will cost share visits and immunizations up to midnight of the day before the child turns 6 years old.

Well-child care for newborns includes the routine care of the baby in the hospital, and a variety of tests, as well as newborn male circumcision. After the baby goes home, up to nine well-baby visits in a 2-year period are covered. The visits will include such things as a history, physical exam, and mental health assessment, and a developmental and behavioral evaluation.

Well-child care is cost shared on either an inpatient or outpatient basis, depending on whether the child is hospitalized or not. The well-child care program includes such procedures as the following:

- Immunizations, according to recommendations set by the Centers for Disease Control and Prevention
- Heredity and metabolic screening tests
- Tuberculin tests, at 12 months of age, and once during the child's second year
- Hemoglobin or hematocrit testing, once each during the first and second years
- Urinalysis, once each during the first and second years
- Annual blood pressure screening between 3 and 6 years of age
- Eye exams for well child, well baby
- Assessment of risk for lead exposure, during each well-child visit from the age of 6 months up to age 6
- Health guidance and counseling, including breast-feeding and nutrition counseling
- Additional services or visits that may be required because of specific findings

Of course, TRICARE Standard also covers other types of medical care for the child, as it would for any eligible person.

For children age 6 and over (indeed, for all dependents), immunizations are also covered, and can be provided independently of other preventive services.

Hospice Care

TRICARE Standard covers the cost of hospice care for terminally ill patients who are expected to live less than six months if the illness runs its normal course. There are no limits on custodial care and personal comfort items under hospice care rules, as there are with other types of care. Also, there are fewer restrictions than in other types of TRICARE Standard covered care. TRICARE Standard also pays the full cost of covered hospice care services, except for small cost-share amounts that may be collected by the hospice for such things as drugs and inpatient respite care. Check with your BCAC/HBA/TSC or your TRICARE contractor for details.

Implants

Surgical implants are covered when they are of a type approved by the Food and Drug Administration (FDA).

Examples: Intraocular lenses, which are implanted in the eye after cataract surgery; cochlear implants, which are electronic instruments surgically implanted in the ear to assist in hearing; breast implants for reconstructive surgery following surgical removal of the breast; and penile implants to correct malformation of the male sex organ that has existed since birth; to correct organic impotency; or to correct what the medical profession calls “ambiguous” reproductive organs.

There are limitations to all of these procedures, so check with your BCAC/HBA/TSC before having any type of surgical implant.

Individual Case Management

The individual case management benefit allows TRICARE-eligible persons who have extraordinary medical or psychological disorders to receive health care benefits that would normally be limited—or not covered at all. Individual case management is intended to address the complex health care needs of catastrophically ill or injured persons. Designed to improve the quality of care, control costs, and support patients through catastrophic medical situations, it provides a bridge between acute-care and long-term-care services. It offers a system for organizing multi-disciplinary services that are often required for the management of extraordinary medical or psychological disorders.

Note: *"Individual case management" is different from "case management" in the more broad-based, generic sense of the term. "Case management" in the broad sense occurs when current benefits available under TRICARE need to be monitored and coordinated to meet the individual's health needs.*

Waivers of normal benefit limits or exclusions under individual case management will be approved and coordinated by case managers, and must be cost-effective and appropriate. The waivers may include—but are not limited to—services or supplies such as home health care, medical supplies, back-up durable medical equipment, extended skilled nursing care, and home health aides.

The individual case management program is separate and distinct from benefits available under the Program for Persons with Disabilities (PFPWD), and from benefits under "generic" case management (see note above).

Patients who want to participate in the individual case management program should contact (or have their representatives contact) their nearest BCAC/HBA/TSC for more details about specific requirements, and about how to get into the program.

Mammograms and Pap Smears

Routine mammograms and Pap smears are covered as diagnostic or preventive health care measures. There are certain rules regarding frequency of the procedures and as to who may provide the services. Check with your BCAC/HBA/TSC for details.

Frequency

TRICARE will not cover screening mammography for an asymptomatic woman under 35 years of age.

For asymptomatic women who are age 35 but under 50 years old who are at high risk for breast cancer (e.g., those with a personal history of breast cancer; those with a personal history of biopsy-proven benign breast disease; those whose mother, sister, or daughter have had breast cancer; and those who did not give birth before age 30), TRICARE will allow one baseline screening mammogram.

Coverage is limited to the following:

- One baseline mammogram at age 35
- One screening mammogram every 24 months thereafter

For asymptomatic women age 40 but under 50 who are not at high risk for breast cancer, coverage is limited to the following:

- One baseline mammogram at age 40
- One screening mammogram every 24 months thereafter

An asymptomatic woman at age 50 years or over is allowed one screening mammogram every 12 months.

In addition, TRICARE will cover charges for a brief or intermediate level office visit associated with the screening service.

For TRICARE to share the cost of mammography services, the supplier must be certified by Medicare for participation as a mammography supplier or be certified by the American College of Radiology as having met its mammography supplier standards.

TRICARE will share the cost of the technical component (the radiology technician's charges for performing the service).

TRICARE will also share the cost for a radiologist's interpretation of a physician-requested diagnostic mammogram.

Beyond the charges for the initial office visit, TRICARE will not share the cost of additional or separate charges for the attending or referring physician. The attending or referring physician may not bill for interpretation of a mammogram unless it is within the scope of his or her license.

Preventive services similar to those offered to TRICARE Prime enrollees must be provided in connection with immunizations, Pap smears, mammograms, and certain other cancer screenings. For example, if an eligible female goes in for a routine Pap smear, she is also eligible to receive a wide variety of other preventive services, such as tuberculosis screening, rubella antibody screening, blood pressure screening, cholesterol screening, and preventive counseling services, to name a few. But the same coverage won't be available if she simply makes an appointment for a routine health promotion visit, where one or more of the associated preventive services (Pap smear, mammogram, immunization, etc.) are not performed.

Medical Equipment and Supplies

For medical supplies (such as needles or syringes) and medical equipment under $100 (such as crutches), a doctor's prescription must be sent in with your claim. Durable medical equipment worth more than $100 also needs a prescription. Your BCAC/HBA/TSC will be able to help find a medical supply firm or pharmacy that accepts TRICARE Standard terms.

Medications (Prescriptions, Other)

FDA-approved medications are covered by TRICARE. A complete list of covered drugs can be found on the web site: *www.tricare.osd.mil/pharmacy/formulary.htm*. Beneficiaries may also contact the TRICARE toll-free help line 1-877-DOD-MEDS or 1-877-363-6337, from 7 a.m. to 11 p.m. EST, Monday through Friday, 9 a.m. to 8 p.m. EST on Saturday, and 10 a.m. to 5:30 p.m. EST on Sunday.

Military pharmacies and TRICARE contractors are required to fill prescriptions with generic equivalents of brand-name drugs, where generics exist. Contractors can make exceptions when a provider specifies that a brand name be dispensed as written and provides appropriate clinical information of clinical justification.

Note: *Medications that are available OTC—that is, without a prescription—are not cost shared by TRICARE, even if your physician recommends them. Insulin is an exception.*

Mental Health

TRICARE Standard helps pay for psychotherapy, either in the hospital or on an outpatient basis. If your provider of care believes you need more than five psychotherapy sessions a week in the hospital, or more than two psychotherapy sessions a week as an outpatient, a TRICARE contractor must review the medical necessity for the care. If you need more than eight outpatient psychotherapy sessions in a fiscal year, approval is required. You must get approval for additional sessions from your regional TRICARE contractor.

Remember: *The sessions cannot simply be counseling sessions, such as for people who are having marital or family disagreements. They must be for treatment of a mental disorder that has a medical diagnosis.*

Inpatient care, which needs preauthorization by a TRICARE contractor, is limited to a certain number of days per year unless TRICARE grants a waiver. The limits don't apply to services provided under the PFPWD.

Note: *TRICARE Standard has expanded its coverage of "partial hospitalization" beyond alcoholism or other substance use disorder rehabilitation to include other mental health disorders. Partial hospitalization is when a patient checks into a health care facility on a given day for treatment, but goes home at night.*

The expanded benefit is effective for care received from TRICARE-certified partial hospitalization programs, and is limited to 60 days of treatment per fiscal year, with waivers for unusual cases.

The annual limits for inpatient mental health care covered by TRICARE Standard are as follows: (1) 30 days for patients age 19 or over; (2) 45 days for patients under age 19; (3) 150 days for inpatient care in residential treatment centers (RTCs) which is available only to those under 21-years of age.

Remember: *Before getting mental health care, be sure to check with your BCAC/HBA/TSC because* ***preauthorization*** *may be required. Also, certain reviews and paperwork must be completed at various points before, during, and after mental health care for TRICARE Standard to share the bills.* *(See "Some Care Needs Special Authorization" on page 94 for details about required advance approval for mental health care.)*

Obesity Treatment

TRICARE Standard coverage is limited to three types of surgical treatment for obesity: gastric bypass, gastric stapling, and gastroplasty, including "vertical banded" gastroplasty, when one of the following conditions is met:

- A patient is 100 pounds or more over the ideal weight for height and body 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.
- A patient is 200 percent or more of the ideal weight for height and body structure. An associated medical condition is not required for this category.

- A patient has complications from a non-covered surgical treatment for obesity, such as intestinal bypass, and needs one of the three surgical procedures that are covered.

TRICARE Standard does not cover any other services, medications, or supplies related to obesity or weight reduction. Non-surgical treatment of morbid obesity, such as wiring the jaws, camps for obesity treatment, or special diets, are not covered.

Organ Transplants

TRICARE Standard covers the following organ transplants: cornea, kidney, liver, liver-kidney, heart, lung, heart-lung, small-intestine, combined small intestine-liver, simultaneous pancreas-kidney, and some bone marrow. But there are limits in some circumstances. For example, bone marrow transplants are not covered for treatment of ovarian cancer. Contact your BCAC/HBA/TSC or contractor ahead of time for details on organ transplants. Some organ transplants may only be provided in facilities that are authorized specifically for the particular type of transplant. Some organ transplants may also require preauthorization. Check with your BCAC/HBA/TSC for authorization requirements, and for more information about any additional transplants that may have been added to the approved list since this handbook was published.

Plastic or Reconstructive Surgery

TRICARE Standard covers plastic, cosmetic, and reconstructive surgery only in the following situations:

- Plastic surgery can be cost shared when it is needed to restore function. For example, plastic surgery on a patient's nose would be covered if it were necessary for the patient to breathe. It would not be covered just to improve the person's looks. Because this can be a gray area, check with your BCAC/HBA or the regional TRICARE contractor if you have questions, before getting care.
- Plastic surgery can be cost shared for the following reasons:
  - To correct a serious birth defect, such as a cleft lip.
  - To restore body form or function after an accidental injury.
  - To improve appearance after severe disfiguration or extensive scarring from surgery for cancer.

- Breast reconstructive surgery after a mastectomy is covered by TRICARE Standard regardless of when the mastectomy was performed.
- TRICARE covers breast construction by surgery. Along with the claims for constructive breast surgery, documentation must be submitted showing that the condition had existed since birth or was caused by an accident. TRICARE won't share the cost of reconstructive surgery for a breast that is simply incomplete or underdeveloped.
- Breast reduction surgery may be covered under limited circumstances, for documented, intractable pain that doesn't respond to other treatments. Check with your BCAC/HBA for details.

Private Duty or Visiting Nurses

There are certain limits on TRICARE Standard coverage for private duty nursing, whether in the hospital or at home.

TRICARE Standard does not cover private duty nursing to augment the general nursing staff of a hospital, or in hospitals that have intensive-care units or coronary-care units.

TRICARE Standard does cover "skilled nursing care" at home. Medical care that only a professional can provide, such as giving certain medications, treatment or therapy, can be cost shared. Because this can be quite complicated, check with your BCAC/HBA/TSC before you hire a visiting nurse.

Whether the private duty nurse sees you in the hospital or at home, a copy of all daily nursing notes must be sent in with your claim. The claim should also show the name of the doctor who referred you for private nursing and that he or she is supervising the care. A copy of the physician's treatment plan must be included with the first TRICARE Standard claim you send in.

Residential Treatment Centers

Residential Treatment Centers (RTCs) that provide treatment for children and adolescents (up to age 21) who require mental health care. Patients must be suffering from a serious mental disorder; children who have only disciplinary problems don't qualify. A TRICARE Standard mental health review contractor must certify the medical necessity of a patient's admission to an RTC prior to admission. Contact your region's TRICARE mental health review contractor for information. (See the section in this chapter called "Some Care Needs Special Authorization" for more information.) There are strict requirements for the RTCs to meet the 150-days-per-year limitations for this treatment. Before admitting your child, check with your local BCAC/HBA/TSC or with the RTC itself, to make sure that the facility is TRICARE certified. RTC care is not considered emergency care and requires prior certification by the regional TRICARE mental health contractor.

Same Day (or "Ambulatory") Surgery

Certain surgery, like having your tonsils taken out, can often be done in ambulatory surgery centers, hospitals, or special centers where you can have the operation and go home the same day. This can cost less than inpatient care. For active duty and North Atlantic Treaty Organization (NATO) families, it costs only $25 for the hospital's or surgery center's care, as long as the doctor participates in TRICARE Standard. Others pay only the lesser of 25 percent of an applicable group rate payment, or 25 percent of the billed charges, plus the annual deductible, as long as the doctor participates in TRICARE Standard. If the provider doesn't participate, you may have to pay up to 15 percent over the TRICARE Standard allowable charge, plus your cost share and deductible, if any. (See an explanation in the "Outpatient Costs" section on page 116.)

Don't forget to check with your BACAC/HBA/TSC, or regional TRICARE contractor, to see if the same-day surgery you plan to get needs authorization in advance by the contractor.

School Physical Exams

TRICARE-eligible dependents who are at least 5 years old and less than 12 years old may now get physical exams that are required by a school in connection with the enrollment of the dependent as a student in that school. This benefit does not include physical exams that may be required by the school to participate in school sports.

Wigs for Radiation/Chemotherapy Treatment Patients

When loss of hair is from cancer treatment, TRICARE Standard cost shares one wig or hairpiece during a person's lifetime. Depending on whether your sponsor is an active duty service member or not, you pay either 20 or 25 percent of the allowable charge for your wig or hairpiece. The maximum TRICARE allowable charge is $750. A doctor's note saying you need the wig must be sent in with your claim. TRICARE Standard can't cost share a wig if you've already obtained one through the Department of Veterans Affairs (VA) or an MTF.

Some Care Needs "Special Authorization"

How to Get Approval for Care under the Program for Persons with Disabilities or for Mental Health Care

For care under the *Program for Persons with Disabilities*, (PFPWD) available to active duty family members only, contact your TRICARE contractor for instructions at least 30 to 60 days before you plan to get the needed care. (See the section titled "Program for Persons with Disabilities," beginning on page 43, for more details.) This program augments TRICARE Standard benefits.

Use DD Form 2532 or 2533 when you request approval for care under the PFPWD from your TRICARE contractor. You can get the form from your BCAC/HBA or your claims processor. Your doctor must send a letter to the contractor with the form explaining why you need the care.

How to Get Approval for Mental Health Care

For mental health care, you'll need certification of the medical necessity for mental health care from a TRICARE contractor in the following circumstances:

1. Inpatient mental health care
2. Care at RTCs
3. All requests for extensions to TRICARE's yearly limits on inpatient mental health care
4. Authorizations for extended outpatient mental health care, exceeding two outpatient visits per week, five inpatient visits per week, or eight outpatient visits in a fiscal year

Different TRICARE regions will have different contractors handling mental health care advance approval. For more information, contact your BCAC/HBA/TSC. Always request certification from the appropriate contractor ***before*** you start getting the care, if possible. That way, you and your provider of care will know in advance whether the planned treatment meets the TRICARE rules for medical necessity and appropriateness. The TRICARE contractor will not pay a claim until the mental health contractor's certification has been given. Remember that your BCAC/HBA/TSC can tell you whom you need to contact to get approval for mental health care.

Remember: *Only those cases that meet the special and limited requirements for a waiver will receive approval for care beyond the annual limits of inpatient mental health days. Authorization for the maximum number of days of mental health care in a year is not automatic. All mental health care must meet the test of medical necessity. It may be that* ***fewer*** *days of such care will be paid if it is determined by the appropriate TRICARE contractor that the additional care is not medically necessary.*

How to Get Approval for Dental Care

To get approval for dental care related to a covered medical problem, check with your regional TRICARE contractor.

Reminder: *The TRICARE dental coverage discussed here is completely separate from the TRICARE dental plan for retirees (TRDP). It's also separate from the new TRICARE Dental Program (TDP) (a combined plan for active duty family members and reservists/National Guard and their families), that began operation February 1, 2001.*

How to Get Approval for Organ Transplants

For some organ transplants, you must get advance approval, and you must have the transplant done at a facility that is specifically approved by TRICARE Standard for this procedure. Check with your BCAC/HBA/TSC for details.

What's Not Covered?

This section lists most of what TRICARE does not cover. This list is not inclusive, so check with your BCAC/HBA/TSC before getting care if you have any questions.

Abortions

Abortions are not covered except when the mother's life is in danger. The attending physician must certify in writing that the abortion was performed because a life-endangering condition existed, and must provide medical documentation to the TRICARE claims processor for TRICARE to share the cost of the procedure.

Acupuncture

Anabolic Steroids

Artificial Insemination

Artificial insemination or any form of artificial conception. This non-coverage includes in vitro fertilization and gamete intrafallopian transfer, as well as all other non-coital reproductive methods and all services, supplies, and drugs related to them.

Autopsy Services or Post Mortem Examination

Birth Control

Birth control medications for which you do not need a doctor's prescription are not covered. TRICARE Standard will, however, cost share some kinds of birth control. (See the "Family Planning" section in the chapter titled "What's Covered?" and check with your BCAC/HBA/TSC.)

Bone Marrow Transplants for Treatment of Ovarian Cancer

See the section titled "Cancer Test Project Expansion" in the "What's Covered?" chapter, on page 67.

Camps

Examples of such camps are for diabetics or obese people.

Christian Science "Absent Treatment"

This is also called "treatment through prayer and spiritual means," in which the patient is not physically present when the Christian Science service is rendered.

Chronic Fatigue Syndrome

TRICARE doesn't cover treatment for chronic fatigue syndrome (CFS) as a defined illness, since there are no generally accepted standards for treatment of CFS, and existing treatments have not been consistently shown to be effective. Legitimate treatment for CFS is limited to relieving individual symptoms, such as prescribing medications for headaches or muscle pains.

Cosmetic Drugs

Drugs for cosmetic use as a result of the aging process, such as Retin-A (for individuals over age 35) or Rogaine.

Cosmetic, Plastic or Reconstructive Surgery

These are not covered except as described in the "Plastic or Reconstructive Surgery" section on page 91 of the "What's Covered?" chapter.

Counseling Services

TRICARE doesn't cover nutritional counseling, diabetic self-help counseling, diabetic self-education programs, stress management, life-style modifications, marriage counseling (marriage counseling

isn't the same as treatment by a marriage and family therapist, which is covered under TRICARE Standard), etc. Counseling services may be covered under the expanded preventive care benefit, as long as they are performed in connection with immunizations, Pap smears, mammograms, or examinations for colon and prostate cancer. However, they are expected components of good clinical practice that are integrated into the appropriate office visit at no additional charge.

Custodial Care

Custodial care in an institution or home is not covered. Custodial care is taking care of someone's daily needs, such as eating, dressing, or providing a place to sleep, as opposed to taking care of someone's medical needs. Some aspects of the care may be covered, such as limited specific skilled nursing services (one hour per day), prescription medicines and up to 12 physician visits per calendar year. Medically necessary care for an inpatient in an acute-care hospital is covered, even if the person's medical care is considered "custodial." This can be a gray area, so check with your BCAC/HBA/TSC if you have questions.

Dental Care and Dental X-rays

See the exceptions as provided in the "Dental Care" section on page 70 of the "What's Covered" chapter.

Education or Training

There are certain exceptions under the PFPWD.

Electrolysis

Experimental Procedures (also Referred to as "Unproven" Procedures)

There are exceptions under the National Cancer Institute (NCI) approved clinical trials.

Eyeglasses and Contact Lenses

There are certain exceptions under very limited circumstances, such as corneal lens removal.

Family-furnished Care or Supplies

Care or supplies that are furnished or prescribed by a person in the immediate family are not covered.

Food, Food Substitutes or Supplements, or Vitamins Outside of a Hospital

There are exceptions for home parenteral nutrition therapy, such as prescribed for cancer patients, prenatal care, or as part of a specific vitamin deficiency medical condition.

Foot Care

Except when there's a medical problem, such as diabetes or injury.

Genetic Tests

See the "Having a Baby" section, page 75 of the "What's Covered?" chapter and check with your BCAC/HBA/TSC for possible exceptions. A provider must order genetic tests.

Hearing Aids

There is an exception under the Program for Persons with Disabilities. (See the section titled "Program for Persons with Disabilities" on page 43.)

Hearing Examinations

They are not covered unless it is connection with surgery or some medical problem or under the Program for Persons with Disabilities. But there are hearing examinations under the well-child care benefit.

Immune Globulin

Investigational Drugs

Learning Disabilities

An example would be dyslexia.

Mind Expansion or Elective Psychotherapy

Some examples would be, Erhard Seminar Training, transcendental meditation, and Z-therapy.

Naturopaths

Orthodontia

Exceptions exist in limited cases, such as when related to the surgical correction of a cleft palate.

Orthotics, Orthopedic Shoes, and Arch Supports

An exception would be when it is part of a brace.

Orthomolecular Psychiatric Therapy

Over-the-counter Drugs

Over the counter (OTC) drugs—those not requiring a prescription by a physician—are not covered. Exceptions are alcohol swabs, needles and syringes for home-use injectable drugs; glucose test strips; insulin and insulin syringes; lancets; and spacers for inhalers.

Private Hospital Rooms

A private hospital room is not covered unless the doctor orders it for medical reasons, or a semi-private room is not available. Hospitals that are subject to TRICARE's diagnosis-related group (DRG) payment system may provide the patient with a private room, but will still receive only the standard DRG amount. ***If a patient asks for a private room, the hospital can bill the patient for the extra charges.***

Rest Cure

Retirement Homes

Self-help Help Courses

TRICARE doesn't cover self-help courses, items or charges related to exercising or relaxation, such as spas, whirlpools, hot tubs, swimming pools, and the like.

Sex Changes

Smoking Cessation Products

Speech Therapy

Speech therapist services are authorized when prescribed by a physician and are part of treatment for the physical defect, and not part of any educational or occupational deficit.

Sexual Dysfunction or Inadequacy Treatment

The prescription medication called Viagra is covered, within certain limits, if it's determined by a patient's provider to be medically necessary for treatment of a TRICARE-covered medical problem.

Surgical Sterilization Reversals

Telephone Services or Advice

This includes remote monitoring and consultation, except for trans-telephonic monitoring of pacemakers. Other types of diagnoses or monitoring by telephone may be available. Check with your BCAC/HBA/TSC for details.

Unproven Services or Care

Please check current policy for additional information.

Vitamins – Except for Formulations of Folic Acid, Niacin, and Vitamins D, K, and B12 (Injection)

Weight Control

Weight control or weight reduction services, drugs, and supplies are not covered, except for certain surgical procedures when specific conditions have been met. (See "Obesity Treatment" on page 90 in the "What's Covered?" chapter for details.)

Workers' Compensation

TRICARE will not cost share work-related illnesses or injuries that are covered under workers' compensation programs.

Medical Review

A national medical review organization is under contract to TRICARE to review some types of care received by eligible patients before TRICARE shares the cost of that care. The care that's reviewed includes inpatient care that falls under TRICARE's DRG payment system. Outpatient care may also be evaluated. The review organization makes sure the care is reasonable, necessary, and appropriate.

Physicians and hospitals are generally familiar with, and are required to participate in, a TRICARE contractor's medical review program.

If you have any questions about whether medical review applies to your care, check with your physician or hospital.

Special rules apply in situations where review organizations evaluate care. Requests for reconsideration of review decisions should be submitted directly to the review organization, following the appeal instructions contained in the initial determination letter to you.

Where to Get Care

Use a Military Treatment Facility to Save Money

If possible, try to get your health care from a Military Treatment Facility (MTF). If you live in certain ZIP code catchment areas around a service hospital, you must try to get inpatient care from that hospital first, except in a true medical emergency, or when you have other, non-TRICARE, major medical insurance. Some outpatient care may also require preauthorization. Check with your nearby MTF, or your TRICARE contractor, before getting any type of care.

Using an MTF instead of TRICARE Standard or TRICARE Extra saves you money and paperwork. So, check with your BCAC/HBA to find out if the hospital can care for you.

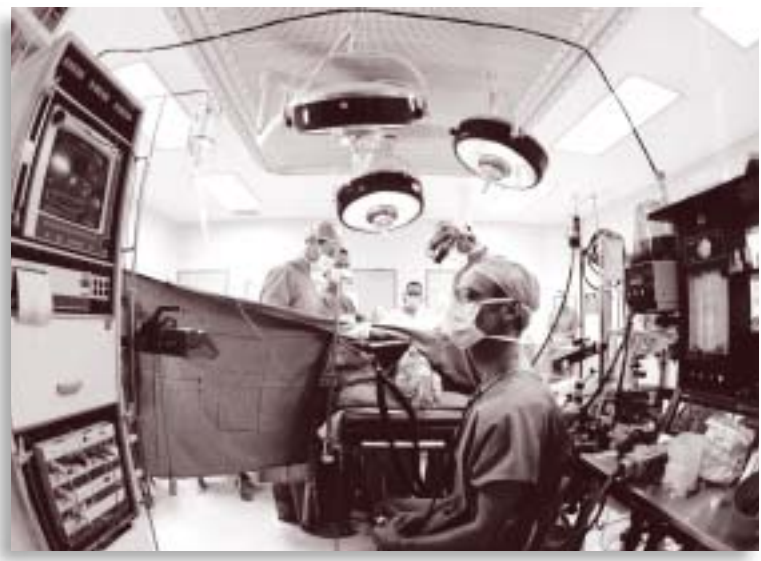
Even if you live far away from an MTF, it can still cost you less to get care there. This is especially true for expensive major procedures. The transportation to and from the military hospital could cost you much less than your cost share under TRICARE Standard. And in some cases, the uniformed services may be able to assist with transportation. Check with your BCAC/HBA/TSC.

If You Live Near a Uniformed Service Hospital, You Must Try It First

If you live in a certain ZIP code area around an MTF ("catchment area"), you must try to use that hospital for non-emergency inpatient care. Otherwise, TRICARE Standard cannot help pay for any of the care if you get it from civilian sources instead.

The ZIP code zones are specific for each military hospital and are updated periodically. Check with your BCAC/HBA/TSC if you aren't sure whether your home address falls within the ZIP code catchment area. (**Note:** Outside the 50 states and Puerto Rico, a 40-mile radius around a hospital is used—not ZIP code zones.)

IMPORTANT: *For some kinds of highly specialized care such as open-heart surgery, the ZIP code catchment areas have been expanded to areas of up to 200 miles around particular military hospitals, or even nationwide in extraordinary cases, such as for certain organ transplants. This means that if you need a certain type of specialized care, you may have to try to get the care at a specific MTF that may be a considerable distance from your home. This new requirement makes it even more important that you check with your nearest BCAC/HBA/TSC before seeking care from a civilian source under TRICARE Standard.*



Nonavailability Statements

If the MTF near you cannot provide the inpatient care you need, you must ask them for a nonavailability statement (NAS).

An NAS is a certification from a military hospital stating that it cannot provide the care. If you don't get an NAS before you get inpatient care from a civilian source, TRICARE may not share your costs.

The NAS system is now automated. This means that, instead of paper copies of the NASs being sent in with the TRICARE Standard claim, the MTF enters the NASs electronically into the DEERS computer files.

IMPORTANT NOTE: *Even though outpatient NASs are no longer required for outpatient procedures (see the Maternity Care section, earlier in this book, for an exception to this), check with your BCAC/HBA/TSC for details on getting advance authorization to have any procedures done. Providers of care—whether or not they participate in TRICARE Standard—are supposed to get these advance authorizations.*

If you live in the ZIP code catchment area around an MTF, the only times you ***don't*** need an NAS for non-emergency inpatient care are as follows:

- **When you have other non-TRICARE Standard major medical care insurance** that pays first on the bills for TRICARE Standard-covered care. (There may be exceptions to this policy for ***outpatient*** care in your TRICARE region. Check with your BCAC/HBA/TSC or Managed Care Support Contractor (MCSC) on this.)
- In a true medical emergency. A condition that would lead a "prudent layperson" (someone with average knowledge of health and medicine), to believe that the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptoms requiring immediate efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director,

TRICARE Management Activity, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however, qualify a maternity case as an emergency, nor would incipient birth after the thirty-fourth (34th) week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

- ***Be sure to check with your nearby MTF every time you need inpatient care.*** Even if they couldn't provide the care you needed the last time you checked, their staffing levels or capabilities may have changed, and they may now be able to care for you.

Remember: *An NAS is valid for a hospital admission that occurs within 30 calendar days after the NAS is issued. It will remain valid from the date of admission until 15 days after discharge for any follow-up treatment that's directly related to the admission.*

For ***newborn care,*** in the event that a newborn stays in the hospital continuously after the mother's discharge, the mother's NAS will remain valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15-day limit, a claim for non-emergency inpatient care requires a valid NAS in the infant's name.

Remember: *Just because an MTF gives you an NAS does not mean that TRICARE Standard can help you pay for all care that you receive from any provider. TRICARE Standard cost shares only the kinds of care allowed by the TRICARE Standard rules. TRICARE Standard helps pay for care only from the kinds of providers TRICARE Standard recognizes. These providers are listed below.*

Where and From Whom Can You Get Care Under TRICARE?

A "provider" is the person, business, or institution that provides or gives you health care. For example, a doctor is a provider. A hospital is a provider. An ambulance company is a provider. There are many other types.

TRICARE Standard or TRICARE Extra can help pay for covered services only from the types of providers listed on the next pages.

In addition to being on the list below, providers must be authorized under the TRICARE Regulation, and must have their authorized status verified (certified) by their regional TRICARE contractor. Being authorized usually means that the providers are licensed by their state, are accredited by a national organization and meet other standards of the medical community. If a provider is not authorized, TRICARE Standard cannot help pay for care from that provider. Most hospitals and doctors are authorized by TRICARE (check with them, just to be certain). But for other types of providers, it's a good idea to check with your regional contractor BCAC/HBA/TSC before getting care to make sure they're authorized by TRICARE.

Generally, active duty service members and civilian employees of the Federal Government who are health care providers are not authorized to be TRICARE providers. So, if a TRICARE-eligible person sees a provider in a civilian facility that they know works at an MTF, they should check to ensure that TRICARE will provide reimbursement.

Health Care Centers

- **College or university infirmaries**
- **Christian Science sanatoriums** if part of the First Church of Christ, Scientist.
- **Hospitals**
- **Skilled nursing facilities,** not including retirement homes or homes for the aged or infirm, which are not covered by TRICARE.
- **TRICARE-approved ambulatory surgery centers**

- **TRICARE-approved birthing centers.** Separate approval is required for care at a birthing center, even if the center is otherwise authorized as a provider of care by TRICARE. Check with your BCAC/HBA/TSC.
- **TRICARE-approved residential treatment centers (RTCs)** for emotionally disturbed children and adolescents.
- **TRICARE-approved special treatment centers,** such as drug and alcohol treatment centers.

  Note: *Check with your BCAC/HBA/TSC before getting care at certain facilities, such as outpatient rehabilitation facilities, birthing centers, pain treatment facilities, mental health clinics, RTCs, and eating disorder clinics. They may not be TRICARE-authorized providers of care, or the services they provide may not be benefits under TRICARE Standard.*

Individual Providers and Services

- **Attending physicians.** Another provider of care (podiatrist, clinical psychologist, oral surgeon, etc.) may be treated as an attending physician, as long as he or she is operating within the confines of the scope of practice of that particular discipline. TRICARE's definition of "surgical assistant" has also been expanded to include other authorized individual professional providers. This will allow dentists or podiatrists to assist when the surgery is complex enough to warrant an assistant.
- **Certified clinical social workers** with at least a master's degree in social work from an accredited school of social work, plus two years of post-graduate clinical experience.
- **Certified marriage and family therapists.** Certified marriage and family therapists may be authorized as independent providers of care (that is, they don't require physician referral and supervision) under TRICARE, but only when they sign an agreement with TRICARE. The agreement requires certified marriage and family therapists to accept the TRICARE Standard allowable charge as the full fee for their services (they can't bill the patient separately for charges disallowed by TRICARE Standard or for non-covered services they provide). Therapists who don't sign the agreement may not be authorized by TRICARE as certified marriage and family therapists.

Note: *TRICARE Standard won't pay for marriage and family counseling, but will share the cost of psychotherapy provided by certified marriage and family therapists in the treatment of a valid mental disorder.*

- **Certified nurse midwives**
- **Certified nurse practitioners** and clinical nurse specialists, if approved by the state in which they work.
- **Certified psychiatric nurse specialists**
- **Christian Science practitioners** and nurses if currently listed in the Christian Science Journal.
- **Dentists** (DDSs or DMDs)
- **Independent laboratories**
- **Medical equipment and supply firms**
- **Most clinical psychologists** with PhDs or PsyDs
- **Optometrists** (ODs)
- **Pharmacies**
- **Physicians,** including both doctors of medicine (MDs) and doctors of osteopathy (DOs).
- **Physician assistants.** Physician assistants (PAs) must meet applicable certification and licensing criteria, and must be supervised by physicians who employ them and who are themselves authorized providers of care under TRICARE.
- **Podiatrists** (DPMs)
- **Radiology services.**

As long as a physician refers you and supervises the care, and other requirements are met, covered services from the providers below can be cost shared. The name of the physician who referred you and is monitoring the care must be indicated on the claim form.

- **Audiologists**
- **Licensed practical nurses** (LPNs)
- **Mental health counselors**

- **Nurse anesthetists**
- **Occupational therapists** (OTs)
- **Pastoral counselors**
- **Physical therapists** (PTs)
- **Registered nurses** (RNs)
- **Speech therapists**

Providers Who Participate in TRICARE Save You Money

Individual providers who "participate" in TRICARE Standard agree to accept the TRICARE Standard "allowable charge" as their full fee for your care. (Note: "Accepting assignment" means the same as participating.) The allowable charges for medical services are based on computations made under a method called the "resource-based relative value system" (RBRVS). Your cost share is based on the allowable charge—no matter what the provider actually bills you. So with providers who participate in TRICARE Standard (and after your annual deductible has been accounted for), you only pay your cost share for TRICARE Standard-covered care and charges for any care not covered by TRICARE Standard. (The provider may ask you to pay your cost-share right away or may wait until after TRICARE Standard has paid the claim.)

Providers who do not participate will bill you for their normal charges. The law says that bill may be up to 15 percent more than the TRICARE Standard allowable charge. You arrange with the provider how you will pay the bill. When you file the TRICARE Standard claim, TRICARE Standard pays you its share of the allowable charge. That means you pay your cost share, and you pay any difference between the allowable charge and the actual bill, up to the legal billing limit. (See the chapter on costs, beginning on page 113, for more information.)

How to Find Providers Who Participate in TRICARE Standard

Individual professional providers of care who have not signed up to be part of a TRICARE Prime or TRICARE Extra network participate voluntarily in TRICARE Standard. They can choose to participate on a case-by-case basis. That is, they may participate one time and not the next time. Check with your nearest BCAC/HBA/TSC, Health Care Finder (HCF), or MCSC.

Before getting care, call and ask if the provider participates in TRICARE Standard. Be sure they understand that by "participating" in TRICARE Standard, they are agreeing to accept the TRICARE Standard allowable charge as their **full** fee for your care. If the provider isn't familiar with TRICARE or has any questions, tell the provider to call the toll-free phone number of the regional TRICARE contractor. Some contractors have a separate, special phone line for providers. Or the provider can ask to be contacted by the contractor's field representative. He or she can tell the provider the allowable charges for the type of care you need. If the provider doesn't know the contractors phone number, he or she should check with the nearest BCAC/HBA/TSC.

Note: *By law, providers may not discriminate against you because of race, color, national origin, religion, sex, handicap, or age. If you believe you've been discriminated against, contact your BCAC/HBA/TSC or write to the TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.*

Also Important: *All hospitals that participate in Medicare, and hospital-based health care professionals who are employed by, or contracted to, such hospitals, are required by law to participate in TRICARE Standard for inpatient hospital services related to hospital admissions. But remember that some individual providers of care who see patients in the hospital may not participate and may bill separately for their services.*

Note For Overseas Travelers: *If you need medical care while traveling in a country where there's no U.S. MTF, contact the nearest U.S. consular office for its recommendations on nearby providers of care. If you're unable to do that, try to identify such providers through local sources such as hospitals or clinics.*

If you do happen to be traveling in a country where there's a U.S. MTF, try to get care there. If the care you need isn't available there, the facility's BCAC/HBA might be able to direct you to the type of health care provider you need.

If you plan to do any traveling outside the United States, claims for any care you receive while overseas should be sent to the TRICARE contractor for the area in which you live.

Also, in another expansion of government health care resource sharing, some Department of Veterans Affairs (VA) medical centers have become TRICARE-authorized providers of care. They provide limited outpatient and inpatient medical and surgical care to TRICARE-eligible persons who live in their areas. The hospitals have coordinators who serve as BCAC/HBA and HCFs for TRICARE-eligible families. Call your nearby VA medical center to find out if it is a TRICARE-authorized provider.

Refer to the "How to File a Claim" chapter of this handbook for information on where to file claims.

How Much Will It Cost?

TRICARE Standard/TRICARE Extra cost shares only certain medical bills. You pay the full bill for most care that is not covered by TRICARE Standard.

And for care that is covered, you still pay for part of the bills. How much you pay (your cost share) depends on:

- Whether (and where) you get care as an outpatient or inpatient. "Outpatient care" is what you receive when you don't need to stay 24 hours or longer in a hospital or other health care center. "Inpatient care" is what you receive when you're admitted to a hospital or health care center with the reasonable expectation that you'll occupy a bed and will remain in the institution for at least 24 hours;
- Whether the provider participates in TRICARE Standard;
- What your sponsor's status is with the service. Active duty families pay a different share than retirees, their families, and families of service members who have died, and eligible former military spouses. (See the exception to this at the beginning of the "Who's Eligible For TRICARE?" section.)

Remember: *It's your responsibility to arrange to pay the provider your portion of the bills. The provider may want you to pay part—or even all—of the cost before you get care.*

The Law Limits How Much You Can Be Charged

Certain health care providers who see TRICARE patients but who don't "participate"—also known as "accepting assignment"—in the program are limited by Federal law in how much they can charge TRICARE patients for the services they provide.

Non-participating providers may charge no more than 15 percent above the TRICARE maximum allowable charge for their services.

Providers who do participate in TRICARE accept the TRICARE maximum allowable charge as the ***full*** fee for the care they render.

The billing restriction for non-participating providers is contained in Section 9011 of the Department of Defense Appropriations Act of 1993 (Public Law 102-396), and was effective on November 1, 1993. The restriction has been included in all subsequent Department of Defense Appropriations Acts. The legal limit on charges is the same as that used by Medicare.

TRICARE patients who believe that they've been overcharged by a provider of care, and who can't resolve the situation with the provider, may write a letter of complaint to the TRICARE contractor for their region. The contractor will send the provider a letter that explains the legal requirement and asks that the provider refund any charges in excess of the limits to the patient within 30 days.

A provider who doesn't comply with the refund request may ultimately lose his or her authorization to treat TRICARE patients and to be reimbursed for it by the Government. What this means to TRICARE-eligible patients is that they could still be treated by such a provider, but they would have to pay the full bill for any care they might receive; there would be no government reimbursement of any part of the cost.

Catastrophic Cap

The next few pages will address the costs of inpatient and outpatient care under TRICARE. While you're reading this material, keep the following important points in mind. A catastrophic cost "cap" has been placed on your cost share—that is, on how much you have to pay—for TRICARE-covered medical bills.

The cap includes enrollment fees, inpatient and outpatient cost shares, and copayments for such things as visits to the doctor.

- For active duty families enrolled in TRICARE Prime, the cap is $1,000 per fiscal year (October 1 through the following September 30). The point-of-service (POS) option, which is explained in the TRICARE Prime section, explains that medical expenses will not be capped. For all other TRICARE Prime enrollees, it's $3,000 per enrollment year, unless you get care on your own without a referral from your TRICARE Prime PCM and without an authorization from the HCF (this is called using the, POS option, which is explained in the TRICARE Prime section). If you do that, your POS medical expenses will **not** be "capped." *For more details about cost caps, check with your BCAC/HBA/TSC.*
- There is a cap of $3,000 per year on allowable charges for covered services under TRICARE Standard and TRICARE Extra.

The cap applies only to the amount of money required to meet your family's annual deductibles and cost shares based on TRICARE Standard allowable charges for covered medical care received in any one fiscal year. You must pay any charges, up to the legal limit, in excess of those TRICARE determines to be reasonable, or "allowable," for covered care. You must pay all charges for treatment not covered by TRICARE, such as acupuncture, for example. Likewise, any costs you pay under the TRICARE Program for Persons with Disabilities (PFPWD) are not counted toward the cap.

Keep track of how much you pay in annual deductibles and cost shares in a fiscal year. The best way to keep track of medical expenses that count toward meeting the cap is to keep a copy of your TRICARE Explanation of Benefits (EOB), which is provided with each claim that is processed. TRICARE contractors also keep track, and when your family's deductibles and cost shares in

a given fiscal year add up to the cap amount, TRICARE will pay the full allowable charges for covered care provided during the rest of the fiscal year.

Remember: *The catastrophic cap applies only to allowable charges for covered services. There's no annual cap on charges for services that aren't covered, or on the yearly accumulation of what non-participating providers of care may bill you above the allowable charges for the care you received.*

For more details on the medical expense cost-share caps, contact your BCAC/HBA/TSC.

Outpatient Costs

For outpatient care for most families, there is a yearly deductible of $150 for one person or $300 for a family. That is, you pay your provider(s) the first $150 (or, for a family, $300) worth of TRICARE Standard allowable medical and pharmacy bills in a fiscal year. The deductible for family members of active duty E-4s and below is $50 for an individual and $100 for the entire family.

After the deductible is met, active duty families pay 20 percent of the TRICARE Standard allowable charge for each medical bill (except for ambulatory surgery centers, free-standing birthing centers and hospital-based birthing rooms, for which the charge is a flat $25) and all others pay 25 percent. If a health care provider who does not participate in TRICARE Standard bills you for more than the allowable charge, you also pay the additional amount, up to the legal limit of 15 percent above the TRICARE Standard allowable charge.

The allowable charge is the maximum amount TRICARE Standard will pay for care given by physicians and other providers. It's determined by comparing the actual billed charges, the prevailing charges (what most providers have been charging) for a particular service, and a charge arrived at by applying a Medicare-related formula—then using the lowest of the three as the TRICARE Standard allowable charge.

Outpatient Costs With Providers Who Participate in TRICARE

A provider who participates in TRICARE will send in the claim for your care to the TRICARE contractor. TRICARE Standard will send its share of your medical bills directly to the participating provider. You should arrange with the provider how and when to pay your part of the bill.

Note: *A new, simpler claim form for patients, the DD Form 2642 ("CHAMPUS Claim—Patient's Request for Medical Payment") was introduced in 1994. The new form replaced the DD Form 2520, which is no longer used in the United States. The new form is only half the length of the old form, and doesn't require a provider's signature. Providers who send claims to TRICARE will use the HCFA Form 1500 (for individual providers) or the UB-92 form (for institutional providers, such as hospitals).*

The TRICARE contractor knows the allowable charge for the TRICARE-covered care you receive. Any applicable deductible and cost shares are subtracted from that amount. The claims processor then sends your provider a check for the TRICARE Standard share of the remaining amount.

How Much Is Paid?

- For families of active duty service members, the check will be for 80 percent of the remaining allowable amount. You must pay the other 20 percent, plus the deductible if it has not already been paid, to your provider—except for care in ambulatory surgery centers and freestanding birthing centers. (See previous page.)
- For retirees, their families, families of service members who have died, and for eligible former military spouses, the check will be for 75 percent of the remaining allowable amount. You must pay your provider the other 25 percent, plus the deductible if it has not already been paid.

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Here's an example of how this works. Sergeant King is an E-5. His wife, Becky, went to see Dr. Moffett because of stomach pains. Dr. Moffett normally charges $150 for the care Becky received. But Dr. Moffett said he would participate in TRICARE

Standard (sometimes also called "accepting TRICARE Standard assignment"), which meant he would accept the TRICARE allowable charge of $100 for the care. And, he told Becky she could pay after TRICARE Standard had paid its share of the bill.

The TRICARE contractor knew from the files that all of Becky's care was covered and the allowable charge for the care was $100. The files also showed that Becky had already paid her $150 deductible that year. Since Becky was married to an active duty service member, the contractor sent Dr. Moffett a check for 80 percent of the allowable, or $80. The contractor also sent Becky a notice (or "Explanation of Benefits") that Dr. Moffett had received $80 and that she needed to pay Dr. Moffett the remaining $20. So her total cost for the care was $20 (20 percent of the allowable charge of $100).

Outpatient Costs With Providers Who Don't Participate in TRICARE Standard

If your provider doesn't participate in TRICARE Standard, the bill may legally be for up to 15 percent more than the TRICARE Standard allowable charge. And you must arrange payment to the provider for the entire bill, up to the legal limit.

If you're filing the claim, you fill out and sign the DD Form 2642 claim form. Ask your provider for a fully itemized bill. Then send the claim form, and a copy of the bill, to your TRICARE contractor. (See the "How to File a Claim" chapter for a list of contractors.) TRICARE Standard can then pay you what it would have paid the provider, if the provider had participated in TRICARE Standard.

The contractor still uses the allowable charge to figure the TRICARE Standard cost share for covered care—no matter what the provider charges you. The deductible is subtracted from the TRICARE Standard allowable charge first; then the cost share is figured based on the remaining balance, unless you have already paid your deductible for that year. The contractor then sends you a check for the TRICARE Standard portion of the remaining allowable amount.

For families of active duty members, the check will be for 80 percent of the remaining amount, except for care in ambulatory surgery centers or in freestanding birthing centers. (See the "Outpatient Costs" section at the beginning of this chapter.)

For retirees, their families, families of service members who have died, and eligible former spouses, the check will be for 75 percent of the remaining amount. (See the exception for surviving family members at the beginning of the "Who's Eligible For TRICARE?" section.)

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Here's an example of how this works. Lieutenant Sorenson's son, Jerry, went to see Dr. Manning because of a swollen finger. Dr. Manning examined Jerry and X-rayed his finger. Dr. Manning said he would not participate in TRICARE Standard, nor would he file the claim for them. He charged Jerry's parents $225.

Dr. Manning wanted to be paid "up front," so the Sorensons paid him $225. They then filled out a DD Form 2642 (Patient's Request for Medical Payment) claim form and sent it to their TRICARE contractor. They included a copy of Dr. Manning's fully itemized bill. Soon, Jerry's parents received a check for $160 from the TRICARE contractor.

How did the contractor know to pay Jerry's parents $160? The contractor saw from the bill that all of Jerry's care was covered by TRICARE Standard. The allowable charge for the care was $200. Since Lieutenant Sorenson was an active duty member, and had already paid the family deductible, TRICARE Standard paid 80 percent of the allowable charge of $200.

Notice that in this case, the Sorensons ended up paying $65 of Dr. Manning's bill for $225. They paid 20 percent of the allowable charge, plus the $25 difference between the allowable charge ($200) and Dr. Manning's bill ($225).

Note also that non-participating providers such as Dr. Manning are limited by law from charging more than 15 percent above the TRICARE allowable charge for the care they provide to TRICARE patients. The extra $25 that Dr. Manning charged in this case is less than 15 percent above the $200 allowable charge, so the Sorensons were legally obligated to pay it.

Inpatient Costs

Care in a hospital is not necessarily inpatient care. Usually, if you stay in a hospital for less than 24 hours, you're an out-patient. If you are admitted to the hospital for an overnight stay (usually 24 hours or more), you're an inpatient. There is no deductible for inpatient care. But, remember, just as for outpatient care, you pay in full for most inpatient care not covered by TRICARE Standard.

Active Duty Family Members:

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductible	None	$150/individual or $300/family for E-5 & above; $50/$100 for E-4 & below	$150/individual or $300/family for E-5 & above; $50/$100 E-4 & below
Annual Enrollment Fee	None	None	None
Civilian Outpatient Visit	No cost	15% of negotiated fee	20% of allowable charge
Civilian Inpatient Admission	No cost	Greater of $25 or $11.90/day	Greater of $25 or $11.90/day
Civilian Inpatient Mental Health	No cost	$20/day	$20/day

Retirees, Their Family Members, and Others:

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductible	None	$150/individual or $300/family	$150/individual or $300/family
Annual Enrollment Fees	$230/individual $460/family	None	None
Civilian Copays:	$12	20% of negotiated fees	25% of allowed charges for covered services
Outpatient Visit	$30		
Emergency Care	$25		
Mental Health Visit	($17 for group visit)		
Civilian Inpatient Cost Share	$11/day ($25 minimum) charge per admission	Lesser of $250/day or 25% of negotiated charges plus 20% of negotiated professional fees	Lesser of $414/day or 25% of billed charges plus 25% of allowed professional fees
Civilian Inpatient Mental Health	$40/day	20% of institutional & negotiated professional fees	Lesser of $154/day or 25% of allowable fees

Most Hospitals Participate in TRICARE Standard

When the hospital and doctors participate in TRICARE Standard, they usually fill out and send in the claims for both the hospital's and the doctors' bills. However, you must arrange with them when and how to pay your part of the bills. How much you pay depends on your sponsor's status with the service.

As mentioned earlier, all hospitals that participate in Medicare must, by law, participate in TRICARE Standard as well. *But some individual providers of care who see you in the hospital are not employed by that hospital. These providers may or may not participate in TRICARE Standard. They may bill separately, and may charge more than the TRICARE Standard allowable charge for their services*.

Inpatient Costs With Providers Who Don't Participate in TRICARE Standard

It's very rare that a hospital does not participate in TRICARE for inpatient care since all hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient services related to hospital admissions. If this should happen to you, contact your BCAC/HBA/TSC for help.

But be aware that just because a civilian hospital participates does not mean that the doctors or other providers of care (such as anesthetists) who treat you at that hospital will. The hospital may participate while some doctors or other providers may not, because they are not employees or contractors of the hospital.

Remember, if the doctor doesn't participate, the bill may be for more than the TRICARE Standard allowable charge. You arrange with the doctor how and when to pay the bills.

If the provider of care doesn't participate in TRICARE Standard and refuses to file the claim, you may have to fill out and file the claim form. Get a fully itemized bill. Then sign and send the claim form and a copy of the bill to your TRICARE contractor. TRICARE Standard can then pay you what it would have paid the doctor had the doctor participated in TRICARE Standard. (See the section titled "Fully Itemized Bills" on page 134 in the "How to File a Claim" chapter.)

For families of active duty members, TRICARE Standard pays the allowable charge. You pay anything over that, up to the legal limit of 15 percent above the TRICARE maximum allowable charge.

For retirees, their families, some former spouses, and the families of service members who have died, TRICARE Standard pays 75 percent of the allowable charge for the doctors' services. You pay 25 percent plus anything over the allowable charge, up to the legal limit. (See the exception for this category of eligible persons at the beginning of the "Who's Eligible For TRICARE" section, on page 28.)

All families also pay the full amount for any care that is not covered by TRICARE Standard.

Other Health Insurance

If you have other health insurance (OHI) in addition to your TRICARE Standard benefits, TRICARE Standard pays after all other plans you may have, except for the following:

- Medicaid (a public assistance program);
- Benefits under a State Victims of Crime Compensation Program; and
- Certain insurance policies that are specifically designated as **TRICARE supplements** (these policies are designed to reimburse out-of-pocket expenses that you incur after a TRICARE claims has been processed, and after TRICARE has paid its share of the costs of care).

This means that if you have another health plan in addition to TRICARE Standard, the other plan must pay whatever it covers before TRICARE Standard will make any type of payment. You may have coverage for yourself and your family through an employer, an association, or a private insurer. This also includes the medical portion of an auto insurance policy, or any coverage that students in the family may have through their schools.

When your other plan has paid, then TRICARE Standard will pay for covered outpatient services, within certain limits. Here are two examples of how the Government determines its payment for your covered civilian health care (both examples assume that you have already satisfied your annual outpatient deductible):

First Example:

If you go to a provider of care who participates in TRICARE Standard, the TRICARE contractors will pay the lesser of the following:

1. The amount of the provider's billed charges, minus the other health insurance's payment; or
2. The amount that TRICARE Standard would have paid if you didn't have any other primary health insurance.

Here's an illustration of the above example: *The participating doctor bills you $100, which is the same as the TRICARE Standard allowable charge for the care. Your other insurance pays $80,*

leaving $20 unpaid. Since you're a military retiree, the TRICARE Standard share of the doctor's bill would be $75 if you didn't have other insurance. Since you do have other insurance, TRICARE Standard will pay whichever amount—$75 or $20—is less. So, in this illustration, TRICARE Standard pays the $20 that your other insurance didn't cover.

Second Example:

If you go to a non-participating provider—one who does not accept the TRICARE Standard allowable charge as the full fee for the care provided, and may charge more for your care—the TRICARE contractors will pay the *lesser* of the following:

1. An amount up to 15 percent *more* than the TRICARE Standard allowable charge, *minus* the amount your other health insurance paid; *or*
2. The amount that TRICARE Standard *would* have paid if you didn't have any other health insurance.

Here's an illustration of the second example: *Although the allowable charge for the care is $100, the non-participating doctor bills you $150. Your other insurance pays $125 of that, leaving $25 unpaid. The TRICARE Standard share of the doctor's bill would be $75—that is, 75 percent of the allowable charge—if you didn't have other insurance. Since you do have other insurance, and it paid $125, TRICARE Standard will pay nothing.*

Why? Because the TRICARE Standard payment for care received from a non-participating provider, when you have other insurance, is limited to 15 percent above the allowable charge (in this case, $115), minus the amount your other insurance paid (in this case, $125). Since the other insurance paid **more** *than $115, TRICARE Standard won't pick up any of the rest of the charges.*

Of course, you are responsible for any unpaid amounts the provider has not been paid for TRICARE-covered services, but only up to the legal limit of 15 percent above the allowable charge. In the second illustration (above), the non-participating provider has been paid more than 15 percent above the $100 allowable charge, so you would owe nothing. In this illustration, you would not be legally liable for more than $115 in medical bills.

You must, however, pay all charges for care that aren't covered by TRICARE Standard.

For ***inpatient*** care in hospitals subject to the TRICARE Standard DRG payment system, payments will be limited to the DRG amount or whatever part of it remains after your other health plan has paid everything it's going to pay.

Sometimes your other plan will pay your entire claim, leaving nothing for TRICARE Standard to pay. *You should still have the claim submitted to your TRICARE contractor*, even though TRICARE Standard won't pay anything if the other plan paid the whole bill. This will ensure that the amounts paid by the other plan are counted toward your TRICARE Standard deductible, so you won't be charged the full deductible on other claims you submit to TRICARE. It will also help ensure that the amounts paid by the other plan are counted toward the cost cap explained at the beginning of this chapter.

Or, the other plan may pay nothing if it doesn't cover the care you received. You still must have the claim filed with your other plan first, and get an Explanation of Benefits (EOB) from them, which must be sent in with your TRICARE Standard claim. Then, TRICARE Standard will process your claim and pay its share of your care that's covered under TRICARE Standard.

TRICARE-eligible persons who also have medical coverage through a health maintenance organization (HMO) may have TRICARE Standard cost-share expenses under the same rules as for other health plans that pay before TRICARE Standard.

Caution: *Families who have an HMO as their other health insurance can't jump between the HMO and TRICARE Standard. All covered health care services must be obtained from the HMO.*

When TRICARE Pays Incorrectly

Sometimes, in the processing of more than 25 million claims a year, TRICARE contractors inadvertently overpay claims. The overpayment might go to the patient or to the healthcare provider, depending on who submitted the claim or on whether or not the provider agreed to participate in TRICARE Standard on the claim.

TRICARE contractors might also overpay as follows:

1. If they mistakenly share the cost of care under TRICARE Standard for someone who isn't TRICARE-eligible.
2. If they pay for care that was given by a provider who wasn't authorized to treat TRICARE patients.
3. If a claim is submitted—and paid by the TRICARE contractor—that bills for services that were not provided to a patient, or that bills twice for the same services, or that bills for services that are not a benefit under TRICARE.

When any of these things happens—no matter whose fault the incorrect payment was—the TRICARE contractor must take action to get the money back from the person or organization who received the erroneous payment. That's called "recoupment," and it's done to help ensure that your tax dollars are spent properly, according to the law.

Here's what will happen: The contractor will send a written request for repayment of the amount in question. The request will also explain all of your rights under the law, including any right you may have to appeal the denial of TRICARE benefits, and all actions that the contractor may take to get the money back. You should respond to a repayment request within 30 days after you've received it.

IMPORTANT*: Do not ignore a letter that asks you to repay money that was wrongly sent to you. Answer it promptly.*

If the overpayment wasn't your fault, the TRICARE contractor will make every effort to help you get your debt repaid. If you can't afford to pay the money all at once, you may be able to make monthly payments. You'll be asked to complete a financial statement, and—depending on your situation—the TRICARE contractor may consider reducing the debt or waiving collection altogether.

If you ignore the letters asking for repayment, two things could happen:

1. The amount could be subtracted from any money you might have coming from future TRICARE Standard claims.
2. The TRICARE contractor may take legal action against you, as permitted by state law.

Emergency Room Charges

TRICARE cost shares emergency room charges on an inpatient basis when the intent was to admit the patient to the hospital once his or her condition was stabilized in the emergency room, but the patient died before being formally admitted. The change from outpatient to inpatient cost sharing in this situation means that TRICARE begins paying with the first dollar of medical bills, instead of waiting until the family has satisfied the annual outpatient deductible.

How to File a Claim

Do You Have Other Insurance?

Are you covered by other health insurance (OHI)—maybe through your husband or wife, maybe through a job, or under medical coverage for accidental injuries under your automobile insurance policy? If so, you or your provider must file a claim for your health care with the insurance plan before filing with TRICARE Standard. After your OHI has decided what it's going to pay, a claim may be filed with TRICARE Standard. A copy of the other health plan's payment determination, and a copy of the bill, must be sent along with your TRICARE Standard claim.

Some providers, even if they agree to participate in TRICARE Standard, may ask you to file with the other insurance first. Discuss this with them when you arrange to pay your part of the bills. If you have TRICARE Standard supplemental insurance—a policy that's specifically designated to be a supplement to TRICARE Standard health benefits, and is sold by many military associations and some private firms—you don't file with them first. Go ahead and have the claim sent to the TRICARE contractor. Make sure that the name of your insurance and other information about the policy is indicated on the claim form.

If you don't tell the TRICARE contractor about your OHI, the claim your provider sends in could be delayed in processing or even denied.

Were You Injured in an Accident?

Were you hurt in a car crash, on the job, or in any other type of accident, such as a slip-and-fall, where someone else may be legally responsible (for example, the other driver or your employer)? If so, they or their insurance may have to pay some or all of the medical bills. You or the provider can file claims with TRICARE right away, but be sure to point out on the claim that another person may be responsible. You'll have to complete and attach DD Form 2527, Statement of Personal Injury—Possible Third Party Liability. It's available from your BCAC/HBA or from your TRICARE contractor. This will also speed up the processing of your TRICARE Standard claim.

If a TRICARE Standard claim appears to involve an injury, and the **Form 2527** is not attached, the contractor will write back, sending a blank "2527" and asking for information on the circumstances of the injury. If you don't provide the information, your claim will be denied. **Don't ignore this form,** even if some of the questions on it don't seem to apply to your situation. Even if your accident wasn't caused by someone else, there may be other insurance available to cover part of the cost. For example, you may have a medical benefit as part of your auto insurance or homeowner's liability insurance, or you may be covered by workers' compensation. Be sure to point out this kind of coverage on your TRICARE Standard claim. If you have insurance that pays ***before*** TRICARE Standard does, the TRICARE contractor will not pay your claim until you provide evidence of the amount the other insurance paid toward your medical expenses.

When your OHI has paid, TRICARE Standard will then pay its share of the costs as your secondary coverage. The following types of coverage are primary to TRICARE Standard and must pay before TRICARE Standard does:

1. Workers' compensation
2. Personal injury (medical payments) protection under your auto insurance policy
3. Coverage under the no-fault or uninsured motorist provisions of your auto insurance policy

Are You Registered in the DEERS Files?

If you don't appear in the Defense Enrollment Eligibility Reporting System (DEERS) database as eligible for TRICARE benefits, TRICARE Standard will deny your claim. (See DEERS section on page 25.)

It's Important to Fill Out a Claim Form Correctly

The TRICARE contractors get thousands of claims every day. The claims are computer-processed for speed in paying you or your health care provider. Any mistake, forgotten signature, or other missing information can slow down your claim because the contractor may have to call or write back to get the needed information.

Reminder: *Whoever submits the claim should be sure to enter the* ***military sponsor's*** *social security number on the claim form.*

Which Claim Form to Use

If your doctor files the claim, he or she will generally send in completed HCFA 1500 claim form. When the hospital files the claim, as it must for inpatient care, it will use the UB-92 claim form.

If you file the claim, you'll have to submit a DD Form 2642 ("CHAMPUS Claim—Patient's Request for Medical Payment") Be sure to attach a copy of the provider's itemized bill to the claim form. After the claim has been submitted, the claims processor may require additional information. If this occurs, the claims processor will notify you of what additional information may be required.

Form	Use
DD Form 2642	For care from doctors and other individual providers; sent in by patient/family.
HCFA 1500	For care from doctors and other individual providers; sent in by provider.
UB-92	For inpatient or outpatient care from hospitals and other institutions. The hospital or other institution completes the UB-92. Outside the United States and Puerto Rico, the DD Form 2642 is the only claim form used for care rendered from hospitals, institutions, and for professional services.

Where to Get the Form

Many providers already have the TRICARE/CHAMPUS forms on hand. You can also get forms from your BCAC/HBA/TSC or TRICARE contractor. Or, you can get claim forms by writing to TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, CO 80011-9066. The forms are also available on the TRICARE web site at *www.tricare.osd.mil*.

What Goes in Along with the Claim?

One or more of the following may need to go in with the claim. If they are not provided to the TRICARE contractor when needed, your claim could be denied or delayed. So read this section very carefully.

When your provider files the claim for your care, you may have to get these papers together for the provider, and perhaps have the nearest military hospital file the nonavailability statement electronically. Be sure to make copies of paper documents and keep the originals for yourself, except the claim form—make sure the original claim form is sent in, and keep a copy for yourself.

All attachments should be sent in with each claim, even if a claim was previously filed for similar services during the same course of treatment.

- **Nonavailability Statement**

  If you live within the ZIP code zone (in Europe or elsewhere outside the 50 states and Puerto Rico, it's approximately a 40-mile radius) around a military hospital, that hospital must file a nonavailability statement (NAS) electronically with the Defense Department's DEERS computer files for inpatient care at a civilian hospital (except for emergency care). This includes claims for a doctor's services while you were an inpatient, and for inpatient or outpatient maternity care.

For some highly specialized types of treatment, the ZIP code zone may be much wider (perhaps 200 miles), or even nationwide. Check with your nearest BCAC/HBA/TSC before getting care under TRICARE, to be sure you've followed the rules for getting an NAS.

Note: *If you have another health insurance policy that pays **first** for the cost of medical services, you don't have to get an NAS from the local military hospital.*

IMPORTANT: *In late 1996, there were significant changes to the rules about when—and for what—you need an NAS. For details about these changes, see the chapter titled "Where to Get Care," page 103. Also note the information in the same chapter and in the chapter titled "What's Covered?," page 63 about authorizations needed for certain types of care.*

- **Statement from Another Insurance Plan**

  If you have other insurance (other than a TRICARE supplement), its statement of how much is paid must be attached to the TRICARE Standard claim. This includes coverage under your auto insurance and workers' compensation. If the other plan doesn't pay, you must provide the exclusion section of its policy or a copy of its denial along with your claim. A denial from an HMO or preferred provider organization (PPO) that states you did not use the available services does not count as an exclusion.

- **DD Form 2527** (personal injury questionnaire)

  If you had to go to a hospital (or have a doctor bill of $500 or more) as a result of an accidental injury, you should complete a DD Form 2527 and include it with your claim. It's a questionnaire about how the accident happened. It's needed to complete the processing of your claim. Get a copy from BCAC/HBA/TSC or TRICARE contractor.

- **Fully Itemized Bills**

  Photocopies of fully itemized bills must be sent along with your claim. These must be included even if your OHI has made payment and its Explanation of Benefits (EOB) is enclosed.

A fully itemized bill shows the cost for each service or supply you received.

The bill must be on the provider's stationery. And it must show the following:

1. Name of the patient
2. Diagnosis or description of symptoms
3. Each item of service or supply
4. Place of service
5. Number and frequency of each service
6. Date of care
7. Charge for each item of service or supply

Bills for prescription drugs must be on the pharmacy's letterhead or billing form, and must also show the following:

1. Name of the drug
2. Strength of the drug
3. How much of the drug you bought (the number of pills or amount of other medicine)
4. Cost of each drug (except prepaid prescription plans)
5. Prescription number and date prescription was filled (you should also include a copy of the actual prescription that was written out by your doctor)
6. Name and address of the prescribing doctor
7. Name and address of the pharmacy

TRICARE will not accept canceled checks or cash register receipts. These are not fully itemized bills.

Always make copies of documents that go in with the claim, and keep the originals of these documents for your files.

Daily Nursing Notes

If you get care from a private duty nurse, copies of the daily nursing notes must be sent along with your claim. The claim should also show which doctor referred you for private nursing and is supervising the care. This is true for all private duty nursing care, whether it was at home or in a hospital. (See the "Private Duty or Visiting Nurses" section on page 92 in the chapter titled "What's Covered?")

Doctor's Prescription

For medical supplies (such as syringes, needles, catheters, ostomy bags, etc.) or medical equipment costing $100 or less (such as crutches), a doctor's prescription must go in with your claim. For durable medical equipment worth more than $100 (such as wheelchairs or respirators), the prescription must spell out the particular type of equipment needed and why and how long you need the equipment. (See the "Durable Medical Equipment" section on page 72 in the "What's Covered?" chapter.)

Program for Persons with Disabilities

See the section in the Special Programs chapter for information about what must be sent to the TRICARE claims processor with Program for Persons with Disabilities (PFPWD) claims.

Helpful Hints for Filing Claims

1. All receipts should be on (or attached to) 81/2- by 11-inch sheets of paper.
2. Include the sponsor's social security number on all pieces of correspondence and attachments to claims.
3. Do not highlight information on documents with a "highlighter" or "magic marker." It is either lost in scanning or blackens the information you want to emphasize. Circle the information instead.

Where to Send the Claim

Send claims to the TRICARE contractor for the area where you live.

Here are TRICARE claims filing addresses for U.S. and overseas areas as of early 2002. TRICARE For Life addresses are italicized. These addresses may change, so call before sending in claims:

- **Alabama**—Palmetto Government Benefits Administrators (PGBA), CHAMPUS Claims,

  P.O. Box 7033, Camden, SC 29020-7033 (resource sharing claims)

  P.O. Box 7034, Camden, SC 29020-7034 (mental health claims)

  P.O. Box 7035, Camden, SC 29020-7035 (active duty claims)

  P.O. Box 7036, Camden, SC 29020-7036 (Program for Persons with Disabilities claims)

  P.O. Box 7037, Camden, SC 29020-7037 (adjunctive dental care claims)

  P.O. Box 7031, Camden, SC 29020-7031 (all other claims)

  TRICARE For Life claims: P.O. Box 7053, Camden, SC 29020-7053

  Toll-free phone: 1-800-403-3950.

- **Alaska**—PGBA, CHAMPUS Claims, P.O. Box 870001, Surfside Beach, SC 29587-8701. Toll-free phone: 1-800-930-2929. *TRICARE For Life claims: P.O. Box 7059, Camden, SC 29020-7059.*

- **Arizona** (***except*** for the Yuma area; see California listing for Yuma)—PGBA, P.O. Box 870026, Surfside Beach, SC 29587-8726. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*

- **Arkansas** (***except*** a small part of Arkansas in the Naval Hospital, Millington, TN, service area)—Wisconsin Physicians Service (WPS), P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832. The Millington area's address and toll-free phone number are the same as the listing for Alabama. *TRICARE For Life claims use same address.*

- **California** (***including*** the Yuma, AZ area)—PGBA, CHAMPUS Claims, P.O. Box 870001, Surfside Beach, SC 29587-8701. Toll-free phone: 1-800-930-2929. *TRICARE For Life claims: P.O. Box 7059, Camden, SC 29020-7059.*
- **Colorado—**PGBA, P.O. Box 870027, Surfside Beach, SC 29587-8727. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Connecticut—**PGBA, CHAMPUS Claims, P.O. Box 7011, Camden, SC 29020-7011. Toll-free phone: 1-800-578-1294. *TRICARE For Life claims: P.O. Box 7051, Camden, SC 29020-7051.*
- **Delaware—**Same as listing for Connecticut.
- **District of Columbia—**Same as listing for Connecticut.
- **Florida—**Same as listing for Alabama.
- **Georgia—**Same as listing for Alabama.
- **Hawaii—**Same as listing for California.
- **Idaho** (***except*** for the six Idaho counties listed below)—PGBA, P.O. Box 870028, Surfside Beach, SC 29587-8728. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Northern Idaho** (these six Idaho counties only: Benewah, Bonner, Boundary, Kootenai, Latah, Shoshone)—WPS TRICARE-NW, P.O. Box 8929, Madison, WI 53708-8929. Toll-free phone: 1-800-404-0110. *TRICARE For Life claims use same address.*
- **Illinois—**PGBA, CHAMPUS Claims, P.O. Box 7021, Camden, SC 29020-7021. Toll-free phone: 1-800-493-1613. *TRICARE For Life claims: P.O. Box 7052, Camden, SC 29020-7052.*
- **Indiana—**Same as listing for Illinois.
- **Iowa—**PGBA, P.O. Box 870029, Surfside Beach, SC 29587-8729. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057*
- **Kansas—**PGBA, P.O. Box 870030, Surfside Beach, SC 29587-8730. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*

- **Kentucky—**Same as listing for Illinois.
- **Louisiana** (western two-thirds, mainly west of Baton Rouge)—WPS, P.O. Box 8999, Madison, WI 53708-8999. Toll-free phone: 1-800-406-2832. *TRICARE For Life claims use same address.*
- **Louisiana** (eastern third of the state, including Baton Rouge and New Orleans)—Same as listing for Alabama.
- **Maine—**Same as listing for Connecticut.
- **Maryland—**Same as listing for Connecticut.
- **Massachusetts—**Same as listing for Connecticut.
- **Michigan—**Same as listing for Illinois.
- **Minnesota—**PGBA, P.O. Box 870129, Surfside Beach, SC 29587-9729. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Mississippi—**Same listing as for Alabama.
- **Missouri** (***except*** the St. Louis area)—PGBA, CHAMPUS Claims, P.O. Box 870130, Surfside Beach, SC 29587-9730. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Missouri** (the St. Louis area)—Same as listing for Illinois.
- **Montana—**PGBA, P.O. Box 870127, Surfside Beach, SC 29587-9727. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057*
- **Nebraska—**PGBA, P.O. Box 870128, Surfside Beach, SC 29587-9728. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Nevada—**PGBA, P.O. Box 870033, Surfside Beach, SC 29587-8733. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **New Hampshire—**Same as listing for Connecticut.
- **New Jersey—**Same as listing for Connecticut.
- **New Mexico—**PGBA, P.O. Box 870032, Surfside Beach, SC 29587-8732. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*

- **New York—**Same as listing for Connecticut.
- **North Carolina—**Same as listing for Illinois.
- **North Dakota—**PGBA, P.O. Box 870031, Surfside Beach, SC 29587-8731. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Ohio—**Same as listing for Illinois.
- **Oklahoma—**Same as listing for Arkansas.
- **Oregon—**Same as listing for Northern Idaho.
- **Pennsylvania—**Same as listing for Connecticut.
- **Rhode Island—**Same as listing for Connecticut.
- **South Carolina—**Same as listing for Alabama.
- **South Dakota—**PGBA, P.O. Box 870131, Surfside Beach, SC 29587-9731. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Tennessee—**Same as listing for Alabama (except for a small part of northern Tennessee near Fort Campbell, KY, which has the same listing as Illinois).
- **Texas** (***except*** southwestern corner of state that includes El Paso, and the Cannon Air Force Base, NM, service area ZIP codes that fall in Texas)—Same as listing for Arkansas.
- **Texas** (southwestern corner including El Paso, and Cannon Air Force Base, NM, ZIP codes that fall in Texas)—PGBA, P.O. Box 870133, Surfside Beach, SC 29587-9733. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims use same address.*
- **Utah—**PGBA, P.O. Box 870132, Surfside Beach, SC 29587-9732. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Vermont—**Same as listing for Connecticut.
- **Virginia** (the entire state, ***except*** for some ZIP codes—generally, 20100 through 24485—in the part of Northern Virginia that's located in the Washington, DC area; check with your nearest BCAC/HBA/TSC if you aren't sure whether your ZIP code falls into this category)—Same as listing for Illinois.

- **Northern Virginia** (includes ZIP codes—generally, 20100 through 24485—that are in the Washington, DC area; check with your BCAC/HBA/TSC if you aren't sure whether the ZIP code of your residence falls into this region)—Same as listing for Connecticut.
- **Washington—**Same as listing for Northern Idaho.
- **West Virginia** (the entire state, ***except*** for certain ZIP codes—generally 25401 through 26866—in northeastern WV that have been placed in TRICARE Region 1; check with your nearest BCAC/HBA/TSC if you're uncertain which region your ZIP code falls into)—Same as listing for Illinois.
- **Northeastern Tip of West Virginia** (generally includes ZIP codes from 25401 through 26866; check with your BCAC/HBA/TSC if you aren't sure whether the ZIP code of your residence falls into this region)—Same as listing for Connecticut.
- **Wisconsin—**Same as listing for Illinois.
- **Wyoming—**PGBA, P.O. Box 870126, Surfside Beach, SC 29587-9726. Toll-free phone: 1-800-225-4816. *TRICARE For Life claims: P.O. Box 7057, Camden, SC 29020-7057.*
- **Puerto Rico—**WPS, P.O. Box 7985, Madison, WI 53707-7985. Telephone: (608) 224-2728. *TRICARE For Life claims use same address.*
- **Europe, Africa, Middle East** (plus active duty members' foreign claims)
  - For active duty member claims: Foreign Claims, ATTN: Active Duty Claims, P.O. Box 7968, Madison, WI 53707-7698
  - For active duty family members' claims: WPS, P.O. Box 8976, Madison, WI, USA 53708-8976. Telephone: (608) 224-2727.
- **Canada, Mexico, Central America, South America, Bermuda, West Indies—**WPS, P.O. Box 7985, Madison, WI, USA 53707-7985. Phone: (608) 224-2728.

- **Pacific Area (China, Thailand, Korea, Australia, Japan, etc.)—**WPS, P.O. Box 7985, Madison, WI USA 53707-7985. Phone: (608) 224-2727.

  Note: *If you're a retiree, and are not living in an overseas area, but are just traveling there, be sure to send your claims to the TRICARE claims processing contractor for the state or region in which you live.*

  Active-duty service members should file claims with WPS, based on their overseas address.

  Active-duty service members or their family members who have been stationed overseas and are traveling in the United States, but who have not yet signed in at their new stateside duty station, should file claims based on their overseas address.

- **Adjunctive dental claims** (worldwide)—***within the continental United States (CONUS)*** claims should be sent to the specific TRICARE contractors. ***Outside CONUS***, claims (including those for persons traveling outside the United States, and claims for active-duty service members who are under TRICARE Europe) should go to: Foreign Claims, ATTN: Foreign Claims, P.O. Box 7968, Madison, WI USA 53708-7968. Telephone: 1-608-259-4847.

- **Christian Science claims—**Christian Science claims for services should be sent to the TRICARE contractor for a given region.

Abbreviations of the names of TRICARE contractors stand for the following:

- **Sierra:** Sierra Military Health Services, Inc. is the main TRICARE contractor for Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Delaware, Maryland, New Jersey, New York, Pennsylvania, the District of Columbia, part of Northern Virginia, and a small part of northeastern West Virginia. Sierra has subcontracted its claims processing operation to PGBA. That's why PGBA is listed for the above states instead of Sierra.

- **TriWest:** TriWest Healthcare Alliance. TriWest is the main TRICARE contractor for Nevada, Arizona, New Mexico, Colorado, Utah, Wyoming, Montana, North and South Dakota, Nebraska, Kansas, Minnesota, Iowa, Missouri, all of Idaho except the following counties: Benewah, Bonner, Boundary, Kootenai, Latah, and Shoshone; and the southwestern corner of Texas that includes El Paso. TriWest has subcontracted its claims processing operations to PGBA. That's why PGBA is listed for the above states, instead of TriWest.
- **WPS:** Wisconsin Physicians Service. WPS is a subcontractor that works for the main TRICARE contractors in TRICARE Regions 6 and 11 and that processes claims for those regions. WPS also processes TRICARE claims for overseas areas.
- **HNFS:** Health Net Federal Services (formerly known as Foundation Health Federal Services). HNFS is the main TRICARE contractor for TRICARE Regions 6, 9, 10, 11, and for Alaska and Hawaii. HNFS has subcontracted its claims processing operations to PGBA for TRICARE Regions 9 and 10, and for Alaska and Hawaii; and to WPS for Regions 6 and 11.
- **Humana:** Humana Military Healthcare Services. Humana is the main TRICARE contractor for Florida, Georgia, South Carolina, Alabama, Mississippi, Tennessee, the eastern third of Louisiana, and a small part of Arkansas near the Naval Hospital in Millington, TN Humana is also the main TRICARE contractor for North Carolina, most of Virginia, Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, a small part of Tennessee near the Kentucky border, the St. Louis area in Missouri, and most of West Virginia except for a small part of the northeastern tip of the state near Washington, DC. Humana has subcontracted its claims processing operations to PGBA. That's why PGBA is listed for the above states, instead of Humana.
- **Palmetto Government Benefits Administrators (PGBA):** PGBA is a subcontractor that works for the main contractors in several different TRICARE regions, and that processes TRICARE claims for all regions except Regions 6 and 11.

When the Claim Should Be Sent in

You or your provider of care should send your TRICARE Standard claim forms to the TRICARE contractor as soon as possible after you get care. The sooner your TRICARE contractor gets the claim forms and other papers, the sooner you or your provider will be paid.

The contractor must receive claims within one year of the date the service was received—or, in the case of inpatient care, within one year of the date of an inpatient's discharge.

What the Submitter Gets Back and How Long It Takes

If everything is okay with your claim, the contractor should send whoever filed the claim a notice called an Explanation of Benefits (EOB) in about a month. The EOB shows the following:

- What the provider billed
- The TRICARE Standard allowable charge at the time of care
- How much of your annual deductible has been met
- How much you've paid toward your annual cost cap
- Your cost share for the care
- How much TRICARE paid

If your provider did not agree to participate in TRICARE Standard and didn't file the claim for you (this means you had to file the claim), you (instead of the provider) get a check for the TRICARE Standard cost share. It's your responsibility, of course, to make sure that the provider's bill is paid.

The EOB also gives the reasons for denying services on a claim.

If the claims processor needs additional information, you may get a phone call or letter. If so, you must get that information to the processor within 35 days of the date of the letter or phone call, or else your claim may be denied.

Keep Copies or Originals of Claims and Papers

Keep a copy of the claim and the originals of all other documents that are sent to TRICARE.

Suppose your claim form and papers get lost in the mail? Suppose you have questions about your claim? Suppose you think the contractor has made a mistake with your claim? You will need to have your own copies to support your claim for reimbursement.

Appealing Certain TRICARE Decisions

If you have a dispute with certain decisions made by a TRICARE contractor or by the TRICARE Management Activity (TMA)—formerly known as the TRICARE Support Office, and as CHAMPUS headquarters, or OCHAMPUS—you have the right to ask the TRICARE contractor or TMA to take another look or to get another opinion on the decision.

IMPORTANT NOTE: *This chapter describes the TRICARE appeals procedures applicable to the routine processing of TRICARE claims and authorizations for care, and health care provider sanctions, by TRICARE contractors and TMA. However, TRICARE "demonstration" projects and special programs may be in place that alter the appeal procedures described in this chapter. Whatever the situation, a decision that is appealable should include notice of your right to appeal, including the address of the next level of appeal. If you have any questions about your right to appeal after reading this chapter and the specific notice of your appeal rights included on a TRICARE decision, check with your nearest BCAC/HBA/TSC, or the TRICARE contractor for your region, for more information.*

The appeal process varies, depending on whether the denial of benefits involves a **medical-necessity determination,** a **factual determination,** or a **provider sanction.** All initial and appeal denial determinations include a section that fully explains how, where, and by when you must file the next level of appeal.

Medical-necessity determinations are based solely on the following:

- Whether the care was medically necessary.
- Whether the *level* of care was appropriate.
- Whether the care was custodial. Or—
- Other reasons related to reasonableness, necessity or appropriateness.

Generally, determinations relating to mental health benefits are considered medical-necessity determinations.

The appeal process for adverse medical-necessity determinations is as follows:

1. A ***reconsideration***, conducted by the TRICARE contractor for your region.
2. A ***second reconsideration***, conducted by an independent contractor called the National Quality Monitoring Contractor (NQMC).
3. If services have been provided, a ***hearing*** administered by the TMA Office of Appeals and Hearings, and conducted by an independent hearing officer.

Factual determinations are rendered in cases involving issues other than medical necessity. Examples of factual determinations are those involving the following:

- Coverage issues (that is, whether a service is covered under TRICARE policy or regulation).
- Hospice care.
- The Program for Persons with Disabilities (PFPWD).
- Foreign claims.
- A mix of both medical-necessity *and* factual-determination issues.

- Denial of a provider's request for approval as a TRICARE-authorized provider.

The appeal process for adverse factual determinations is:

1. A reconsideration, conducted by the TRICARE contractor for your region.
2. A ***formal review*** conducted by the TMA Office of Appeals and Hearings.
3. If services have been provided, a hearing administered by the TMA Office of Appeals and Hearings and conducted by an independent hearing officer.

Provider sanction determinations suspend, exclude, or terminate providers because of provider fraud, abuse, conflict of interest, or other reasons. Only the sanctioned provider or his or her representative can appeal. The appeal process applicable to provider sanctions is a hearing administered by the TMA Office of Appeals and Hearings and conducted by an independent hearing officer.

If you have any questions about your right to appeal after reading this handbook and the specific notice of your appeal rights included on a TRICARE decision, check with your nearest BCAC/HBA/TSC, or your region's TRICARE contractor for more information.

What You Can't Appeal

You can't appeal the amount that a TRICARE contractor determines to be the allowable charge for a particular medical service. You may ask the TRICARE contractor to review the amount of the allowable charge to determine if it was calculated correctly.

You can't appeal the decision by TMA or by TRICARE contractors to ask you for more information before action on your claim or other request.

Decisions Relating to Eligibility

You can't appeal decisions relating to your eligibility for TRICARE. Although this issue affects your use of TRICARE, you can't appeal such decisions through TRICARE. The uniformed services decide if someone is eligible for TRICARE and issue ID cards. You must appeal decisions regarding your eligibility through the particular military service involved.

Decisions Relating to the Status of TRICARE Providers

You can't appeal decisions relating to the status of TRICARE health care providers. Although you may want to receive care, or have already received care, from a particular provider, you can't appeal a decision that denies the provider authorization to be a TRICARE provider, or a decision that suspends, excludes, or terminates the provider. The provider in question may appeal on his or her own behalf, however.

Appealing TRICARE Contractor and TMA Determinations

If you disagree about the facts in your case, such as whether your diagnosis was correct or whether you were required to be in the hospital, or if you think there is a mistake in how the law or regulation was interpreted, you can appeal by following the procedures spelled out below.

Appealing Medical-Necessity Determinations

If you disagree with a decision that comes back on the EOB or some other decision by the TRICARE contractor for your region:

- Write back to the regional contractor, or to the address specified in the notice of your right to appeal, included in your EOB or other decision. Your letter must be postmarked or received by the regional TRICARE contractor within **90 days** of the date on the EOB or the notice with which you disagree. Be sure to include a copy of the EOB or notice, as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements and state that you intend to submit additional information. Send the other documents in when you get them.
- The TRICARE contractor will review the case and will issue a reconsideration decision.

If you disagree with a reconsideration decision, and if notice of your right to appeal identifies NQMC as the next level of appeal:

- Write to NQMC, making sure your letter is postmarked within **90 days** of the date on the reconsideration decision with which you disagree. If you have them, be sure to include a copy of the notice as well as any other information or papers to support your position. But even if you don't have some of the

supporting papers yet, send your letter in anyway, to meet the deadline requirements and state that you intend to submit additional information. Send the other documents in when you get them. Your request for a second reconsideration should be sent to the address of the NQMC specified in the reconsideration determination.

- The NQMC will review the case and will issue a second reconsideration decision.
- If the amount still in dispute is less than $300, or if you have not received the services, the reconsideration decision by the NQMC is final.
- If you still disagree, and if $300 or more is still in dispute, and if the services have already been provided, you can ask TMA to schedule an independent hearing.

Note: *There are "expedited" procedures for appealing decisions denying requests for advance authorization of services and requests for continued stays in institutions. If an expedited appeal is available, the initial and appeal denial decisions will include a section fully explaining how, where and by when to file an expedited appeal.*

Appealing Factual Determinations

If you disagree with a decision that comes back on the EOB, or with some other decision by the contractor for your region:

1. Write back to the regional contractor, or to the address specified in the notice of your right to appeal, that's included in your EOB or other decision. Your letter must be postmarked or received by the regional contractor within **90 days** of the date on the EOB or the notice with which you disagree. Be sure to include a copy of the EOB or notice, as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements, and state that you intend to submit additional information. Send the other documents in when you get them.
2. The TRICARE contractor will review the case, and will issue a "reconsideration decision."
3. If the amount in dispute is less than $50, the reconsideration by the TRICARE contractor is final.

4. If you still disagree, and if $50 or more is in dispute, you can ask TMA for a formal review.

If you disagree with a reconsideration decision, or with an initial determination made by TMA, and if notice of your right to appeal any decision identifies TMA as the next level of appeal:

Write to TMA, making sure your letter is postmarked, or received by TMA, within **60 days** of the date on the notice or reconsideration decision with which you disagree. If you have them, be sure to include a copy of the notice, as well as any other information or papers to support your position. But even if you don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements and state that you intend to submit additional information. Send the other documents in when you get them. Your request for a formal review should be sent to TMA Office of Appeals and Hearings, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

TMA will review the case and issue a formal review decision. If either the amount still in dispute is less than $300, or you have not received the services, the formal review decision by TMA is final.

If you still disagree, and if $300 or more is still in dispute, and if the services have already been provided, you can ask TMA to schedule an independent hearing.

Appealing Provider Sanction Determinations

A sanctioned provider may request that TMA schedule an independent hearing.

Requesting a Hearing

When you receive the second reconsideration from the NQMC, or the formal review decision from TMA, denying TRICARE benefits—it tells you the steps for requesting a hearing.

Write to TMA, making sure your letter is postmarked, or received by TMA, within **60 days** of the date on the notice or reconsideration or formal review decision with which you disagree. If you have them, be sure to include a copy of the notice as well as any other information or papers to support your position. But even if you

don't have some of the supporting papers yet, send your letter in anyway, to meet the deadline requirements and state that you intend to submit additional information. Send the other documents in when you get them. Your request for a hearing should be sent to TMA Office of Appeals and Hearings, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

An independent hearing officer at a location convenient to both the requesting party and the Government conducts the hearing.

The hearing officer issues a recommended decision. The final decision is issued by either the TMA Director (or designee), or the Assistant Secretary of Defense for Health Affairs.

Be Aware

- Only the patient, the participating provider or a sanctioned provider, the parent of a child under 18, the guardian of a patient who is not competent to act in his or her own behalf, or an appointed representative can appeal. For example, a military sponsor can't appeal the denial of a spouse's claim unless the spouse appoints the sponsor in writing as representative.
- The appealing party must prove that he or she is entitled to TRICARE benefits.
- TRICARE network providers are never parties to an appeal and cannot appeal an adverse decision.
- You must meet the deadlines discussed on the previous pages in this chapter. Your requests must be postmarked or received within the required deadlines. If not, the TRICARE regulation says the decision—the one you want to appeal—is final. If you want to submit additional information, and can't get it submitted within the filing deadline, you still must file your appeal by the deadline, but you can indicate that more information is coming.
- Your appeal must go through a formal review by TMA, or a second reconsideration by the NQMC, before an independent hearing can be held.
- TRICARE cannot pay for any of your costs in making an appeal.

- When part of an episode of care is cost shared by TRICARE and part is denied, **the whole episode of care** will be reviewed when you appeal.
- For appeal-filing purposes, a postmark is a cancellation mark issued by the U.S. Postal Service (for persons who live overseas and who file appeals, postmarks from other countries don't count). Private mail carriers don't issue postmarks. If your letter requesting an appeal is not postmarked by the U.S. Postal Service, the appeal will be considered filed on the date it is ***received*** by the TRICARE contractor or TMA.
- Filing an appeal by facsimile transmission (fax) is acceptable. An appeal submitted is considered filed on the date it is received by the TRICARE contractor or TMA.

Appealing Medical Treatment Facility Decisions

As a TRICARE beneficiary receiving care in an MTF, you have certain appeal rights. Check with the MTF's BCAC/HBA to find out their local appeals process. If it cannot be resolved at the MTF level, use your region's Lead Agent office.

Tips on Using TRICARE Standard

For Everyone

- Know how to reach the nearest Beneficiary Counseling and Assistance Coordinator (BCAC)/Health Benefits Adviser (HBA), or the people at the TRICARE Service Center (TSC) in your area.
  - They can help you get the most from your health benefits. Also, learn the location of your local contractor's nearest TSC.
- Use Military Treatment Facilities (MTFs) whenever possible. They save you money and paperwork.
- If you live within the ZIP code catchment area of an MTF, check with the BCAC/HBA/TSC there to find out if your home address falls within the hospital's ZIP code catchment area for health care. If so, you must try to use the service hospital first for any non-emergency inpatient civilian care. If that specific care is not available at the service hospital,

you must get a nonavailability statement (NAS) before using TRICARE Standard—unless you have a private health insurance policy that pays first for medical services. If that's the case, you don't need an NAS. For certain kinds of highly specialized or very expensive care, ZIP code areas may be expanded. Check with your BCAC/HBA/TSC on this before getting care.

- Certain outpatient procedures must be authorized ahead of time for patients who live in areas where the TRICARE program is in operation. (See the chapter titled "Where to Get Care" for more information.)
- You can save money by going to a doctor or other healthcare provider who "participates in TRICARE Standard." The BCAC/HBA/TSC may help you find one. Or ask a provider to participate, and have the provider call the claims processor for information on the allowable charge.

  Remember: *Providers can participate on a case-by-case basis. (See the definition of "participating provider" in the Glossary.)*

- Even if a hospital participates in TRICARE Standard, sometimes the doctors and other providers who care for you at that hospital do not. If possible, check on this by phone before you go to get care.
- Check your family's Defense Enrollment Eligibility Reporting System (DEERS) listings annually to make sure the most accurate eligibility and home-address information are included. Enroll newborns in DEERS as soon as possible. You can do this at your nearest uniformed services personnel office. Keeping your DEERS files current helps your TRICARE contractor process claims for your family quicker.
- When you go to get care, have your ID card with you. Discuss with the provider's office how and when to pay your part of the bills. If you are getting outpatient care and have already paid your deductible for that year, bring your Explanation of Benefits (EOB) showing that.
- If you have to file your own claims, fill out claim forms carefully and neatly to speed payment. Be sure to include both your daytime and evening phone numbers. That way, the TRICARE contractor can call you if there are any problems with the form.

- Don't forget to send a copy of the medical bill and clear copies of any other papers that support the claim form.
- TRICARE Standard claims should go to the TRICARE contractor who serves the area ***in which you live***. Your BCAC/HBA/TSC can give you the right address and toll-free telephone number. Also, see the "How to File a Claim" chapter in this handbook on page 129 for addresses and phone numbers.
- You'll find it easier to reach the claims processors on the toll-free telephones during "non-peak" hours—that is, from the beginning of work hours until 9 a.m., and from 2:30 p.m. until closing, Tuesdays through Thursdays. Remember, their phones are usually open during work hours for the states where their headquarters are located. They'll also have an automated phone system operating after normal office hours that you can use to get answers to simple questions, check on claims status, or request forms.
- Keep copies of all your TRICARE Standard claims and papers even when your provider sends them in.
- To ensure prompt payment, TRICARE Standard claims should be filed soon after the care is received. Claims must arrive at the contractor's processing office within one year of the date on which you get care—or, for inpatient care, one year from your date of discharge from an inpatient facility.
- If your contractor asks you for more information on a claim, be sure to respond within 35 days of the request. Otherwise, the claim may be denied. Be sure your sponsor's social security number is on the response and include a copy of the letter requesting the information.
- Families, including active duty, who use TRICARE Standard often should consider supplemental insurance to cover the cost share under TRICARE Standard. Your BCAC/HBA/TSC can direct you to military associations or companies that offer supplemental insurance.
- Congress may change TRICARE Standard coverage and cost share terms.

For Retirees and Survivors

- Remember, if you're eligible for Medicare (Part A) and you're enrolled in Medicare Part B, you're now covered by TRICARE as second payer to Medicare, regardless of your age. (See the note under "Medicare and TRICARE" in the "Who's Eligible For TRICARE" section.) See TRICARE Senior Pharmacy for Part B exceptions.
- Make sure your ID card reflects TRICARE eligibility and that DEERS is updated.
- If you're covered by Medicare, remember that Medicare doesn't cover you outside the United States. If you'll be outside the United States, you may want to consider private health insurance. See the section earlier in the handbook on TRICARE For Life (TFL).
- You're not covered by the TRICARE Program for Persons with Disabilities (PFPWD). But the survivors of deceased active duty sponsors are covered for the 3 years after the sponsor's death as active duty dependents, after they fall into the all other category.
- Because your cost share is more, it makes even more sense for you to:
  - Use an MTF whenever possible, and
  - Get TRICARE supplemental insurance from a military association or a private company, or buy a "primary" health insurance policy—one that pays before TRICARE does—for your covered health care.

If You Suspect Fraud or Abuse

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

Fraud and abuse drive up health care costs. Review your bills and Explanation of Benefits (EOB) forms carefully for any discrepancies. Notify your TRICARE contractor immediately using the toll-free telephone number that's on the EOB.

If something doesn't seem right about your medical bills—perhaps the same item is billed twice, or you've been billed for services you never received, or—

- You think someone is providing inappropriate or unnecessary services, and billing for them, or
- You think someone is providing lower-cost or used equipment while billing for higher-cost or new equipment, or
- A supplier is completing a "certificate of medical necessity" for a physician, or
- A provider is incorrectly reporting diagnoses, procedures, medications, or equipment to get a higher payment, or

- Brand-name prescription medications are being billed for when generic drugs were provided, or
- Individual psychotherapy is billed for when it was group counseling that was actually provided—

Here's what to do:

1. Double-check the billings from your provider of care and the EOB you received from your TRICARE contractor. Be sure that the only services listed are ones you actually received.
2. If you can't resolve any problems you find by talking to the provider's billing office (some discrepancies might simply be the result of errors in billing), write to the program integrity unit of your regional TRICARE contractor. Explain what you think the problem is, and include copies of the EOB and any other relevant documents.
3. If you know, or have evidence of, another individual—whether it be a provider of care or a TRICARE-eligible person—submitting fraudulent claims to TRICARE, write to the Managed Care Support Contractor (MCSC) in your area.
4. Although cost shares under TRICARE may vary, it's illegal for a provider to waive those cost shares. When a cost share is waived, it may keep you from seeking a much-needed second opinion. Here's an example: *A woman is diagnosed with a terminal disease. Her physician waived her cost share (the portion of the medical bills she was supposed to pay), and the woman didn't seek a second opinion because she didn't want to pay a share of the second physician's charges. Months later, she found out that she wasn't terminally ill after all. A second opinion could have saved her months of unnecessary worry.* You and TRICARE are partners in the payment of your medical expenses. Report to your regional TRICARE contractor any provider who waives your cost share.

Millions of tax dollars are lost to fraud and abuse of your health benefits programs each year. Your vigilance and alertness may be able to help bring perpetrators of health care fraud and abuse to justice.

The TRICARE Dental Program

Two TRICARE dental plans joined forces on February 1, 2001, and became the new TRICARE Dental Program (TDP). The TDP combines into one program the TRICARE Family Member Dental Plan, which has served active-duty uniformed services families; and the TRICARE Selected Reserve Dental Plan, which has provided dental coverage for eligible reservists, National Guard, and their families.

The TRICARE Retiree Dental Plan (TRDP) remains separate from the new combined program.

The TDP covers a wide range of diagnostic, preventive, and restorative services—dental X-rays, exams, cleaning, fluoride applications, fillings, root canals, crowns, orthodontics, anesthesia, etc.

Improvements in the TDP over the two previous plans include the following:

- Reduction of the 24-month mandatory enrollment period (in the previous plan for active-duty families) to 12 months for the TDP. The TDP requires sponsors to have 12 months of service remaining at the time of enrollment.
- Enrollment in the TDP is easier and more efficient than before because the contractor, United Concordia Companies, Inc. (UCCI), handles enrollment instead of having it done by service personnel offices. UCCI has ready access to the Defense Enrollment Eligibility Reporting System (DEERS) database to check eligibility.
- Certain reservists, National Guard, and family members of incarcerated sponsors, who previously couldn't enroll because they didn't have an active payroll account, may now enroll, because the contractor will bill them directly for their monthly premiums.
- The maximum benefit coverage is increased to $1,200 annually (from the previous $1,000 for both the active-duty and reserve plans) for routine care. The lifetime maximum benefit for orthodontic care has increased to $1,500.
- There's a "staged" cost share structure that reduces cost shares for certain procedures for enlisted members in pay grades E-1 to E-4. Since some enlisted families in these pay grades don't seek dental care because of the cost, the reduction in cost shares for some dental procedures encourages them to get needed care and improve their dental health.
- Under the TDP, children are automatically enrolled at age 4, but sponsors may enroll their children at age 1. The TDP strongly encourages diagnostic and preventive care for younger children.

Who Can Use the TRICARE Dental Program?

Those eligible to enroll in the TDP are as follows:

- Family members of all active-duty uniformed-service members
- Selected Reserve and Individual Ready Reserve (IRR) members and their families. Sponsors must have at least 12 months remaining of their service commitments at the time they or their families enroll. *Reservists and National Guard who are ordered to active duty for more than 30 consecutive days have the same benefits as active-duty service members. Included are the Active Guard/Reserve (AGR) and reservists who are on active duty for special work or training.*

Who Is Not Eligible to Use the TRICARE Dental Program?

Active-duty service members are not eligible; they get their dental care from their service branches. Also not eligible are former spouses, parents, parents-in-law, disabled veterans, foreign military personnel, and uniformed-services retirees and their families.

Note: *Retirees and their families may enroll in the Retiree Dental Plan, which is separate from the TDP. For more information on this plan, call the contractor, Delta Dental, at 1-888-838-8737. Or, check out Delta Dental's web site at* www.ddpdelta.org.

How Do You Enroll in the TRICARE Dental Program?

If you want to enroll in the TDP, you can get an enrollment application by calling UCCI at 1-888-622-2256. Or, you can contact your nearest BCAC/HBA/TSC, a military dental treatment facility, or a uniformed-services personnel office. Enrollment applications are also available on-line, at UCCI's web site at *www.ucci.com*.

You and your family's various enrollment options (sponsor only, family only, single family member, etc.) are also explained on the UCCI web site.

Your enrollment application must be received by UCCI not later than the 20th day of the month, for coverage to begin on the first day of the next month. If UCCI receives your application after the 20th day of the month, your coverage may not begin until the month following the next month.

Once enrolled, you or your family members must stay in the TDP for at least 12 months (with certain exceptions, such as loss of DEERS eligibility because of divorce, marriage of a child, etc.). After that, you may continue enrollment on a month-to-month basis.

You must send one month's premium payment in with your enrollment. The premium amount is shown on the enrollment form. After the first month, you'll pay monthly premiums by payroll allotment, payroll deduction or—in some cases—by being billed directly.

What Will the TRICARE Dental Program Cost?

For the first year of the TDP (February 1, 2002-January 31, 2003), the monthly cost for an **active-duty family** is as follows: Single enrollment—$7.90. Family enrollment—$19.74.

For a **member of the Selected Reserve or the mobilized IRR (more than 30 consecutive days), or for the reservist's family members,** the monthly cost is Sponsor only—$7.90. Family enrollment—$19.74.

For a **non-mobilized member of the IRR, or for his/her family members,** the monthly costs will be Sponsor only—$19.75. Single family member—$19.75. Family enrollment—$49.36.

For More Information...

When you enroll in the TDP, you'll receive a member handbook that contains many details about what's covered, how to use the program, etc. You can also access this handbook online at the UCCI web site. In addition, you can get general information about the program by calling UCCI at 1-800-866-8499.

Note: *The TDP is separate from, and has nothing to do with, any medical care-related dental treatment that may be provided to TRICARE-eligible persons under the TRICARE Standard basic program.*

The TRICARE Retiree Dental Program

The Fiscal Year 2000 National Defense Authorization Act provided for enhanced dental benefits for uniformed service retirees and their families. The enhanced benefits allow for additional diagnostic, restorative (e.g., cast crowns), and preventive services (a second cleaning per year), and adds coverage for prosthodontic (dentures, etc.) and orthodontic services.

Uniformed service retirees and their family members are offered dental benefits through voluntary enrollment in the TRICARE Retiree Dental Program (TRDP). They do not have dental benefits under the TDP for active duty family members and eligible Reserve component personnel, which was implemented February 1, 2001.

The TRDP provides dental care for uniformed service members who are entitled to retired pay, members of the Retired Reserve under the age of 60, persons who have received the Congressional Medal of Honor, un-remarried surviving spouses, and certain other eligible family members. By law, former spouses are not eligible for TRDP coverage. Enrollment in TRDP is voluntary and is administered by the Delta Dental Plan (DDP) of California. The TRDP is funded solely by enrollees and receives no government subsidy. It was implemented under different legislation and different rules from those applicable to active duty family members and Reserve and National Guard members. More than 600,000 retirees and their family members are enrolled.

Additional information about the TRDP including enrollment forms is available at the DDP web site: *www.ddpdelta.org*.

DDP representatives are also available as follows:

- Customer Service: P.O. Box 537007, Sacramento, CA 95853-7007
  - Toll-free telephone: 1-888-336-3260
  - E-mail: *ddpservice@delta.org*
- Enrollment: P.O. Box 537008, Sacramento, CA 95853-7008
  - Toll-free telephone: 1-888-838-8737
  - E-mail: *ddpenroll@delta.org*
- Billing: P.O. Box 537008, Sacramento, CA 95853-7008
  - Toll-free telephone: 1-888-336-3260
  - E-mail: *ddpbill@delta.org*

Separation from the Service or Loss of Benefits

If you are leaving the Service or you lose eligibility for TRICARE, there are some options available for you and your family. The following sections explain these benefits.

Continued Health Care Benefit Program

The Continued Health Care Benefit Program (CHCBP) is intended to provide transitional benefits for a specified period of time (18-36 months) to former service members and their families, some unremarried former spouses, and emancipated children (living on their own) who enroll and pay quarterly premiums.

The benefits available under CHCBP are similar to TRICARE Standard, and although it is not part of TRICARE Standard, it operates under most of the same rules. The quarterly premiums for the coverage are $933 for one person and $1,996 for a family.

To receive coverage under CHCBP, eligible persons must enroll within 60 days after separating from active duty or from losing their eligibility for military health care.

The Department of Defense (DoD) has contracted with Humana Military Healthcare Services, Inc., to help us administer the CHCBP. You may contact Humana Military Healthcare Services, Inc., in writing or by phone for any information regarding CHCBP. This includes your eligibility for enrolling in CHCBP, to request a copy of the enrollment application, to obtain information about the benefits, and to obtain information regarding the premiums and out-of-pocket costs once you are enrolled.

Humana Military Healthcare Services, Inc.
Attn: CHCBP
P.O. Box 740072
Louisville, KY 40202
1-800-444-5445

A copy of the CHCBP enrollment application can also be found on the web at *www.tricare.osd.mil* and at *www.humana-military.com.*

Former Active Duty Members and Families

Congress has granted limited eligibility for TRICARE benefits to four categories of ***former*** active duty service members under the Transitional Health Care Benefit (THCB). If the service member served:

- Less than six years, they receive TRICARE benefits for up to 60 days after the separation date
- More than six years, they receive benefits for up to 120 days

Eligible service-member categories:

- A member involuntarily separated from active duty
- A reserve component member separated from active duty who was called up or ordered in support of a contingency operation for an active duty period of more than 30 days
- A member separated from active duty after involuntarily retained in support of a contingency operation
- A member separated from active duty following a voluntary agreement to stay on active duty for a period of less than one year in support of a contingency mission

Family members of service members who separated **on or before** December 31, 2001 are also eligible for THCB; those separated **after** December 31, 2001 are eligible for transitional health care under the Transitional Health Care Demonstration Project (THCDP). The THCDP provides the same level of health care that eligible service members receive under THCB.

Each Service branch determines THCB eligibility and provides that eligibility information to DEERS. TRICARE contractors check DEERS for eligibility status when processing claims. Claims for eligible members are processed the same as those for active duty family members. For details about THCB eligibility, contact your nearest service personnel representative. For benefit information, see your BCAC/HBA/TSC.

Voluntary Separation Benefits

Service members voluntarily separated under the Special Separation Benefit (SSB) or the Voluntary Separation Incentive (VSI) are entitled to all benefits provided to involuntarily separated members. Members who choose SSB or VSI (and their families) may receive health benefits by enrolling in the Continued Health Care Benefit Program (see page 165).

Program of the Department of Veterans Affairs

Although very similar to TRICARE Standard in terms of benefits, it's important to note that Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a separate program, distinctly different from TRICARE Standard.

CHAMPVA is the Department of Veterans Affairs' (VA) version of TRICARE Standard, in which VA shares with eligible VA beneficiaries the cost of covered health care services and supplies. Administration of CHAMPVA, including the determination of eligibility, the authorization of benefits, and the processing of claims, is the sole responsibility of the Veterans Affairs Health Administration Center in Denver, CO. For information, contact the following:

Veterans Affairs Health Administration Center
300 Jackson Street
P.O. Box 65023
Denver, CO 80206-5023

Toll-free phone: 1-800-733-8387

CHAMPVA For Life

The CHAMPVA began the program called CHAMPVA For Life, on October 1, 2001. This benefit is designed for spouses or dependents who are 65 or over. They must be family members of veterans who have a permanent and total service-connected disability, who died of a service-connected condition, or who were totally disabled from a service-connected condition at the time of death. They also must have Medicare coverage.

CHAMPVA will pay benefits for covered medical services to eligible beneficiaries who are 65 or older and enrolled in Medicare Parts A and B. The CHAMPVA For Life benefit is payable after payment by Medicare or other third-party payers. For services not covered by Medicare or other insurance, such as outpatient prescription medications, CHAMPVA will be the primary payer.

CHAMPVA beneficiaries who reached age 65 as of June 5, 2001, but were not enrolled in Medicare Part B on that date, will be eligible for this expanded benefit even though not enrolled in Medicare Part B. There is no change in CHAMPVA coverage for those beneficiaries 65 and over who do not qualify for Medicare.

Your can find more information about the new benefit under CHAMPVA by contacting the VA Health Administration Center (HAC), P.O. Box 469028, Denver, Colorado 80246-9028. Veterans and family members can also call toll-free, 1-888-289-2411, to obtain the latest recorded information, leave a change of address, or request information to be mailed to them. This phone line is available 24 hours a day. Inquiries may also be e-mailed to *hac.inq@med.va.gov*.

Updates about CHAMPVA For Life and other benefits information will be posted to VA's HAC web site at *www.va.gov/hac*.

Glossary

Accept TRICARE Standard Assignment
See "Participate in TRICARE."

Allowable Charge
The amount on which TRICARE Standard figures your cost-share for covered care. TRICARE Standard computes the allowable charge using a method called the "resource-based relative value system" (RBRVS). The claims processor can tell a provider the allowable charge amount for specific services or procedures. Also known as the "CHAMPUS Maximum Allowable Charge" (CMAC).

Authorized Provider
A doctor or other individual authorized provider of care, hospital or supplier who is licensed by the state, accredited by a national organization, or meets other standards of the medical community, and is specifically listed as being authorized to provide benefits under TRICARE. Regional TRICARE contractors must verify (certify) a provider's authorized status before they can pay for services received from that provider. If a provider isn't authorized, TRICARE can't help pay the bills. (See the "Where to Get Care" chapter for other providers.)

Balance Billing

This is when a provider bills you for the rest of his or her charges (the "balance" of the charges), after your civilian health insurance plan or TRICARE has paid everything it's going to pay. Federal law says you aren't legally responsible for amounts in excess of 15 percent above the TRICARE allowable charge.

Beneficiary Counseling and Assistance Coordinator

Beneficiary Counseling and Assistance Coordinator (BCACs) are persons at military hospitals or clinics, at TRICARE Service Centers, or at military Lead Agents' offices, who are there to answer questions, help solve your health-care-related problems, and help you get the medical care you need through the military and through TRICARE. Contact a BCAC whenever you have questions on obtaining medical care. But remember—while BCACs can give valuable advice and assistance, they can't guarantee coverage under TRICARE. Your TRICARE contractor must review each claim and make payment determinations in accordance with uniformed service eligibility rules and TRICARE regulations. BCACs were previously known as Health Benefits Advisers (HBA).

Beneficiary Services Representative (BSR)

A person who works at your TRICARE Service Center, who can provide information about using the three TRICARE options, and help with other matters affecting your access to health care, including appointment scheduling is a Beneficiary Services Representative (BSR). This term is used interchangeably with BCAC.

BRAC Site

A military base that has been closed or targeted for closure by the Government's Base Realignment and Closure Commission (BRAC).

Capitation

A fixed amount of money that a managed-care plan gives to a doctor or hospital to care for a patient, no matter what the patient's care actually costs.

Case Management

A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual's health care needs using resources available to provide quality and cost-effective outcomes. Case management is not restricted to catastrophic illnesses and injuries.

Catastrophic Cap

A cost "cap" or upper limit has been placed on TRICARE Standard-covered medical bills in any fiscal year. The limit that an active duty family will have to pay is $1,000; the limit for all other TRICARE Standard-eligible families is $3,000. (See the beginning of the "How Much Will It Cost?" chapter, page 113, for more details about this cap on your medical expenses and for the limitations that applies.)

Catchment Area

Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of five-digit ZIP codes, usually within an approximate 40 mile radius of an inpatient military treatment facility (MTF). Beneficiaries not enrolled in TRICARE Prime residing in these areas are required to receive all inpatient care from the MTF or obtain a Nonavailability Statement (NAS, see definition) that authorizes civilian inpatient care for a particular inpatient service.

Claims Processor

That's the contractor that handles the TRICARE claims for care received within a particular state or region. Claims processing contractors have toll-free phone numbers, so you can reach them easily if you have questions.

Copayment

This is a fixed amount you'll pay when you're enrolled in TRICARE Prime and you visit the doctor for some type of medical care (the family members don't have to make co-payments for their care).

Cost Share

That's the percentage you pay—and the part TRICARE Standard pays—of the allowable charges for care on each claim. Your cost share depends on your sponsor's status (active or retired) in the service.

Deductible

That's the amount you must pay on your bills each year toward your outpatient medical care, before TRICARE begins sharing the cost of medical care. That is, you pay your provider(s) the first $150 for an individual, or $300 for a family, worth of medical bills each fiscal year—from October 1 through September 30 (for the families of active duty members in pay grade E-4 and below, the deductible amounts are $50 for an individual and $100 for a family). The contractor keeps track of your deductible and subtracts it from your claims during the year. How much you've paid toward your deductible is spelled out on the Explanation of Benefits (EOB). The deductible is separate from, and in addition to, your cost share.

DEERS

The Defense Enrollment Eligibility Reporting System (DEERS) is the computerized data bank that lists all active and retired military members and should also include their family members. Active duty and retired service members are listed automatically, but they must take action to list their dependents and report any changes to family members' status (marriage, divorce, birth of a child, adoption, etc.), and any changes to mailing addresses. TRICARE contractors check DEERS before processing claims to make sure patients are eligible for TRICARE benefits.

Diagnosis-Related Groups

Diagnosis-related groups (DRGs) are a way of paying civilian hospitals for inpatient care under TRICARE Standard. They're effective in 49 states, the District of Columbia, and Puerto Rico. Only Maryland is exempt from the Federal DRG payment system. Under DRGs, TRICARE Standard pays most hospitals a fixed rate for inpatient services, regardless of how much the care actually costs. The goal is to cut health care costs for both military families and the Government.

Durable Medical Equipment

Equipment for which the allowable charge is over $100 and which:

1. Is medically necessary for the treatment of a covered illness or injury;
2. Improves the function of a malformed, diseased, or injured body part, or retards further deterioration of a patient's physical condition;
3. Is used primarily and customarily to serve a medical purpose rather than primarily for transportation, comfort, or convenience;
4. Can withstand repeated use;
5. Provides the medically appropriate level of performance and quality for the medical condition present (that is, non-luxury and non-deluxe);
6. Is other than spectacles, eyeglasses, contact lenses, or other optical devices, hearing aids, or other communication devices; and
7. Is other than exercise equipment, spas, whirlpools, hot tubs, swimming pools, or other such items.

Explanation of Benefits

A statement the TRICARE contractor sends you and the provider who participates in TRICARE Standard that shows who provided the care, the kind of covered service or supply received, the allowable charge and amount billed, the amount TRICARE Standard paid, how much of your deductible has been paid, and your cost share is called the Explanation of Benefits (EOB). It also gives the reason for denying a claim. Sometimes also called the TRICARE Explanation of Benefits (TEOB).

Extra

See “TRICARE Extra.”

Family Therapy

A form of psychotherapy directed toward the family as a unit, instead of a single individual. It is based on the assumption that mental or emotional illness and the functional impairment of the identified patient is related to family interactions, and therefore, the family as a unit should be treated.

Fiscal Intermediary

Fiscal Intermediary (FI), see "Claims Processor."

Fraud (and Abuse)

Fraud occurs when a person or organization deliberately deceives others to gain some sort of unauthorized benefit. TRICARE fraud generally involves billing for services that weren't provided, or billing for a service at a higher rate than is actually justified. Health care abuse occurs when providers supply services or products that are medically necessary or that don't meet professional standards.

Health Benefits Adviser

Persons at military hospitals or clinics who are there to help you get access to the medical care you need through the military and through TRICARE are called Health Benefits Advisers (HBAs). Contact an HBA when you have any questions on obtaining medical care or using your TRICARE benefit. But remember—while HBAs can give valuable advice and assistance, they can't guarantee coverage under TRICARE. Your TRICARE contractor must review each claim and make payment determinations in accordance with uniformed services eligibility rules and the TRICARE Standard regulation. The term HBA is being changed, and they are now called Beneficiary Counseling and Assistance Coordinator (BCAC). The term also includes Health Benefits Counselor.

Health Care Finder

Health Care Finders (HCFs) are health care professionals, generally registered nurses, who help you find needed care. If you're enrolled in TRICARE Prime, they work with your Primary Care Manager (PCM) to locate the specialty care you may require. They can also help with referrals, appointments, nonavailability statements, and interpretation of benefits HCFs are located at TRICARE Service Centers.

Health Maintenance Organization

A Health Maintenance Organization (HMO) is a health plan to which you pay a fixed premium (and often, small user fees) for an assortment of medical services, usually including primary and preventive care. The HMO employs physicians, therapists, etc., to serve your medical needs.

Lead Agent

The designated major military medical hospital or center that acts as a TRICARE region's lead agent, having tri-service responsibility for the development and execution of a single, integrated health care network.

Managed Care

A concept under which an organization (like an HMO) delivers health care to enrolled members and controls costs by closely supervising and reviewing the delivery of care.

Medical Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in the following:

- Serious jeopardy to health of the individual, or in the case of a pregnant woman, the health of the woman and the unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any body organ or part.

Medically (or Psychologically) Necessary

Medical (or psychological) services or supplies that are considered appropriate care and are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, mental disorders, or well-child care.

Military Treatment Facility

We use Military Treatment Facility (MTF) as shorthand for all uniformed services hospitals and clinics including the several former Public Health Service hospitals that are now called "designated providers" under TRICARE.

MTF Catchment Area

See "Catchment Area."

Naturopath

A person who practices naturopathy, that is, a drugless system of therapy making use of physical forces such as air, light, water, heat, and massage.

Network Provider

Care provided by the network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. Thus a "network provider" is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor.

Nonavailability Statement

A certification from the uniformed service hospital that says it can't provide the care you need is a Nonavailability Statement (NAS). If you live in certain ZIP codes around a military hospital, you must get a NAS before getting non-emergency inpatient care at a civilian hospital under TRICARE Standard. Don't forget—TRICARE does not determine eligibility, nor does it issue nonavailability statements. The statements must be entered electronically in the Defense Department's DEERS computer files by your nearby MTF. (See the "Nonavailability Statements" section on page 105 of the "Where to Get Care" chapter for the exceptions to this rule.)

The NAS is being phased out gradually at MTFs and will be eliminated the earlier of 28 December 2003, or with the implementation of new contracts.

Non-Network Provider

Any care not provided by "network providers" (see definition of "Network Provider"), except care provided to a TRICARE Prime enrollee by a "non-network provider" upon referral from the contractor. A "non-network provider" is one who has no contractual relationship with the prime contractor to provide care to TRICARE beneficiaries. A "non-network claim" is one submitted for "non-network care."

Nonparticipating Provider

A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a TRICARE beneficiary, but who did not agree on the TRICARE claim form to participate or to accept the TRICARE-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider.

North Atlantic Treaty Organization Member

A military member of an armed force of a foreign North Atlantic Treaty Organization (NATO) nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Czech Republic, Denmark, France, Federal Republic of Germany, Greece, Hungary, Iceland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Spain, Turkey, and the United Kingdom.

Other Health Insurance

If you have other health care coverage—besides TRICARE Standard or TRICARE Extra or TRICARE Prime—for yourself and your family through an employer, an association or a private insurer; or if a student in the family has a healthcare plan obtained through his or her school—that's what TRICARE considers "other health insurance" (OHI). It may also be called "double coverage" or "coordination of benefits." It doesn't include TRICARE supplemental insurance. It also does not include Medicaid. (See "TRICARE Supplemental Insurance" later in this glossary.)

Participate in TRICARE

Health care providers who "participate" in TRICARE, also called "accepting assignment," agree to accept the TRICARE allowable charge (including your cost share and deductible, if any) as the full fee for your care. Individual providers can participate on a case-by-case basis. They file the claim for you and receive the check, if any, from TRICARE. Hospitals that participate in Medicare must, by law, also participate in TRICARE Standard for inpatient care. For outpatient care, hospitals may or may not participate.

Participating Provider

See "Participate in TRICARE."

Point-of-Service

If you're enrolled in TRICARE Prime, you may choose to get care—***without*** *a referral from your Primary Care Manager*—from a provider who's either inside or outside the TRICARE Prime provider network. If you do this, you'll be getting care under the "point-of-service" option, which has higher costs than TRICARE Prime. For more details about point-of-service, see the first chapter of this book, titled "A Look at TRICARE," beginning on page 1. Point-of-service doesn't apply to TRICARE Standard or TRICARE Extra.

Preferred Provider Organization
A network of health care providers who provide services to patients at discounted rates or cost shares is a Preferred Provider Organization (PPO).

Prime
See "TRICARE Prime."

Program for Persons with Disabilities
The Program for Persons with Disabilities (PFPWD) provides financial assistance to reduce the effects of mental retardation or a serious physical disability. It is not a stand-alone program; subject to certain restrictions, it may be used concurrently with other TRICARE medical programs. The PFPWD is not an enrollment program.

Provider
A doctor, hospital, or other person or place that delivers medical services or supplies.

Region
A geographic area determined by the Government for civilian contracting of medical care and other services for TRICARE/CHAMPUS-eligible beneficiaries.

Split Enrollment
Refers to multiple family members enrolled in TRICARE Prime under different Lead Agents/contractors, including Managed Care Support Contractors (MCSCs) and Uniformed Services Family Health Plan (USFHP) designated providers.

Sponsor
The unformed service person—either active duty, retired, or deceased—whose relationship to you (spouse, parent, etc.) makes you eligible for TRICARE.

Supplemental Insurance
Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike OHHI plans that are considered primary payers, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

TRICARE

The Department of Defense's (DoD's) managed health care program for active duty service members, service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions below).

TRICARE Extra

This is the second of the three health care options under DoD's TRICARE managed health care program. You don't have to enroll in TRICARE Extra; you may use it on a case-by-case basis. You simply see a provider who's part of the TRICARE Extra network established by the local TRICARE contractor, and pay reduced cost shares for your care. (See the "TRICARE Extra" section on page 5 for more details about TRICARE Extra.)

TRICARE Prime

TRICARE Prime is the HMO-type option, under which you enroll for a year at a time, and agree to seek health care from the network of health care providers and institutions set up by the TRICARE contractor for the region in which you live. (See the "TRICARE Prime" section on page 1 for more details about TRICARE Prime, such as how this option works and how much it costs.)

TRICARE Standard

A health care option provided as part of the TRICARE program where eligible beneficiaries may choose to receive care in facilities of the uniformed services, or from any TRICARE-authorized providers (with standard cost sharing).

TRICARE Supplemental Insurance

These are health benefit plans that are specifically designed to supplement TRICARE Prime, TRICARE Extra, or TRICARE Standard benefits. They generally pay most or all of whatever's left after TRICARE has paid its share of the cost of covered health care services and supplies. These plans are frequently available from military associations and other private or ganizations and firms. Such policies aren't necessarily just for retirees, but may be useful for other TRICARE-eligible families as well.

Uniformed Services

The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the United States Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

Urgent Care

Urgent care is medically necessary treatment that is required for illness or injury that would not result in further disabilityor death if not treated immediately. The illness or injury does require professional attention, and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.

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Notes

TRICARE Management Activity
Falls Church, VA 22041-3206

September 2002

TRICARE Web Site	***www.tricare.osd.mil***
TRICARE Questions	***questions@tma.osd.mil***
TRICARE Questions	**1-888-363-2273**
Hearing- or Speech-Impaired	**1-877-535-6778 (TTY/TDD)**
National Mail Order Pharmacy	**1-800-903-4680**
DEERS	**1-800-538-9552**