STANDARD

TRICARE®
Standard Handbook

Your guide to program benefits

TRICARE®

Important Information

TRICARE Web Site: **www.tricare.mil**

TRICARE North Region

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

TRICARE North Region Contractor

Health Net Federal Services, LLC

www.hnfs.com

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

TRICARE South Region

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

TRICARE South Region Contractor

Humana Military, a division of
Humana Government Business

Humana-Military.com

1-800-444-5445

TRICARE West Region

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

TRICARE West Region Contractor

UnitedHealthcare Military & Veterans

www.uhcmilitarywest.com

1-877-988-WEST (1-877-988-9378)

TRICARE Overseas Program*

TRICARE Overseas Program Contractor

International SOS Assistance, Inc.

www.tricare-overseas.com

TRICARE Eurasia-Africa: 1-877-678-1207

TRICARE Latin America and Canada: 1-877-451-8659

TRICARE Pacific: 1-877-678-1208 (*Singapore*)
1-877-678-1209 (*Sydney*)

* *For overseas contact information, visit* ***www.tricare-overseas.com****.*

An Important Note About TRICARE Program Changes

At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact your regional contractor. More information regarding TRICARE, including the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, can be found online at **www.tricare.mil**. See the inside back cover of this handbook for "TRICARE Expectations for Beneficiaries."

Keep Your DEERS Information Up To Date!

It is essential to keep information in the Defense Enrollment Eligibility Reporting System (DEERS) current for you and your family. Failure to update DEERS to accurately reflect the sponsor's or family member's residential address and/or the ineligibility of a former dependent could be considered fraud and a basis for administrative, disciplinary, and/or other appropriate action.

TRICARE Meets the Minimum Essential Coverage Requirement Under the Affordable Care Act

The Affordable Care Act, also known as the health care reform law, requires that individuals maintain health insurance or other health coverage that meets the definition of "minimum essential coverage" beginning in 2014. Please note that the TRICARE program is considered minimum essential coverage. Most people who do not meet this provision of the law will be required to pay a fee for each month they do not have adequate coverage. The fees will be collected each year with tax returns. Watch for future communications from TRICARE or visit **www.tricare.mil/aca** for more information about your minimum essential coverage requirement. You can also find other health care coverage options at **www.healthcare.gov**.

Important Contact Information

Use this page as a guide for the most important resources available to you.

TRICARE Web site: **www.tricare.mil**

TRICARE Regional Contractors		
TRICARE North Region	**TRICARE South Region**	**TRICARE West Region**
Health Net Federal Services, LLC 1-877-TRICARE (1-877-874-2273) www.hnfs.com	**Humana Military, a division of Humana Government Business** 1-800-444-5445 Humana-Military.com	**UnitedHealthcare Military & Veterans** 1-877-988-WEST (1-877-988-9378) www.uhcmilitarywest.com
TRICARE Overseas Program[1]		
International SOS Assistance, Inc. TRICARE Eurasia-Africa: 1-877-678-1207 TRICARE Latin America and Canada: 1-877-451-8659 TRICARE Pacific: 1-877-678-1208 (*Singapore*) 1-877-678-1209 (*Sydney*) TRICARE Overseas Program Web site: www.tricare-overseas.com		

*1. For overseas contact information, visit **www.tricare-overseas.com**.*

Premium-Based TRICARE Standard Health Plans

TRICARE Reserve Select	www.tricare.mil/trs
TRICARE Retired Reserve	www.tricare.mil/trr
TRICARE Young Adult Standard	www.tricare.mil/tya

Defense Enrollment Eligibility Reporting System (DEERS)

You have several options for updating and verifying DEERS information:

In Person	Phone
Visit a local uniformed services identification card-issuing facility. Find a facility near you at **www.dmdc.osd.mil/rsl**. Call to verify location and business hours.	1-800-538-9552 1-866-363-2883 (*TDD/TTY*)
Online	**Fax**
Update DEERS information using the milConnect Web site at **http://milconnect.dmdc.mil**. Visit **www.tricare.mil/bwe** to access the Beneficiary Web Enrollment Web site.	1-831-655-8317
	Mail
	Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771

TRICARE Dental Options

Visit **www.tricare.mil/dental** for information on all of TRICARE's dental program options.

Active Duty Dental Program	TRICARE Dental Program	TRICARE Retiree Dental Program
United Concordia Companies, Inc. www.addp-ucci.com	**MetLife** www.metlife.com/tricare	**Delta Dental** www.trdp.org

Health Care Claims

You can download forms and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from your regional contractor's Web site. Submit claims to the addresses provided. You can also check the status of your claims at the Web sites provided. For information about filing claims for care received overseas, visit **www.tricare.mil/claims**.

TRICARE North Region	TRICARE South Region	TRICARE West Region
Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 www.myTRICARE.com www.hnfs.com	TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 www.myTRICARE.com Humana-Military.com	TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 www.uhcmilitarywest.com

TRICARE Pharmacy Program

Register for TRICARE Pharmacy Home Delivery, find a TRICARE retail network pharmacy, or find information on how to save money and make the most of your pharmacy benefit.

Express Scripts, Inc.		
www.express-scripts.com/TRICARE 1-877-363-1303 1-877-540-6261 (*TDD/TTY*) Member Choice Center (*convert retail prescriptions to home delivery*): 1-877-363-1433	**TRICARE Pharmacy Home Delivery** Download the *Express Scripts New Patient Home Delivery Form* from **www.express-scripts.com/TRICARE** to register for TRICARE Pharmacy Home Delivery. Mail the form to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954	**TRICARE Retail Network Pharmacy** Send pharmacy claims to: Express Scripts, Inc. TRICARE Claims P.O. Box 52132 Phoenix, AZ 85082
Prescription Drug Formulary Search		
www.tricare.mil/pharmacyformulary		

Other Resources

TRICARE Forms	www.tricare.mil/forms
TRICARE Behavioral Health	www.tricare.mil/mentalhealth
Continued Health Care Benefit Program	www.tricare.mil/chcbp
Customer Service Community Directory	www.tricare.mil/bcacdcao

Welcome to TRICARE Standard® and TRICARE Extra

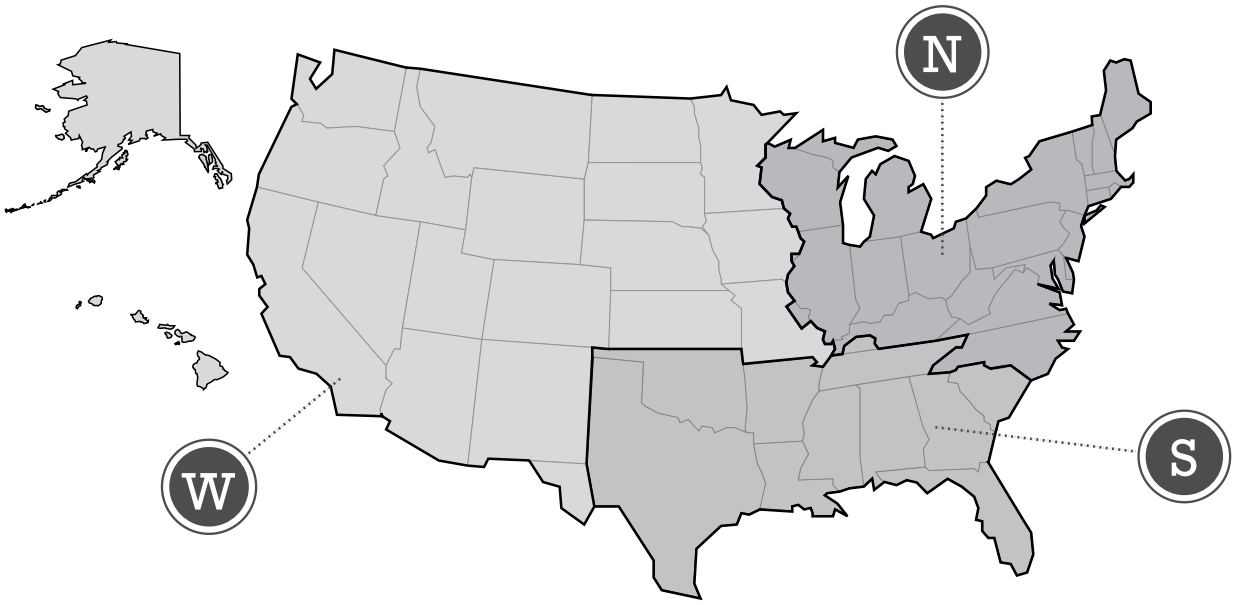
TRICARE Standard and TRICARE Extra (*where offered, based on network availability*) are available to TRICARE-eligible beneficiaries who are not able to or choose not to enroll in a TRICARE Prime option. Unlike TRICARE Prime options, enrollment is not required, meaning there are no forms to fill out and no annual enrollment fees to pay. With TRICARE Standard and TRICARE Extra, you manage your own health care and have the freedom to seek care from any TRICARE-authorized provider you choose.

Premium-based health plans are also available for purchase by qualified individuals. These plans include TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult Standard. They offer TRICARE Standard and TRICARE Extra coverage with the same cost-shares and covered services. Individuals must qualify and apply to purchase coverage. For more information on these options, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook or visit **www.tricare.mil**.

TRICARE Overseas Program Standard is different from and should not be confused with TRICARE Standard and TRICARE Extra in the United States.

Your TRICARE Resources

www.tricare.mil	Visit the TRICARE Web site for further information on any of the topics covered in this handbook.
www.tricare.mil/smart	The SMART site is your best resource for TRICARE materials online. View, print, or download TRICARE briefings, fact sheets, handbooks, and other materials.
www.tricare.mil/subscriptions	Sign up online to receive TRICARE news and publications via e-mail.
http://milconnect.dmdc.mil	Sign up online to receive benefits correspondence via e-mail instead of postal mail.



Your TRICARE Regional Contractor

Regional contractors administer the TRICARE medical benefit in each TRICARE region (*North, South, and West*). Health Net Federal Services administers the benefit in the North Region, Humana Military administers the benefit in the South Region, and UnitedHealthcare Military & Veterans administers the benefit in the West Region. This handbook refers regularly to your regional contractor. TRICARE encourages you to visit your regional contractor's Web site, which includes information on how to access care using TRICARE Standard and TRICARE Extra. If you need assistance, you can call your regional contractor at the appropriate toll-free number listed in the *Important Contact Information* section of this handbook. You may also seek assistance from Beneficiary Counseling and Assistance Coordinators (BCACs), who are located at military hospitals and clinics and at the TRICARE Regional Offices. To find a BCAC near you, visit the Customer Service Community Directory at **www.tricare.mil/bcacdcao**.

Important Note for National Guard and Reserve Members and Their Families

National Guard and Reserve members called or ordered to active service for more than 30 consecutive days become eligible for TRICARE as active duty service members, and their family members become eligible for TRICARE as active duty family members. Activated National Guard and Reserve members must enroll in TRICARE Prime or TRICARE Prime Remote.

Family members may choose TRICARE Prime, TRICARE Prime Remote for Active Duty Family Members, or TRICARE Standard and TRICARE Extra, depending on the programs available at their location. If you have any questions about any of these programs, contact your regional contractor. Your service personnel office determines eligibility for pre-activation benefits. Contact your unit personnel office regarding your eligibility. Your activation orders should contain your unit personnel office address and contact information.

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Choosing TRICARE Standard and TRICARE Extra

Eligibility for TRICARE Standard and TRICARE Extra

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

- Active duty family members (ADFMs)
- Family members of National Guard and Reserve members who are called or ordered to active service for more than 30 consecutive days
- Retired service members
- Family members of retired service members
- Survivors
- ADFMs, retired service members, and family members of retired service members who have Medicare Part B, but are not yet eligible for Part A
- Others (*e.g., certain former spouses, Medal of Honor recipients*)

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

- Active duty service members (ADSMs)
- Activated National Guard and Reserve members
- Any beneficiary enrolled in a TRICARE Prime option (*You must disenroll before using TRICARE Standard and TRICARE Extra.*)
- Retired service members and family members of retired service members who are entitled to Medicare Part A and Part B, or are entitled to Part A only
- Dependent parents and parents-in-law

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

Note: During the early-eligibility period, National Guard and Reserve members may be eligible for TRICARE, but should wait until reaching their final duty location and follow command guidance when enrolling in TRICARE Prime or TPR. In the case of early eligibility, the effective date is the later of either (1) the date of issuance of the delayed-effective-date active duty order or (2) 180 days before the date on which the period of active duty is to begin. Until then, you should coordinate care with your unit. If eligible, your family members may enroll in TRICARE Prime or TRICARE Prime Remote for Active Duty Family Members during the early-eligibility period.

For more information about these beneficiary categories, visit **www.tricare.mil/eligibility**.

Qualifying for TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult

TRICARE Reserve Select is available for purchase by qualified members of the Selected Reserve of the Ready Reserve, their family members, and qualified survivors. TRICARE Retired Reserve is available for purchase by qualified members of the Retired Reserve, their family members, and qualified survivors. TRICARE Young Adult is available for purchase by qualified dependents until reaching age 26. Qualification and enrollment in these programs varies from eligibility for TRICARE Standard and TRICARE Extra. For more information about these programs, including qualification information and instructions on how to purchase coverage, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook, or visit **www.tricare.mil**.

Plan Overview

You may use TRICARE Standard and TRICARE Extra interchangeably as often as you like, but it is important to understand the differences between the two.

The key difference between TRICARE Standard and TRICARE Extra is in the providers that you use for care. With TRICARE Standard, you choose TRICARE-authorized non-network hospitals and providers and pay higher cost-shares. With TRICARE Extra, you choose TRICARE network hospitals and providers and pay discounted cost-shares. Expenses for care received under either TRICARE Standard or TRICARE Extra count toward the deductible and catastrophic cap.

The following figure provides a quick comparison of the two options. Specific provider types will be discussed later in this handbook. For cost details, visit **www.tricare.mil/costs**.

Comparison of TRICARE Standard and TRICARE Extra

	TRICARE Standard	TRICARE Extra
Provider type	TRICARE-authorized, non-network[1]	TRICARE-authorized, network
Outpatient cost-share after deductible is met	• **Active duty family members (ADFMs) and TRICARE Reserve Select (TRS):** 20% of the TRICARE-allowable charge	• **ADFMs and TRS:** 15% of the negotiated rate
	• **Retirees, their families, TRICARE Retired Reserve (TRR), and all others:** 25% of the TRICARE-allowable charge	• **Retirees, their families, TRR, and all others:** 20% of the negotiated rate

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

Getting Started

Finding a Provider

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

TRICARE Provider Types

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

Military Hospitals and Clinics

Military hospitals and clinics provide medical and/or dental care to eligible individuals including members of the uniformed services and their eligible family members. Military hospitals and clinics are usually located on or near military installations. To locate a military hospital or clinic near you, visit **www.tricare.mil/mtf**.

TRICARE Provider Types

<table>
<tr><th colspan="3">TRICARE-Authorized Providers</th></tr>
<tr><td colspan="3">• TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers (e.g., laboratories, radiology centers), and pharmacies that meet TRICARE requirements. If you see a provider that is not TRICARE-authorized, you are responsible for the full cost of care. To find a list of TRICARE-authorized providers, visit www.tricare.mil/findaprovider.
• There are two types of TRICARE-authorized providers: network and non-network.</td></tr>
<tr><th>Network Providers</th><th colspan="2">Non-Network Providers</th></tr>
<tr><td rowspan="2">• Regional contractors have established networks.
• TRICARE network providers:
  • Have a signed agreement with your regional contractor to provide care
  • Agree to file claims for you</td><td colspan="2">• Non-network providers do not have a signed agreement with your regional contractor and are considered “out of network.”
• There are two types of non-network providers: participating and nonparticipating.</td></tr>
<tr><td>Participating</td><td>Nonparticipating</td></tr>
<tr><td>• Using a participating provider is your best option if you are seeing a non-network provider.
• Participating providers:
  • May choose to participate on a claim-by-claim basis
  • Have agreed to accept payment directly from TRICARE and accept the TRICARE-allowable charge (less any applicable patient costs paid by you) as payment in full for their services</td><td>• If you visit a nonparticipating provider, you may have to pay the provider first and later file a claim with TRICARE for reimbursement.
• Nonparticipating providers:
  • Have not agreed to accept the TRICARE-allowable charge or file your claims
  • Have the legal right to charge you up to 15 percent above the TRICARE-allowable charge for services (You are responsible for paying this amount in addition to any applicable patient costs.)[1]</td></tr>
</table>

*1. Overseas, there may be no limit to the amount that nonparticipating non-network providers may bill, and you may be responsible for paying any amount that exceeds the TRICARE-allowable charge. Visit **www.tricare.mil/overseas** for more information.*

U.S. Department of Veterans Affairs Health Care Facilities

All U.S. Department of Veterans Affairs (VA) health care facilities have signed agreements with the regional contractors to become TRICARE network providers, agree to accept a negotiated rate as the full fee for services, file claims, and handle paperwork for you. While VA facilities may or may not provide primary care, many provide specialty care. If you need care and a participating VA health care facility near you can provide that care (*within TRICARE access standards*), you may be asked to use that VA facility.

Each VA facility has established a TRICARE beneficiary point of contact and check-in process. It is important to indicate, prior to receiving care, that you are using your TRICARE benefit. Failure to do so could result in higher out-of-pocket expenses and/or denial of payment for services rendered.

Note: VA providers cannot bill Medicare and Medicare cannot pay for services received from VA. If you are eligible for both TRICARE For Life (TFL) and VA benefits and elect to use your TFL benefit for non-service connected care, you will incur out-of-pocket expenses when seeing a VA provider. By law, TRICARE can only pay up to 20 percent of the TRICARE-allowable amount. If you receive care at a VA facility, you may be responsible for the remaining liability. When using your TFL benefit, your least expensive option is to see a Medicare or TRICARE provider that is not a VA provider.

Social Security Number Reduction

The Department of Defense (DoD) is removing Social Security numbers (SSNs) from uniformed services identification (ID) cards, including the Common Access Card (CAC), as part of the continued effort to protect the privacy and security of TRICARE's beneficiaries. SSNs are being replaced with 10-digit DoD ID numbers. If you have DoD benefits, (*e.g., health care, commissary, exchange privileges*), an 11-digit DoD Benefits Number (DBN) is also printed on the card. The DBN is a unique number that ensures your records are clearly aligned with your treatments. The DBN is located above the bar code on the back of your uniformed services ID card or CAC.

When submitting health, pharmacy, and dental claims, be sure to include either the sponsor's SSN or the DBN listed on the back of the ID card (*eligible former spouses should use their own SSN or DBN, not the sponsor's*). The DoD ID number that appears on the front of the ID card should not be used when filing claims.

The replacement process is expected to last several years until all current uniformed services ID cards are replaced as they come up for renewal.

You do not need to make a special trip to have your uniformed services ID card updated until 30 days prior to expiration. Your health care providers and pharmacists will be able to access your benefits using either your SSN or your DBN. For more information, visit **www.tricare.mil/ssn**.

Note: A health care provider photocopying your ID card or CAC for authorized purposes is legal.

Getting Care

Emergency Care

TRICARE defines an emergency as a serious medical condition that the average person would consider to be a threat to life, limb, sight, or safety.

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

Note: Most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE. For information about dental coverage, see "Dental Options" in the *Covered Services* section of this handbook.

Urgent Care

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

All Other Care

For all other care, such as routine physicals, ongoing treatment for a chronic condition, visits to a specialist, or covered preventive care, schedule an appointment with a TRICARE network or TRICARE-authorized non-network provider. Some services may require prior authorization (*discussed later in this section*). Learn more about the differences among routine, urgent, emergency, and specialty care at **www.tricare.mil**.

Avoid Using the Emergency Room for Nonemergency Situations

In many cases, using the emergency room is unnecessary and can result in longer wait times and higher costs. You can often be treated more quickly by a military hospital or clinic, a family doctor, or an urgent care center. The "Definitions and Examples of Types of Care" chart on the following page provides information that can help you seek the most appropriate level of service.

Definitions and Examples of Types of Care

Type of Care	Definition	Examples
Emergency	TRICARE defines an emergency as a serious medical condition that the average person would consider to be a threat to life, limb, sight, or safety.	No pulse, severe bleeding, spinal cord or back injury, chest pain, broken bone, inability to breathe
Urgent	Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but does require professional attention within 24 hours.	Minor cuts, migraine headache, urinary tract infection, sprain, earache, rising fever
Routine	Routine (*primary*) care is general health care and includes office visits. Routine care also includes preventive care to help keep you healthy.	Treatment of symptoms, chronic or acute illnesses and diseases, follow-up care for an ongoing medical condition
Specialty Care	Specialty care consists of specialized medical services provided by a physician specialist.	Cardiology, dermatology, gastroenterology, obstetrics

Care at a Military Hospital or Clinic

Military hospitals and clinics provide medical and/or dental care to eligible individuals, including members of the uniformed services and their dependents and are usually located on or near military installations. You may receive care at a military hospital or clinic, but only on a space-available basis. Appointments are limited, and you will have the lowest priority for receiving care. See the following figure for appointment priorities at military hospitals and clinics.

Note: Access to military hospitals and clinics for TRICARE Young Adult beneficiaries is based on the program selected as well as the sponsor's status.

Military Hospital and Clinic Appointment Priorities

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

If you wish to receive care at a military hospital or clinic, first check to see if they can provide you with the care you need. Visit **www.tricare.mil/mtf** to locate a military hospital or clinic. Otherwise, seek care from a civilian TRICARE network or TRICARE-authorized non-network provider.

Note: If you are admitted to a military hospital or clinic and require any service not available within that facility (*e.g., ambulance, MRI, CT scan, specialist appointment*), those services will be covered by your TRICARE Standard benefit. The military hospital or clinic will not pay for these services.

Prior Authorization for Care

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

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

The following services require prior authorization:

- Adjunctive dental services
- Extended Care Health Option services
- Home health services
- Hospice care
- Nonemergency inpatient admissions for substance use disorders or behavioral health care
- Outpatient behavioral health care visits to an authorized provider beginning with the ninth visit per fiscal year (*October 1–September 30*) for a medically diagnosed and covered condition
- Transplants—all solid organ and stem cell

This list is **not** all-inclusive.

Each regional contractor has additional prior authorization requirements. Visit your regional contractor's Web site to learn about each region's requirements, which may change periodically. See the beginning of this handbook for your regional contractor's Web site and toll-free number.

Combat-Related Disability Travel Reimbursement

Medically retired service members who have a determination letter from their service's Combat-Related Special Compensation Board identifying a Department of Defense-determined disability or disabilities as combat-related may be reimbursed for reasonable travel expenses for medically necessary care. For more information, visit **www.defensetravel.dod.mil/site/perdiem.cfm**.

Covered Services

TRICARE Standard and TRICARE Extra cover most care that is medically necessary and considered proven. There are special rules and limitations for certain types of care, and some types of care are not covered at all. TRICARE policies are very specific about which services are covered and which are not. It is in your best interest to take an active role in verifying coverage.

This section is **not** all-inclusive. For more information on covered services, visit **www.tricare.mil/coveredservices**.

Behavioral Health Care Services

For detailed coverage information on outpatient behavioral health care services, inpatient behavioral health care services, and substance use disorder services, visit **www.tricare.mil/mentalhealth**. For additional information about covered and non-covered behavioral health care services and how to access care, contact your regional contractor. Additional limitations on behavioral health care services may apply overseas. Contact the TRICARE Overseas Program Regional Call Center for additional information.

Note: In the event of a behavioral health emergency, go immediately to the nearest emergency room or call 911.

Telemental Health Program

The Telemental Health program uses secure audio-visual conferencing to provide certain behavioral health care services to eligible beneficiaries, including TRICARE Standard and TRICARE Extra beneficiaries in the United States. Covered services provided through Telemental Health services have the same limitations and referral and authorization requirements as any other behavioral health care services. Visit **www.tricare.mil/mentalhealth** or contact your regional contractor for more information.

Inpatient Behavioral Health Care Services

Prior authorization from your regional contractor is required for all nonemergency inpatient behavioral health care services. Psychiatric emergencies do not require prior authorization for admission to an inpatient unit, but authorization is required for continued stay. Admissions resulting from psychiatric emergencies should be reported to your regional contractor within 24 hours of admission or on the next business day, and must be reported within 72 hours of an admission. Authorization for continued stay is coordinated between the inpatient unit and your regional contractor.

Substance Use Disorder Services

Substance use disorders include alcohol or drug abuse or dependence. Services are only covered by TRICARE-authorized institutional providers—an authorized hospital or an organized treatment program in an authorized freestanding or hospital-based substance use disorder rehabilitation facility. Treatment includes detoxification, rehabilitation in an inpatient or partial hospitalization program setting, and outpatient individual, group, and family therapy. TRICARE covers three substance use disorder treatment benefit periods in a lifetime and one per benefit period. A benefit period begins with the first date of the covered treatment and ends 365 days later.

Emergency and inpatient hospital services are considered medically necessary only when the patient's condition requires hospital personnel and facilities. Generally, these services may be medically necessary in certain detoxification circumstances or for stabilization of a medical condition. All treatment for substance use disorders (*except for emergency services that are medically necessary for the active medical treatment of substance abuse withdrawal*) requires prior authorization from your regional contractor.

Suicide Prevention

If you or a loved one has suicidal thoughts, call the National Suicide Prevention Lifeline at **1-800-273-TALK (1-800-273-8255)**. Visit **www.militaryonesource.mil** for resources and additional information.

TRICARE Smoking Cessation Program

TRICARE is dedicated to helping ADSMs, veterans, retirees, and their families succeed in the attempt to quit tobacco. Below are three ways to help you get the necessary assistance to break the cycle:

- TRICARE-covered smoking-cessation medications
- TRICARE's Smoking Quitline is a telephone support and referral service with trained smoking-cessation coaches.
- The Department of Defense's Web site, **www.ucanquit2.org**, provides education and a wide range of tools to help you become tobacco-free.

Visit **www.tricare.mil/quittobacco** for more information to help you quit.

Smoking-Cessation Medications

TRICARE covers prescription and over-the-counter medications to help you quit smoking. Covered smoking-cessation medications are available at no cost through TRICARE Pharmacy Home Delivery and military pharmacies. Smoking-cessation medications are not covered when purchased at retail pharmacies.

TRICARE Smoking Quitlines

TRICARE's Smoking Quitlines provide toll-free telephone support and referral triage services and are available 24 hours a day, seven days a week. Current smokers who want to quit or former smokers concerned about relapsing may call the Smoking Quitline in their region to speak with a trained smoking-cessation coach who will inform the smoker about the availability of resources to quit smoking or remain smoke-free.

Note: The Smoking Quitline is only available to TRICARE beneficiaries in the 50 United States and the District of Columbia who are not eligible for Medicare.

Regional TRICARE Smoking Quitline Contact Information

TRICARE North Region	Health Net Federal Services, LLC 1-866-459-8766
TRICARE South Region	Humana Military 1-877-414-9949
TRICARE West Region	UnitedHealthcare Military & Veterans 1-888-713-4597

Counseling Services

Smoking-cessation counseling is covered for all TRICARE beneficiaries age 18 and older who are not Medicare-eligible and who reside and receive counseling in one of the 50 United States or the District of Columbia.

Clinical Preventive Services

Comprehensive Health Promotion and Disease Prevention Examinations

Clinical Preventive Services: Coverage Details

Service	Description
Comprehensive Health Promotion and Disease Prevention Examinations	**Adult:** A comprehensive clinical preventive examination is covered if it includes an immunization, Pap test, mammogram, colon cancer screening, or prostate cancer screening. Beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without receiving an immunization, Pap test, mammogram, colon cancer screening, or prostate cancer screening (*one examination per age group*): 18–39 and 40–64. **Pediatric:** A comprehensive clinical preventive examination is covered if it includes an immunization. Beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without receiving an immunization (*one examination per age group*): 2–4, 5–11, 12–17. School enrollment physicals for children ages 5–11 are also covered.

Targeted Health Promotion and Disease Prevention Services

The screening examinations listed below may be covered if provided in conjunction with a comprehensive clinical preventive examination. The intent is to maximize preventive care.

Clinical Preventive Services: Coverage Details

Service	Definition

Cancer Screenings	• **Colonoscopy:**
	  • Average risk: Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50.
	  • Increased risk: Once every five years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second-degree relatives.
	  • High risk: Once every one to two years for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20–25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.
	• **Fecal occult blood testing:** Testing covered annually starting at age 50.
	• **Breast cancer:**
	  • **Clinical breast examination:** For women under age 40, a clinical breast examination may be performed during a preventive health visit. For women age 40 and older, a clinical breast examination should be performed annually.
	  • **Mammograms:** Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15 percent or greater lifetime risk of breast cancer (*according to risk assessment tools based on family history such as the Gail, Claus, and Tyrer-Cuzick models*), or who have any of the following risk factors:
	  • History of breast cancer, ductal carcinoma in situ, lobular carcinoma in situ, atypical ductal hyperplasia, or atypical lobular hyperplasia
	  • Extremely dense breasts when viewed by mammogram
	  • Known BRCA1 or BRCA2 gene mutation
	  • First-degree relative (*parent, child, sibling*) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves
	  • Radiation therapy to the chest between ages 10 and 30
	  • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes
	  • **Breast screening magnetic resonance imaging (MRI):** Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20 percent or greater lifetime risk of breast cancer (*according to risk assessment tools based on family history such as the Gail, Claus, and Tyrer-Cuzick models*), or who have any of the following risk factors:
	  • Known BRCA1 or BRCA2 gene mutation
	  • First-degree relative (*parent, child, sibling*) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves
	  • Radiation to the chest between ages 10 and 30
	  • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes

Clinical Preventive Services: Coverage Details (continued)

Service	Definition

Cancer Screenings (*continued*)	• **Proctosigmoidoscopy or sigmoidoscopy:**
	  • Average risk: Individuals at average risk for colon cancer are covered once every three to five years beginning at age 50.
	  • Increased risk: Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer.
	  • High risk: Annual flexible sigmoidoscopy, beginning at age 10–12, for individuals with known or suspected familial adenomatous polyposis.
	• **Prostate cancer:** A digital rectal examination and prostate-specific antigen screening is covered annually for certain high-risk men ages 40–49 and all men over age 50.
	• **Routine Pap tests:** Covered annually for women starting at age 18 (*younger if sexually active*) or less often at patient and provider discretion (*though not less than every three years*). Human papillomavirus (HPV) DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap test, and only for women age 30 and older.
	• **Skin cancer:** Examinations are covered at any age for individuals at high risk due to family history or increased sun exposure.

Cardiovascular Diseases	• **Cholesterol test (*non-fasting*):** Testing is covered for a lipid panel at least once every five years beginning at age 18. • **Blood pressure screening:** Screening is covered annually for children from age 3 until reaching age 6 and a minimum of every two years after reaching age 6 (*children and adults*).

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

Hearing	Preventive hearing examinations are only covered under the well-child care benefit (*birth until reaching age 6*). A newborn audiology screening should be performed on newborns before hospital discharge or within the first month after birth. Evaluative hearing tests may be performed at other ages during routine examinations.
Immunizations	Age-appropriate doses of vaccines, including annual influenza vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). The HPV vaccine is a limited benefit and may be covered when the beneficiary has not been previously vaccinated or completed the vaccine series. • Females: The HPV vaccine Gardasil (HPV4) or Cervarix (HPV2) is covered for females ages 11–26. The series of injections must be completed before reaching age 27 for coverage under TRICARE. • Males: The HPV vaccine Gardasil (HPV4) is covered for all males ages 11–21 and is covered for males ages 22–26 who meet certain criteria. A single dose of the shingles vaccine Zostavax® is covered for beneficiaries age 60 and older. **Note:** Immunizations for ADFMs whose sponsors have permanent change-of-station orders to overseas locations are also covered. Immunizations for personal overseas travel are not covered.

Clinical Preventive Services: Coverage Details (continued)

Service	Definition
Infectious Disease Screening	TRICARE covers screening for the following infectious diseases: hepatitis B, rubella antibodies, and HIV, and screening and/or prophylaxis for tetanus, rabies, hepatitis A and B, meningococcal meningitis, and tuberculosis.
Patient and Parent Education Counseling	Counseling services expected of good clinical practice that are included with the appropriate office visit are covered at no additional charge for dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; dental health promotion; accident and injury prevention; stress; bereavement; and suicide risk assessment.
School Physicals	Covered for children ages 5–11 if required in connection with school enrollment. **Note:** Annual sports physicals are not covered.
Well-Child Care (*birth until reaching age 6*)	Covers routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference measurement; routine immunizations; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with American Academy of Pediatrics (AAP) and CDC guidelines. Your child can receive preventive care well-child visits as frequently as the AAP recommends, but no more than nine visits in two years. Visits for diagnosis or treatment of an illness or injury are covered separately under outpatient care.

Dental Options

This section highlights your dental program options and costs when using the TRICARE Active Duty Dental Program, the TRICARE Dental Program, or the TRICARE Retiree Dental Program. These dental options are separate from TRICARE health care options. Each benefit is administered by a separate dental contractor and may have monthly premiums and cost-shares. Your out-of-pocket expenses for any of the costs listed in this section are not applied to the TRICARE catastrophic cap.

TRICARE Dental Program Options

Dental Program Option	Beneficiary Types	Description of Program Option
TRICARE Active Duty Dental Program (ADDP)	• Active duty service members (ADSMs) • National Guard and Reserve members active for a period of more than 30 consecutive days	• Benefit administered by United Concordia Companies, Inc. • For ADSMs who are either referred for care by a military dental clinic to a civilian dentist or have a duty location and live greater than 50 miles from a military dental clinic
TRICARE Dental Program (TDP)[1]	• Eligible active duty family members • Survivors • National Guard and Reserve members and their family members • Individual Ready Reserve members and their family members	• Benefit administered by MetLife • Voluntary enrollment and worldwide, portable coverage • Single and family plans with monthly premiums • Lower specialty care cost-shares for E-1 through E-4 pay grades • Comprehensive coverage for most dental services • 100% coverage for most preventive and diagnostic services

1. The TDP is divided into two geographical service areas: stateside and overseas. The TDP stateside service area includes the 50 United States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. The TDP overseas service area includes areas not in the stateside service area and covered services provided aboard a ship or vessel outside the territorial waters of the stateside service area, regardless of the dentist's office address.

TRICARE Dental Program Options (continued)

Dental Program Option	Beneficiary Types	Description of Program Option
TRICARE Retiree Dental Program (TRDP)	• Retirees and their eligible family members worldwide • National Guard and Reserve retirees until reaching age 60 (*when they may continue as retirees with retired pay*)	• Benefit administered by Delta Dental of California • Voluntary enrollment and worldwide, portable coverage • Single, dual, and family plans • Monthly premiums vary regionally by ZIP code; deductible and cost-shares apply • Comprehensive coverage for most dental services; visit any dentist within the TRDP service area • 100% coverage for most preventive and diagnostic services

Hospice Care

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

Note: Hospice care is only available in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

Maternity Care

Prenatal care is important, and TRICARE strongly recommends that those who are pregnant, or who anticipate becoming pregnant, seek appropriate medical care. TRICARE Standard and TRICARE Extra cover all necessary maternity care, from your first obstetric visit through six weeks after your child is born. TRICARE does not cover routine ultrasound screening. Only medically necessary maternity ultrasounds are covered by TRICARE. For detailed coverage information, visit **www.tricare.mil/maternitycare**.

TRICARE Extended Care Health Option

TRICARE Extended Care Health Option (ECHO) provides supplemental health and non-health care services to active duty family members who qualify based on specific mental or physical disabilities. ECHO offers beneficiaries integrated services and supplies beyond those offered by the TRICARE Basic Program.

Active duty sponsors with family members seeking ECHO registration must enroll in their service's Exceptional Family Member Program (EFMP) (*unless waived in specific situations*) and register for ECHO with their regional contractors to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Prior authorization must be obtained from the regional contractor for all ECHO services. For more information about EFMP, contact your service branch's EFMP representative or visit **www.militaryonesource.mil/efmp**.

Note: ECHO is not available for all of the TRICARE programs described in this handbook. Visit **www.tricare.mil/echo** for more information.

TRICARE Pharmacy Program

TRICARE offers comprehensive prescription drug coverage and several options for filling your prescriptions. To fill a prescription, you need a written prescription and a valid uniformed services identification (ID) card or Common Access Card. The TRICARE pharmacy benefit is administered by Express Scripts, Inc.

Note: In the Philippines, you must use a certified host nation pharmacy.

Military Pharmacies

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

TRICARE Pharmacy Home Delivery

TRICARE Pharmacy Home Delivery is your least expensive option when not using a military pharmacy. There is no cost for TRICARE Pharmacy Home Delivery for active duty service members. For all other beneficiaries, there is no cost to receive up to a 90-day supply of formulary generic medications. Copayments apply for brand-name and non-formulary medications (*up to a 90-day supply*). Home delivery is best suited for maintenance medications (*medications you take on a regular basis*), and some medications are not available for home delivery. Prescriptions are delivered to you with free standard shipping, and refills can be ordered easily online, by phone, or by mail.

Note: Beneficiaries residing in Germany cannot use the home delivery option due to country-specific legal restrictions.

TRICARE Pharmacy Home Delivery Registration Methods

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

TRICARE Retail Network Pharmacies

Another option for filling your prescriptions is through a TRICARE retail network pharmacy. You may fill prescriptions (*one copayment for each 30-day supply*) when you present your written prescription signed by your provider along with your uniformed services ID card to the pharmacist. This option allows you to fill your prescriptions at network pharmacies without having to submit a claim. You have access to a network of more than 56,000 retail pharmacies in the United States and the U.S. territories of Guam, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa or the Northern Mariana Islands. To find the nearest TRICARE retail network pharmacy, visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303**.

Non-Network Retail Pharmacies

At non-network retail pharmacies, you will pay full price for your medication and file a claim for reimbursement. Reimbursements are subject to deductibles, out-of-network cost-shares, and TRICARE-required copayments. All deductibles must be met before any reimbursement can be made.

Claims

Health Care Claims

If you use the TRICARE Extra option, your provider will submit claims on your behalf. If you use the TRICARE Standard option, you may be required to submit your own health care claims. Submit all claims, except claims for care received overseas, to the claims processor for the region where you live.

In the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), claims must be filed within one year of either the date of service or the date of inpatient discharge. Overseas, claims must be filed within three years of either the date of service or the date of inpatient discharge. You **must** submit proof of payment with all claims for care received overseas.

To file a claim, obtain and complete a *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request for Medical Payment* (DD Form 2642). You can download forms and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from your regional contractor's Web site.

Note for Medicare-eligible beneficiaries: Medicare-participating providers file your claims with Medicare. After paying its portion, Medicare automatically forwards the claim to TRICARE for processing (*unless you have other health insurance [OHI]*). TRICARE pays after Medicare and OHI for TRICARE-covered health care services. Medicare generally does not cover health care obtained outside of the United States and U.S. territories.

Stateside Regional Health Care Claims-Processing Information

TRICARE North Region	TRICARE South Region	TRICARE West Region
Send claims to: Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 Check the status of your claim at **www.myTRICARE.com** or **www.hnfs.com**	**Send claims to:** TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 Check the status of your claim at **www.myTRICARE.com** or **Humana-Military.com**	**Send claims to:** TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29020-7064 Check the status of your claim at **www.uhcmilitarywest.com**

TRICARE Overseas Program Claims-Processing Information

Active Duty Service Members (ADSMs) (*all overseas areas*)	TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968
Non-ADSMs, TRICARE Eurasia-Africa (*Africa, Europe, and the Middle East*)	TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976
Non-ADSMs, TRICARE Latin America and Canada (*Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands*)	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
Non-ADSMs, TRICARE Pacific (*Asia, Guam, India, Japan, Korea, new Zealand, and Western Pacific Remote countries*)	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985

Pharmacy Claims

To file a pharmacy claim:

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

   Express Scripts, Inc.
   TRICARE Claims
   P.O. Box 52132
   Phoenix, AZ 85082

Prescription claims require the following information for each drug:

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

If you have OHI with pharmacy benefits, see "Coordinating Benefits with Other Health Insurance" later in this section. Call Express Scripts, Inc. at **1-877-363-1303** with questions about filing pharmacy claims.

Proof-of-Payment Requirement Overseas

You **must** submit proof of payment with all claims for care received overseas. Proof of payment is necessary for TRICARE to validate claims and safeguard benefit dollars. Proof of payment may include a receipt, canceled check, credit card statement, or invoice from the provider that clearly states payment was received. If you paid for care or supplies in cash, TRICARE may ask for proof of cash withdrawal from your bank or credit union along with a receipt from your provider.

When submitting your *DD Form 2642*, you should also include an itemized bill or invoice, diagnosis describing why you received medical care, and an explanation of benefits from your OHI, if applicable.

Visit **www.tricare.mil/proofofpayment** for more information on proof-of-payment requirements overseas.

Coordinating Benefits with Other Health Insurance

TRICARE is the sole payer for active duty service members. For active duty family members, TRICARE is the last payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs and plans as identified by the Department of Defense.

If you have OHI, fill out the *TRICARE Other Health Insurance Questionnaire*, available at **www.tricare.mil/forms**, to keep your regional contractor informed about your OHI so they can coordinate your benefits and help ensure that your claims are not delayed or denied. Follow the OHI's rules for filing claims and file the claim with the OHI first. If there is an amount your OHI does not cover, you or your provider can file the claim with TRICARE for reimbursement. It is important to meet your OHI's requirements. If your OHI denies a claim for failure to follow its rules, such as obtaining care without authorization or using a non-network provider, TRICARE may also deny your claim.

Appealing a Claim or Authorization Denial

TRICARE has a multilevel appeals process to address claim and authorization denials. You may appeal the denial of a requested authorization of services, as well as TRICARE decisions regarding the payment of claims. The appeals process only applies to covered TRICARE health benefits. Submit appeals to your regional contractor. For more detailed information on the appeals process, visit **www.tricare.mil/claims** or contact your regional contractor.

Changes to Your TRICARE Coverage

TRICARE Standard and TRICARE Extra continue to provide health care coverage for you and your family as you experience major life events. However, you will need to take specific actions to make sure you remain eligible for TRICARE. With every life event listed in this section, the first step is to update your information in the Defense Enrollment Eligibility Reporting System (DEERS). You have several options for updating and verifying DEERS information. See the *Important Contact Information* section at the beginning of this handbook for details.

Note: TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and TRICARE Young Adult (TYA) each have program-specific rules regarding changes to your coverage. For more information on these options, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

The following provides information about what to do when you get married or divorced, have a child, move, retire, and more. For more information about how TRICARE coverage may change when you become Medicare-eligible, see **www.tricare.mil/medicare**.

Life Changes and TRICARE

Life Change	Eligibility
Marriage	Sponsors must register new spouses in the Defense Enrollment Eligibility Reporting System (DEERS) to ensure they are eligible for TRICARE. A spouse's TRICARE options will vary depending on the sponsor's status and location.
Divorce	Sponsors must update DEERS when there is a divorce. The sponsor will need to provide a copy of the divorce decree, dissolution, or annulment. Former spouses who are not eligible for TRICARE may not continue seeking health care services under the TRICARE benefit.
Children[1]	Any child who retains eligibility under the sponsor remains TRICARE-eligible until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support*), as long as his or her DEERS information is current. Your dependent child's TRICARE coverage ends if his or her DEERS record is not updated before reaching age 21. Dependent children who have aged out of TRICARE coverage, but have not yet reached age 26, may be eligible to purchase TRICARE Young Adult. It is available for purchase by unmarried adult children who do not have access to an employer-sponsored health plan.
Going to College	Children of TRICARE-eligible sponsors remain TRICARE-eligible until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support*), as long as their DEERS information is current.

1. Children with disabilities may remain TRICARE-eligible beyond the normal age limits. Check with your sponsor's service for eligibility criteria.

Having a Baby or Adopting a Child

Children are automatically covered by TRICARE Standard and TRICARE Extra at the time of birth or adoption. Coverage will be continuous as long as you register your child in DEERS within 365 days of birth or adoption. Register your child in DEERS at a uniformed services identification (ID) card-issuing facility. A birth certificate or certificate of live birth from the hospital is required. If your child is not registered in DEERS within 365 days after the date of birth or adoption, DEERS will show "loss of eligibility," and the child will no longer be TRICARE-eligible until registered in DEERS.

If at least one other family member is enrolled in TRICARE Prime, children are automatically covered as TRICARE Prime beneficiaries for 60 days after birth or adoption.

Note: TRS and TRR each have program-specific rules about enrolling new children. For more information on these requirements, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook. TYA does not cover dependents of enrollees.

Traveling

Traveling within the United States

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

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

Traveling Overseas

If you need emergency care while traveling overseas, go to the nearest emergency care facility or call the Medical Assistance number for the overseas area where you are traveling. If you are admitted, contact the TRICARE Overseas Program (TOP) Regional Call Center **before leaving the facility**, preferably within 24 hours or on the next business day, to coordinate authorization, continued care, and payment. Contact the TOP Regional Call Center for urgent care assistance. See the *Important Contact Information* section at the beginning of this handbook for TOP contact information.

Use TOP Standard to receive care from any host nation provider when traveling overseas, unless local restrictions apply. TOP Standard, including cost-shares and deductibles, is similar to the stateside program. TRICARE Extra is not available overseas. TRICARE nonparticipating non-network providers may charge up to 15 percent above the TRICARE-allowable amount in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). However, there may be no limit to the amount that nonparticipating non-network providers overseas may bill, and you are responsible for paying any amount that exceeds the TRICARE-allowable charge.

Note: When seeking care from a host nation (*overseas*) provider, be prepared to pay up front for services and then file a claim with the TOP claims processor. You must submit proof of payment with all overseas claims. In the Philippines, you must use certified providers. Visit **www.tricare-overseas.com/philippines.htm** to find a certified provider.

Filling Prescriptions on the Road

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

Note: In the Philippines, you must use a certified pharmacy provider.

Moving

Moving within the United States

Whether you are moving to another area within the same TRICARE region or to a different TRICARE region, moving with TRICARE Standard and TRICARE Extra is easy. All you need to do is update your personal information in DEERS, find a new network or TRICARE-authorized non-network provider, and continue to receive care when you need it. If you move to a new region, be sure to learn who your new regional contractor is and where to file your claims. See the *Claims* section of this handbook for more information.

Moving Overseas

You can use TOP Standard and receive care from any host nation provider without a referral, unless local TOP restrictions require seeing only approved providers. TOP Standard, including cost-shares and deductibles, is similar to the stateside program and is administered by International SOS Assistance, Inc. There are some limits for overseas health care services and pharmacy coverage.

Note: In the Philippines, you must use a certified host nation provider and pharmacy. Visit **www.tricare-overseas.com/philippines.htm** for more information or to find a certified provider.

Contact the TOP Regional Call Center for the overseas area where you are moving or visit **www.tricare-overseas.com** to find a host nation provider. For TOP contact information, see the *Important Contact Information* section at the beginning of this handbook. For a list of U.S. Embassies and Consular Offices worldwide, visit **www.usembassy.state.gov**.

Separating from the Service

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

Transitional Assistance Management Program

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

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

Contact your regional contractor or a Beneficiary Counseling and Assistance Coordinator to discuss your family's eligibility for this program. You also can visit **www.tricare.mil/tamp** for more information.

Continued Health Care Benefit Program

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

TRICARE Reserve Select®

TRS is a premium-based health plan that members of the Selected Reserve of the Ready Reserve may qualify to purchase for themselves and/or their family members. TRS provides comprehensive health care coverage with patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra, but TRS beneficiaries must pay monthly premiums. TRS beneficiaries may access care from any TRICARE-authorized providers, unless overseas restrictions apply. Active duty family member (ADFM) annual deductibles and cost-shares apply. For more information on this option, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

TRICARE Retired Reserve®

TRR is a premium-based health plan that members of the Retired Reserve may qualify to purchase for themselves and/or their family members. TRR provides comprehensive health care coverage with patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra, but TRR beneficiaries must pay monthly premiums. TRR beneficiaries may access care from any TRICARE-authorized providers, unless overseas restrictions apply. Retiree annual deductibles and cost-shares apply. For more information on this option, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

Transitional Care for Service-Related Conditions

If you are eligible under TAMP and have a newly diagnosed medical condition that is related to your active duty service, you may qualify for the TCSRC program, which provides 180 days of care for your condition with no out-of-pocket costs. If you believe you have a service-related condition that may qualify you for TCSRC, visit **www.tricare.mil/tcsrc** for instructions on how to apply.

Retiring from Active Duty

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

Until retirement, your sponsor is enrolled in either TRICARE Prime or TRICARE Prime Remote (TPR). If the sponsor does not reenroll into TRICARE Prime, he or she will use TRICARE Standard and TRICARE Extra.

Note: TPR is not available to retirees.

When your status changes to family member of a retired service member, the TRICARE Standard and TRICARE Extra cost-shares and catastrophic cap will increase. Here are a few of the other TRICARE Standard and TRICARE Extra changes you will experience when your active duty sponsor retires:

TRICARE Standard and TRICARE Extra Changes upon Sponsor Retirement from Active Duty

Outpatient Cost-Shares and Copayments	Increases to retired family rates
Catastrophic Cap	Increases to retired family rate
Health Care Services	Eye examinations no longer covered Hearing aids no longer covered
Entitlement to premium-free Medicare Part A	Must also have Medicare Part B to remain eligible for TRICARE coverage under TRICARE For Life.

Note: Some specialized services are covered in connection with the medical or surgical treatment of a covered illness or injury.

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

Becoming Entitled to Medicare

Active Duty Status

Active duty service members (ADSMs) and ADFMs who are entitled to premium-free Medicare Part A remain eligible for TRICARE Prime and TRICARE Standard programs without signing up for Medicare Part B. To avoid a break in TRICARE coverage, ADSMs and ADFMs must sign up for Medicare Part B **before** the sponsor leaves active duty status. ADSMs and ADFMs can sign up for Medicare Part B during a special enrollment period without having to pay monthly late enrollment premium surcharges. ADSMs and ADFMs with end-stage renal disease do not have a special enrollment period and should enroll in Medicare Part A and Part B when first eligible. The special enrollment period is available anytime the sponsor is on active duty or within the first eight months following the month that (1) the sponsor leaves active duty status or (2) TRICARE coverage ends, whichever is first.

Retired Status

Retirees and their dependents who are entitled to premium-free Medicare Part A must also have Medicare Part B to remain TRICARE-eligible regardless of their age or place of residence. TRICARE For Life coverage automatically begins the first month both Medicare Part A and Part B are effective. TRICARE eligibility is terminated for any period of time in which a retiree family member is entitled to Medicare Part A and does not have Medicare Part B. To avoid a break in TRICARE coverage, ADFMs must sign up for Medicare Part B before their sponsor's active duty status ends.

Survivor Coverage

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

- A surviving spouse who has not remarried prior to age 55 (*eligibility cannot be regained later, even if you divorce or your new spouse dies*)
- A surviving unmarried child until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support*)

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

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

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

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

Loss of Eligibility

If your DEERS record indicates loss of TRICARE eligibility, your TRICARE Standard coverage will automatically end. If you believe you are still eligible for TRICARE, you will need to update your DEERS record to reestablish your eligibility. Contact the Defense Manpower Data Center directly at **1-800-538-9552**. Once DEERS is updated, you will be covered under TRICARE Standard and TRICARE Extra.

If your DEERS record is correct and you have lost eligibility, you may qualify for transitional health care. See "Separating from the Service" earlier in this section for details about transitional health care options.

Upon loss of TRICARE eligibility, each family member will automatically receive a certificate of creditable coverage. The certificate of creditable coverage is a document that serves as evidence of prior health care coverage under TRICARE.

Premium-Based TRICARE Standard Health Plans

TRICARE Reserve Select

TRICARE Reserve Select (TRS) is a premium-based, worldwide health care plan that qualified Selected Reserve of the Ready Reserve members and qualified survivors may purchase for themselves and/or their family members. TRS offers comprehensive health coverage similar to TRICARE Standard and TRICARE Extra (*in the United States*) or TRICARE Overseas Program (TOP) Standard (*overseas*). Enrollment is required. You must qualify for and purchase TRS to participate. Monthly premiums, annual deductibles, and cost-shares apply. The initial two-month premium payment is due with the enrollment form. With TRS, you may receive care from any TRICARE-authorized provider (*network or non-network*), and no referrals are required, though some services require prior authorization. For more information about TRS, including eligibility requirements and how to purchase it, visit **www.tricare.mil/trs**.

Note: Authorized providers who are not part of the TRICARE network of civilian providers may charge beneficiaries using TRICARE Standard up to 15 percent above the TRICARE-allowable charge for services. Beneficiaries are responsible for that additional 15 percent, along with applicable cost-share and deductible amounts. Overseas, there may be no limit to the amount that nonparticipating non-network providers may bill, and you are responsible for paying any amount that exceeds the TRICARE-allowable charge. Visit **www.tricare.mil/overseas** for more information.

TRICARE Retired Reserve

TRICARE Retired Reserve (TRR) is a premium-based, worldwide health care plan that qualified Retired Reserve members and qualified survivors may purchase for themselves and/or their family members. TRR offers comprehensive health coverage similar to TRICARE Standard and TRICARE Extra (*in the United States*) or TOP Standard (*overseas*). Enrollment is required. You must qualify for and purchase TRR to participate. Monthly premiums, annual deductibles, and cost-shares apply. The initial two-month premium payment is due with the enrollment form. With TRR, you may receive care from any TRICARE-authorized provider (*network or non-network*), and no referrals are required, though some services require prior authorization. For more information about TRR, including eligibility requirements and how to purchase it, visit **www.tricare.mil/trr**.

TRICARE Young Adult

The TRICARE Young Adult (TYA) program is a premium-based health care plan available for purchase by qualified dependents. The TYA benefit includes both TRICARE Prime and TRICARE Standard and TRICARE Extra coverage worldwide. The sponsor's status, the dependent's geographic location and other factors determine eligibility to purchase TYA Prime and/or TYA Standard. Command sponsorship is required for TYA Prime enrollment overseas. TYA coverage includes medical and pharmacy benefits, but excludes dental coverage.

Those who purchase TYA Prime have access to care through their assigned military or civilian primary care managers. Unless enrolled at a military hospital or clinic, TYA beneficiaries are generally limited to primary care access at military hospitals and clinics on a space-available basis. TYA beneficiaries enrolled in U.S. Family Health Plan are not eligible for direct care or military pharmacy benefits at military hospitals or clinics, except in emergencies. TYA is only available for individuals and is not offered as a family plan. For more information about TYA, including eligibility requirements and how to purchase it, visit **www.tricare.mil/tya**.

For Information and Assistance

Beneficiary Counseling and Assistance Coordinators

Beneficiary Counseling and Assistance Coordinators (BCACs) can help you with TRICARE and Military Health System inquiries and concerns and can advise you about obtaining health care. BCACs are located at military hospitals and clinics and TRICARE Regional Offices. To find a BCAC near you, visit the Customer Service Community Directory at **www.tricare.mil/bcacdcao**.

Debt Collection Assistance Officers

Debt Collection Assistance Officers (DCAOs) are located at military hospitals or clinics and TRICARE Regional Offices to help you resolve health care collection-related issues. A DCAO is also located at the Reserve and Service Member Support Office, Great Lakes (*formerly known as the Military Medical Support Office*), for active duty service members and National Guard and Reserve members with service-documented line-of-duty injuries. Contact a DCAO if you have received a negative credit rating or have been contacted by a collection agency due to an issue related to TRICARE services.

Appealing a Decision

If you believe a service or claim was improperly denied, in whole or in part, you (*or another appropriate party*) may file an appeal with your regional contractor. An appeal must involve an appealable issue, such as benefit coverage or medical-necessity determination. For non-appealable issues regarding health care quality or service, you can file a grievance with your regional contractor. For information about filing an appeal or grievance about care received overseas, visit **www.tricare-overseas.com**.

Note: If you are eligible for TRICARE and Medicare and wish to file an appeal, Medicare-related appeals should be submitted to Medicare.

Reporting Suspected Fraud and Abuse

Report suspected fraud and abuse to your regional contractor. You also can report fraud or abuse issues directly to TRICARE at **fraudline@tma.osd.mil** or visit **www.tricare.mil/fraud**.

Regional Appeals Filing Information

TRICARE North Region	TRICARE South Region	TRICARE West Region
Claims Appeals: Health Net Federal Services, LLC TRICARE Claim Appeals P.O. Box 105266 Atlanta, GA 30348-5266 **Claims Appeals Fax:** 1-888-458-2554 **Prior Authorization Appeals:** Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 105087 Atlanta, GA 30348-5087 **Prior Authorization Appeals Fax:** 1-888-881-3622 **Appeals Online:** www.hnfs.com	**Claims Appeals:** TRICARE South Region Appeals P.O. Box 202002 Florence, SC 29502-2002 **Prior Authorization Appeals:** Humana Military ATTN: Utilization Management P.O. Box 740044 Louisville, KY 40201-7444 **Behavioral Health Appeals:** ValueOptions Behavioral Health ATTN: Appeals and Reconsideration Department P.O. Box 551138 Jacksonville, FL 32255-1138	**Claims Appeals:** TRICARE West Region Appeals Department P.O. Box 105493 Atlanta, GA 30348-5493 **Claims Appeals Fax:** 1-877-584-6628 **Prior Authorization Appeals:** TRICARE West Region Appeals Department P.O. Box 105493 Atlanta, GA 30348-5493 **Prior Authorization Appeals Fax:** 1-877-584-6628

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TRICARE Expectations for Beneficiaries

According to the Department of Defense (DoD), as a TRICARE beneficiary, you should expect to have the following abilities and support:

- **Get information:** You should expect to receive accurate, easy-to-understand information from written materials, presentations, and TRICARE representatives to help you make informed decisions about TRICARE programs, medical professionals, and facilities.
- **Choose providers and plans:** You should expect a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.
- **Emergency care:** You should expect to access medically necessary and appropriate emergency health care services as is reasonably available when and where the need arises.
- **Participate in treatment:** You should expect to receive and review information about the diagnosis, treatment, and progress of your conditions, and to fully participate in all decisions related to your health care, or to be represented by family members or other duly appointed representatives.
- **Respect and nondiscrimination:** You should expect to receive considerate, respectful care from all members of the health care system without discrimination based on race, color, national origin, or any other basis recognized in applicable law or regulations.
- **Confidentiality of health information:** You should expect to communicate with health care providers in confidence and to have the confidentiality of your health care information protected to the extent permitted by law. You also should expect to have the ability to review, copy, and request amendments to your medical records.
- **Complaints and appeals:** You should expect a fair and efficient process for resolving differences with health plans, health care providers, and institutions that serve you.

Additionally, the DoD has the following expectations of you as a TRICARE beneficiary:

- **Maximize your health:** You should maximize healthy habits such as exercising, not smoking, and maintaining a healthy diet.
- **Make smart health care decisions:** You should be involved in health care decisions, which means working with providers to provide relevant information, clearly communicate wants and needs, and develop and carry out agreed-upon treatment plans.
- **Be knowledgeable about TRICARE:** You should be knowledgeable about TRICARE coverage and program options.
- **You also should:**
  - Show respect for other patients and health care workers
  - Make a good-faith effort to meet financial obligations
  - Use the disputed claims process when there is a disagreement

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

TRICARE South Region
Humana Military, a division of
Humana Government Business
Humana-Military.com
1-800-444-5445

TRICARE West Region
UnitedHealthcare Military & Veterans
www.uhcmilitarywest.com
1-877-988-WEST (1-877-988-9378)

www.tricare.mil

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