



2025
US Family Health Plan
Member Handbook

 Martin's Point

Martin's Point

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Please note: In this Member Handbook, when the term “US Family Health Plan” or “Plan” is used, we are referring to the Martin's Point US Family Health Plan.

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Welcome to the Martin's Point US Family Health Plan!

Thank you for choosing the Martin's Point US Family Health Plan. We look forward to providing the health care and service you and your family have earned.

Background of Martin's Point Health Care and the US Family Health Plan

Martin's Point Health Care, a former Uniformed Services Treatment Facility (USTF) within the Military Health System (MHS), has been providing health care to military beneficiaries for over 30 years. Martin's Point Health Care is a not-for-profit organization that offers primary care services in Maine and New Hampshire and also offers health plans to certain groups. One of these plans is the US Family Health Plan, a TRICARE Prime® option offered through a Department of Defense contract.

The US Family Health Plan provides medical benefits for retirees from the uniformed services, their family members, and active-duty family members of the seven uniformed services: the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service (PHS), and the National Oceanic and Atmospheric Administration (NOAA).

Medical services are provided by a network of primary care providers (PCPs), specialists, hospitals, and pharmacies within our designated service area of Maine, New Hampshire, Vermont, upstate New York, and northern and western Pennsylvania.

How the Plan Works

The US Family Health Plan is a managed-care plan, designed to provide comprehensive medical benefits to enrolled beneficiaries at a low out-of-pocket cost. The provider-patient relationship is at the heart of the US Family Health Plan. As an enrolled beneficiary, you are

required to select a PCP who will coordinate your medical care, including routine care, urgent care, and preventive health care needs, and refer you for specialty care and hospitalization, if needed.

Let's Get Started

The staff at the US Family Health Plan wants to ensure you understand your military health care and you receive the health care services you need.

This Member Handbook will help you understand the following:

- Your rights and responsibilities
- The role of your PCP
- How to obtain health care services
- The health care services covered by TRICARE Prime and the US Family Health Plan
- The health care services not covered by TRICARE Prime and the US Family Health Plan
- What to do in case of an emergency or when in need of urgent care
- The easiest and least expensive way to receive prescription drugs

We hope you will take the time to read and understand this handbook and to call us if you have any questions. Our Member Services team is available Monday–Friday, 8 am–5 pm, to help you find the answers you need in the sometimes confusing world of health care. Member Services can be reached by calling, toll-free, **1-888-674-8734 (TTY: 711)**.

Register for Member Portal

Access important health care information including claims, referrals, authorizations and more by signing up for the Member Portal at martinspoint.org/memberportal.

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An Important Note About TRICARE Program Information

Please be advised that, at the time of printing, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact Martin's Point.

Quick Reference Telephone Numbers

Medical Emergencies and After Hours

- Call 911 for emergencies.
Notify your PCP within 48 hours of your emergency room visit so all follow-up care can be arranged and approved by your PCP.
- Call the Suicide Hotline for mental health emergencies: 988
- Call the 24-Hour Nurse Line
1-800-574-8494 (TTY: 711)—Option #2.

Urgent Care (including evenings, weekends, holidays, etc.)

- Call your PCP first to get instructions for urgent care. You can self-refer (see a provider without calling your PCP) for urgent care, but you should call your PCP to let him/her know what happened, especially if follow-up care is needed. The telephone number is printed on the front of your Member Identification (ID) Card.
- Call the 24-Hour Nurse Line
1-800-574-8494 (TTY: 711)—Option #2.

Specialty Care

- Call your PCP first as all specialty care requires that your PCP submit a referral to the Plan.

The telephone number is printed on the front of your Member ID Card.

Reminder: Check the provider directory to determine the network status of a new specialist.

Mental Health

- Behavioral HealthCare Program (BHCP): call 1-888-812-7335 (TTY: 711).
- NOTE: For more information regarding mental health services, see the "Covered Services Needing Additional Explanation" section below.

US Family Health Plan

- Member Services: 1-888-674-8734 (TTY: 711)
- Mail-Order Pharmacy: 1-800-707-9853 (TTY: 711)

Defense Enrollment Eligibility Reporting System (DEERS)

- Manpower Data Center
Support Office: 1-800-538-9552
(TTY/TTD: 1-866-363-2883)
Fax: 1-800-336-4416

Members' Rights and Responsibilities

We are dedicated to protecting the rights and responsibilities of our beneficiaries. This section is designed to inform you of your rights and responsibilities as a member of the US Family Health Plan.

Our notification of Members' Rights and Responsibilities is provided to all new beneficiaries here in the Member Handbook, and is posted on the Martin's Point website at MartinsPoint.org/USFHPResources

Members' Rights

As a Martin's Point US Family Health Plan member, you have the right to:

- Notify the health plan of any changes in your other health insurance.
- Notify the health plan of any changes in your physical or mailing address.
- Receive information about covered benefits and cost sharing
- Receive information about the Martin's Point US Family Health Plan, our services, licensure, certification, and accreditation status
- Receive information about our provider and health care facilities, including information about the composition of our network
- Have a choice of health care providers that is sufficient to ensure access to appropriate, high-quality health care
- Have a candid discussion of all medically necessary treatment options, regardless of cost of benefit coverage
- Receive information on beneficiary satisfaction and your rights and responsibilities
- Be informed of the processes for accessing specialists and emergency services
- Receive considerate and respectful care and service, with recognition of your personal dignity at all times
- Have access to all of the health care and treatment services we provide, including care management information, consistent with available resources and generally accepted standards
- Have access to emergency health care services when and where the need arises
- Refuse treatment to the extent permitted by law and government regulations and be informed of the consequences of such refusal of treatment
- Question the adequacy of care being provided
- Have privacy and confidentiality concerning your medical care and records to the extent permitted by law. You have the right, and will be afforded the opportunity, to approve or refuse the release of such information, except when release is required by law or the federal government.
- Receive information from us in a way that works for you. Our plan offers free language interpretation services for non-English-speaking beneficiaries that can be accessed by calling Member Services.
- Know the identity and professional status of the health care provider primarily responsible for providing and managing your care, as well as other health care personnel involved in your treatment
- Participate in decisions involving your health care, including mutually agreed-upon goals, to the degree possible. Beneficiaries who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.

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- Understand an explanation of the diagnosis, treatment, and prognosis of your health condition
- Be informed of possible complications, risks, benefits, and alternative treatments associated with consent or refusal for treatment, in order to make knowledgeable decisions about your course of care
- Be advised if the Martin's Point US Family Health Plan proposes to engage in or perform experimental research in order to make knowledgeable decisions about your care
- Refuse to participate in experimental research
- Receive care and treatment in a safe environment and to be informed of the facility's rules and regulations that relate to patient and visitor conduct
- Be informed of the Martin's Point US Family Health Plan member grievance (feedback) and appeals process designated for the initiation, review, and resolution of patient grievances (feedback) and appeals. You have the right to file grievances (feedback) and appeals with Martin's Point, as outlined in the "Grievance (Feedback) and Appeals Process" section of this Member Handbook.
- Make recommendations for the rights and responsibilities section
- Providing your PCP and other health care providers complete information, to the best of your knowledge, regarding your medical history and other matters relating to your health
- Becoming involved in specific health care decisions
- Complying with the medical and nursing treatment plan, including the follow-up care, agreed upon by you and your health care provider(s). This includes keeping appointments and notifying providers, in a timely manner, when an appointment cannot be kept. You also have the responsibility of letting your provider know whether or not you understand the treatment plan and what is expected of you.
- Making a good-faith effort to meet financial obligations, including paying applicable copayments at the time the services are received and enrollment fees, as required
- Being considerate of the rights of other patients, and of Martin's Point Health Care personnel and network providers
- Being respectful of the property of other persons and facilities
- Reporting recommendations or questions you have to a Member Services representative or Martin's Point Health Care Center manager
- Using our internal grievance (feedback) and appeals processes to address concerns that may arise
- Following provider facility rules and regulations concerning patient conduct, including no-smoking rules, parking regulations, etc.
- Reporting wrongdoing and fraud to appropriate resources or legal authorities

Members' Responsibilities

As a Martin's Point Health Plan member, you are responsible for:

- Becoming knowledgeable about your Plan coverage and options, including all covered benefits, limitations, and exclusions; rules regarding referrals and use of network providers, coverage, and authorizations; appropriate processes to secure additional information; and the process to appeal coverage decisions

US Family Health Plan Member ID Card

All members of the US Family Health Plan receive a Member ID Card soon after joining the Plan. Member ID Cards do not have an expiration date and are not issued each year. If you recently enrolled in the US Family Health Plan and have not received your US Family Health Plan Member ID Card, you can print and request a new ID card on the Member Portal. You can also call Member Services, toll-free, at **1-888-674-8734** (TTY: 711) and let us know that you are still waiting for your card.

A picture of our US Family Health Plan Member ID Card is shown below. You will notice that the card provides a great deal of valuable information for you and the health care providers you see while enrolled in this Plan.

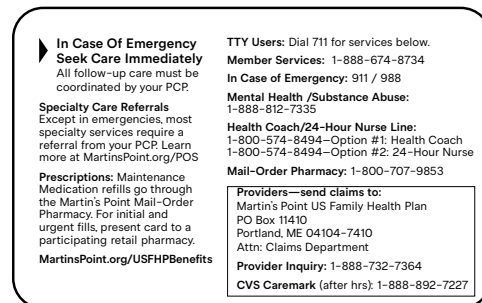
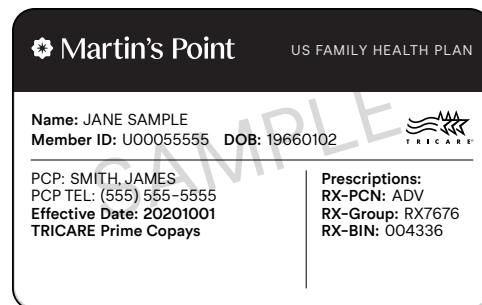
This information includes:

- Your name, date of birth, and Member Number (MBR)
- The name and office telephone number of your PCP
- Your effective date as a beneficiary in the US Family Health Plan
- Your copayment responsibilities for office visits and emergency room visits
- Instructions and telephone numbers for medical emergencies, mental health emergencies, substance abuse emergencies, and other needs (listed on the back of your card)
- The address that health care bills or claims should be sent to (listed on the back of your card)

Please review your Member ID Card for accuracy. If any information is incorrect, simply call Member Services and a corrected card will be sent to you within two weeks.

Present your Member ID Card each time you receive health care or fill a prescription. This ID Card lets the doctor's office staff, hospital, and pharmacy know what your copayment is and where to send the bill for the services you receive from them. Because you never know when an emergency may occur, we recommend you carry this card with you at all times. If you are a parent, we suggest that you keep your children's cards with you, too. If you share custody of your children with another individual, simply request a second Member ID Card for each child so that both parties can obtain health care for your children.

If you lose or damage your card, access a copy of your Member ID card online at martinspoint.org/idcard or please call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)** and we will send you a replacement Member ID Card.



Primary Care Provider (PCP)

Choosing Your Primary Care Provider

US Family Health Plan members are required to select an in-network primary care provider (PCP). Each enrolled family member should also select an in-network PCP with whom they are comfortable. If you or an enrolled family member ever wishes to choose a different PCP, simply call our Member Services team, toll-free, at **1-888-674-8734 (TTY: 711)**. They will update your information and send you a new Member ID Card listing your new PCP. You are free to change your PCP at any time during your membership. Please ensure that you notify Member Services if you change your PCP. A directory of participating providers is available online at MartinsPoint.org/USFHPDirectory

Role of Your Primary Care Provider

Your PCP and their team are the key to accessing services that will meet your health care needs. They see you for all of your routine health needs, monitor the medications you receive, perform or order preventive care, order tests or special services such as physical therapy, when needed, and maintain your medical records. If you have a complex problem, your PCP may refer you to one of our many qualified contracted specialists. Your PCP and the specialist will work together as a team to meet your health care needs.

There are many advantages to choosing a designated PCP:

- You have only one office to call whenever you need care.
- Your medical records are kept in one secure place.
- Your PCP has good working relationships with the specialists and hospitals that they refer you to.

- Your prescriptions can be monitored for adverse interactions.
- You develop a trusting relationship with your PCP over time and they become familiar with your medical history and personal needs/preferences.
- Your PCP and their staff can help you navigate the complex world of health care.

Although we would like to promise that your PCP will always be available when you need routine or urgent care, there may be times when you will be seen by another member of your care team. This is usually another physician, physician assistant, or nurse practitioner within the same practice who knows your PCP and will report back to them after the appointment. Your PCP's office will submit claims to Martin's Point for any services you receive at that practice. You should not receive a bill (other than your copay) for most routine and preventive care received from your PCP. If you do receive a bill from your PCP for anything other than your copayment or authorized cost share, please contact Member Services, toll free, at **1-888-674-8734 (TTY: 711)**.

Changing Your Primary Care Provider

If there is a change in PCP, it is important to establish a relationship with the new PCP as soon as possible. Here are some helpful hints for establishing the relationship:

- You must establish care with your PCP, the health plan does not do this for you.
- Call your new PCP's office to ask about its process for establishing a patient-provider relationship.
- If you are currently taking medications on a daily basis, obtain a 90-day supply from your former provider (before you change your PCP) to ensure you don't run out prior to your first visit with your new PCP

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- Call your former PCP's office and request a transfer of your medical records to the office of your new PCP.
- You must notify the plan of any change in PCP.
- You can make this change/notification via the member portal or by contacting Member Services.

Provider Directory

The names, addresses, and telephone numbers of all participating PCPs, specialists, mental health care providers, hospitals, and facilities are listed in your Provider Directory. Directories are subject to change and are updated on a regular basis. To check the current status of any provider or to get information about a provider's professional qualifications use our online directory at MartinsPoint.org/USFHPDirectory. You can also call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**. This directory is updated daily.

If You Need Specialty Care

Your PCP will determine any specialty care you need and assist you in selecting a specialty provider who is in the network. Except for instances when you may self-refer (see "Self-Referrals" section below), **your PCP should refer you to a specialist** to verify the medical necessity of the specialty service *before you see any other provider or specialist*. NOTE: Some referred services may also require AUTHORIZATION by the US Family Health Plan. *Reminder, a referral from a network provider does not mean that specialist will be in network. Please check the provider directory or contact Member Services to determine provider status.* (Please see the "Referrals and Authorizations" section below for information.)

IMPORTANT! Before you receive services, please make sure to check whether the provider/facility is in the Martin's Point US Family Health Plan network. To find out if a provider or facility is in our

network, you may call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)** or check our online directory at MartinsPoint.org/USFHPDirectory. **If you choose to see an out-of-network provider when an in-network provider is available to perform a needed service, the service may be covered under the Point of Service option at a much higher cost to you.** (See "Point of Service" section below.)

We highly recommend that beneficiaries call Member Services for coverage/cost information when considering going to an out-of-network provider.

Continuity of Care

If you are following a treatment plan prescribed by a specialty physician prior to joining the US Family Health Plan and you require ongoing management of this condition, please note the following important steps to take to ensure continuity of your care:

- You must notify your US Family Health Plan primary care provider (PCP) as soon as possible.
- Some specialty services also require **AUTHORIZATION** (a determination from the US Family Health Plan that the service is medically necessary and covered under the plan). It is the provider's responsibility to seek authorization for those services **PRIOR to the continued delivery of these services**.
- **VERY IMPORTANT:** If the specialist is not in the US Family Health Plan network, additional **Referral Approval may be required** in order for the service to be covered at the standard TRICARE Prime benefit level. **In many cases, if you choose to receive covered services from an out-of-network provider in a non-emergency situation without receiving Referral Approval from the US Family Health Plan to do so, these services will be covered at the Point of Service (POS) option benefit**

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level, at a much higher cost to you. (See "Point of Service" section below.)

We highly recommend that beneficiaries call Member Services prior to receiving continued treatment to confirm coverage.

New episodes of care by out-of-network providers you may have seen prior to enrolling in the US Family Health plan may not be authorized.

If You Are Admitted to a Hospital

If you require a planned hospitalization, your PCP or specialist will make the necessary arrangements for you at a network facility.

Your hospital care will be coordinated by your PCP or another network provider. If you are admitted to a hospital on an emergency basis, you or a family member should notify your PCP within 24 hours, or the next business day. You should also notify the US Family Health Plan by calling Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Self-Referrals

There are a few services you may obtain without receiving a referral from your PCP:

- Emergency care for treatment of a potentially life-threatening condition
- Urgent care for an illness or injury that is not life-threatening
- Visits to a network provider for mental health or substance abuse treatment. To ensure that you make your appointments with a network provider, please contact Behavioral HealthCare Program (BHCP) by calling, toll-free, 1-888-812-7335 (TTY: 711) prior to your first appointment. (For more information about your mental health and substance abuse benefit, please see the "Covered Services Needing Additional Explanation" section below.

- One (1) annual routine eye examination with a network optometrist or ophthalmologist
- Annual preventive health care services such as an annual Pap smear or routine mammogram at a network provider office, network hospital, or network diagnostic facility

Referrals and Authorizations

Referrals

Your PCP is responsible for coordinating all your health care services except for life-threatening emergencies, annual eye exams, annual physicals, urgent care, and select mental health services. Should your medical condition require the service of a specialist, your PCP will explain to you why you need to see a specialist and send a referral to the specialist designated to perform that service for you. Your PCP is also responsible for entering the referral in the Martin's Point online provider portal, allowing you to see the referral status in your member portal. *Reminder, a referral from a network provider does not mean that specialist will be in network. Please check the provider directory or contact Member Services to determine provider status.*

NOTE: Some services still require prior authorization, even with a referral. See the Authorizations section below.

If you receive specialty care without an approved referral, you will be subject to the TRICARE Point of Service Option (POS) cost share provisions, which would result in significantly higher costs.

The Point of Service (POS) Option

The POS option allows you to see TRICARE-authorized specialists for covered services without an approved referral, but it comes with significantly higher costs. For details, see the Point of Service section below.

Steps for Accessing Specialty Care

1. Contact Your PCP

Always start with your PCP if you believe you need specialty care. They will review your needs and refer you to the appropriate specialist. Your PCP is responsible for entering the referral in the Martin's Point online provider portal, allowing you to see the referral status in your member portal.

2. Check the Status of Your Referral

- Log in to the US Family Health Plan Online Member Portal to track your referral. This portal shows updates on approvals and provides a central location for managing your referrals. To ensure your specialty care is covered with the lowest-possible cost share, always confirm that your referral is on file and approved before scheduling an office visit with your specialist.
- For members who don't use the portal, paper copies of referral determinations can be sent upon request.

NOTE: While specialty care typically requires a referral, visits to an urgent care center or emergency room do not. If you need immediate care, don't hesitate to seek it.

Make Sure Your Listed PCP is Correct: If you haven't already, please check that the Primary Care Provider (PCP) listed in our records is correct. If you need to update your PCP information, you can:

- Log in to your Online Member Portal and make the change there.
- Call Member Services for assistance.

Authorizations

Some covered services also must be authorized by the US Family Health Plan **before** the service is delivered. **Authorization by the Plan means that the Plan has reviewed a request for a particular service and has determined that the**

requested service is both medically necessary and is a covered benefit under the plan. It is your provider's responsibility to request authorization from the US Family Health Plan to ensure that the Plan approves the delivery of the proposed service and will cover it.

IMPORTANT NOTE: All requests for out-of-network services are reviewed by the US Family Health Plan to determine if they can be provided within the network. Only those medically necessary services that **cannot** be provided within our network will be approved by the Plan to be covered at the standard TRICARE Prime benefit level. (For information about your option to **choose** to use an out-of-network provider when an in-network provider is available, see the "Point of Service" section below. Using the Point of Service option will result in much higher member costs.)

The Authorization Process

If the requested service requires authorization, your PCP or the referring physician should send a copy of the request for authorization to the US Family Health Plan. The Plan will review the authorization request to determine the following:

- Medical necessity/appropriateness of the requested service
- Whether, and at what level, the service is covered under the Plan
- Network status of the provider/facility

After the review, the Plan will generate and send an authorization approval or denial letter to the beneficiary and the provider.

Question: "Do I need an authorization letter from the US Family Health Plan for every referral that my PCP makes for me?"

Answer: Not necessarily. Some referred services, such as diagnostic testing (e.g., X-rays),

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never require authorization by the US Family Health Plan. Other referred services, such as office consultations and visits, do not require approval from the US Family Health Plan if those services are provided by an in-network provider. Some services, like inpatient hospital services, always require an authorization, regardless of whether you receive those services from an in-network or out-of-network provider.

Question: “How do I find out which services require authorization prior to delivery of the service?”

Answer: To find out which services require authorization prior to delivery you may do the following:

- Call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.
- Ask your PCP to find out, on your behalf.
- For preauthorization of mental health and substance abuse services, please call the Behavioral HealthCare Program, toll-free, at 1-888-812-7335 (TTY: 711).

Question: “What if I want to receive services from a provider who is NOT in the US Family Health Plan provider network?”

Answer: In some cases, the US Family Health Plan may approve a referral to an out-of-network provider to deliver the medically necessary, covered service. If such referral is approved, the service will be covered at the standard TRICARE Prime benefit level.

However, if you choose to receive medically necessary, covered services from an out-of-network provider and have not received advance Plan authorization to do so, those services may be covered at the “Point of Service” benefit level, at a much higher cost to you. (See “Point of Service” section below.)

Question: “How do I find out which providers are in the US Family Health Plan network?”

Answer: The US Family Health Plan provider network continues to expand into new areas of Maine, New Hampshire, Vermont, upstate New York, and northern and western Pennsylvania to offer our beneficiaries more convenient access to high quality, affordable health care. Both you and your PCP are responsible for ensuring that the specialist to whom you are referred is an in-network practitioner. To check the network status of any health care provider, hospital, agency, or company, call Member Services at **1-888-674-8734 (TTY: 711)** or refer to our online directory at MartinsPoint.org/USFHPDirectory.

Utilization Management and the US Family Health Plan Medical Management Department

Utilization Management—Medically Necessary Care

Our “utilization review” process ensures that you receive all of the benefits to which you are entitled. It also ensures that the US Family Health Plan only pays for care that is medically necessary, rendered by a TRICARE-authorized provider, and a service covered under the Plan. Care is considered medically necessary when:

- It is consistent with the condition, illness, or injury of the patient.
- It is in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where and at the time the service or supply is provided.
- It is not solely provided for the convenience of the patient.

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- It is cost-effective treatment for the injury or condition of the patient.

Again, please note that not all care, services, goods, therapies, and equipment that meet the criteria above as medically necessary are covered under the US Family Health Plan.

Rest assured that Martin's Point has your health and well-being at the center of all of our decision-making processes. As a result, our policies reflect the following:

- Utilization Management decision making is based only on appropriateness of care and service and the existence of coverage.
- Martin's Point does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- There are no financial incentives for Utilization Management decision makers designed to encourage decisions that result in underutilization of services or benefits.

Non-emergency Elective Hospital Admissions

The US Family Health Plan will review your referral for non-emergency or elective hospital admission in advance to ensure that the treatment or surgery you are to receive is covered under your Plan and is being provided at a network facility and at the most appropriate level of care. **Most procedures, such as outpatient surgery, require preauthorization by the US Family Health Plan.** It is important to note that without receiving proper preauthorization from the US Family Health Plan, **you will be fully responsible for payment of all charges related to that procedure.**

Emergency Hospital Admissions

If you are admitted to a hospital as a result of an emergency, your emergency service copayment will be waived. You will, however, be responsible for inpatient copayments, as applicable.

If you require inpatient hospitalization as a result of an emergency visit, either you, a family member, or a designee must notify your PCP and Martin's Point within 24 hours of admission.

Care Management Services

Members of the US Family Health Plan are eligible to receive FREE, voluntary, personalized care management and health coaching services. You can request a nurse or social work care manager who will reach out by phone and provide support and education to help you set health goals and work to achieve your best health. In addition, you may have a consultation with a health plan clinical pharmacist to provide education and support.

Who is care management for?

Care management can help people who:

- Have complex or chronic medical/behavioral health conditions
- Need help navigating the health care system
- Need help after discharging from a hospital or inpatient setting
- Struggle with medication or health care costs
- Need help with medication management
- Are expecting a baby
- Face social barriers such as lack of family support, transportation, nutrition, and/or community resources

How can a care manager help?

As an extension of your care team, we provide personalized guidance and resources to help you:

- Understand your health conditions
- Follow your treatment plan
- Understand your medications
- Improve the quality of your life and be as healthy as possible

What care management services does Martin's Point offer?

Chronic Care Management: A nurse care manager helps you learn about your chronic conditions and build skills to proactively manage your health. They review medications, help coordinate your care, and find helpful community resources.

Transitions of Care: A nurse or social work care manager may follow up with you after you go home from a hospital or rehabilitation stay. They provide education, review your treatment plan and medications, and help coordinate follow-up care and services.

Behavioral Health: A social work care manager provides support to you, your family, and/or caregivers. They help connect you with new behavioral health providers, coordinate care with providers, and assist with finding community resources.

Maternity Support: A nurse care manager works with you during pregnancy and after delivery to help you know what to expect, answer questions, and provide support. They help coordinate care with providers and identify community resources. Sign up at any time during your pregnancy.

Wellness Coaching: A care manager will work with you to help manage weight, cholesterol, or blood pressure, start an exercise program, stop smoking, or manage stress levels.

To participate in or learn more about our care management programs, please call **1-800-574-8494, (TTY: 711) option 1.**

24-Hour Nurse Line

You can speak to a registered nurse for free 24 hours a day, 7 days a week—the Nurse Line is toll free at 1-800-574-8494 Option #2 (TTY: 711).

US Family Health Plan Special Programs

The Department of Defense/National Cancer Institute (DoD/NCI) Cancer Prevention and Treatment Clinical Trials Program

To offer TRICARE beneficiaries and the health professionals who care for them the latest in both cancer preventive care and treatment, the Department of Defense joined forces with the National Cancer Institute (NCI) and created an interagency agreement, known as the DoD/NCI Cancer Clinical Trials Demonstration Project. Under this agreement, beneficiaries may be able to participate in approved NCI-sponsored cancer prevention and treatment studies as part of their TRICARE health care benefits. As a US Family Health Plan member, you may be able to participate in this program, which provides coverage for certain types of clinical trials and studies.

NOTE: *Before agreeing to participate in ANY clinical trial, study, or experimental or investigational treatment, call Member Services, toll-free, at 1-888-674-8734 (TTY: 711) to determine coverage.*

Extended Care Health Option (ECHO) Program

The US Family Health Plan authorizes and coordinates services for active-duty family members who qualify for the ECHO Program. The ECHO Program provides financial assistance to reduce the effects of intellectual disability or a serious physical disability. Prior authorization may be required for treatment proposed under a clinical trial.

Beneficiaries must enroll in the Exceptional Family Member Program through their service member's branch of service in order to retain extended health care benefits. For more information, please contact Member Services,

which will refer you to Care Management, toll-free, at **1-888-674-8734 (TTY: 711)**.

Covered Services Needing Additional Explanation

The following services are covered by the US Family Health Plan but warrant some additional explanation. All services must be referred by your PCP, and many services require medical review and a preauthorization letter from the US Family Health Plan prior to receiving the service. If you have any questions regarding these benefits, please call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Dental Care in Support of a Medical Condition

The US Family Health Plan coverage for dental services is very limited. Dental services and oral surgery require both a referral from your PCP and preauthorization by the US Family Health Plan. Medical review is required for all PCP-referred dental or oral surgery services. Prescriptions for dental or oral surgery services are only covered for authorized services. As of the date of publication of this Member Handbook, dental care for military retirees and their family members is provided by FEDVIP.

Durable Medical Equipment and Medical Supplies

- Rental or purchase of medically necessary durable medical equipment is usually covered when ordered by your PCP.
- Beneficiaries are responsible for any applicable copayments.
- Durable medical equipment includes, but is not limited to, hospital beds, wheelchairs, and walkers.

- Some durable medical equipment requires preauthorization by the US Family Health Plan, and not all durable medical equipment is covered under the Plan.
- TRICARE does not cover shoes or shoe inserts, except when a required part of a brace, or when used in special shoes to treat complications of diabetes. Supportive devices for the feet, such as heel lifts, are covered by TRICARE only in very limited circumstances.
- Costs for durable medical equipment products that require preauthorization by the US Family Health Plan that are obtained without preauthorization will be the responsibility of the beneficiary.
- Medical supplies may only be covered when related directly to a covered medical condition and supplied by an in-network provider.

Family Planning/Infertility Services

The US Family Health Plan covers the following:

- Intrauterine devices (IUDs)
- Contraceptive implants (e.g. Norplant®)
- Diaphragms (as well as the measurement for them)
- Birth control pills prescribed by a physician
- Pregnancy tests performed in a provider's office/facility
- Sterilization procedures (including tubal ligation and vasectomy)
- Covered surgical treatments for a diagnosis of infertility

The US Family Health Plan does not cover the following:

- Over-the-counter contraceptives
- Surgery to reverse sterilization
- Assisted reproductive services that are not medically necessary

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- Unproven procedures, services, supplies, and medications

For more specific information, please contact Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Home Health Care

Prior to receiving home health services, a doctor must certify that you need such services and they will order these services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Patients must meet all applicable TRICARE requirements for homebound status to be eligible for home health benefits.

The US Family Health Plan covers medically necessary home health care, including:

- Durable medical equipment (DME), such as wheelchairs, hospital beds, oxygen, and respirators, when arranged and approved by the US Family Health Plan
- Home physical therapy, speech therapy, and occupational therapy for short, defined periods where significant improvement can be expected

NOTE: *Home health care is covered only when such care is medically necessary, and authorized by the US Family Health Plan. It is limited to skilled services. Assistance with the ordinary activities of daily living is not covered.*

Hospice

Hospice care is a program that provides an integrated set of services and supplies designated to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home health care. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients. **Note:** *Eligibility*

determination and referrals to approved hospice care providers are made by PCPs or specialists using established medical criteria and require authorization.

Mental Health and Substance Abuse Services

The US Family Health Plan covers outpatient and inpatient care related to the treatment of diagnosed mental health or substance abuse conditions. The Behavioral HealthCare Program (BCHP) and its affiliated providers provide all mental health services to members of the US Family Health Plan.

You may have mental health and substance abuse visits with an in-network provider without a referral from your PCP. For assistance with your mental health benefits, a customer service representative can be reached by calling the Behavioral HealthCare Program, toll-free, **1-888-812-7335 (TTY: 711)**. For mental health or substance abuse emergencies or hospital admissions after hours, weekends, or holidays, please call, toll-free, 1-888-812-7335 (TTY: 711).

Because the US Family Health Plan is based on the TRICARE Prime universal benefit, there are some limitations to the mental health and substance abuse benefit. For additional information about the mental health benefit or to obtain names of in-network mental health professionals, please contact the Behavioral HealthCare Program, toll-free, at 1-888-812-7335 (TTY: 711).

Obesity Treatment

The following types of surgical treatment for obesity are covered when medically necessary: gastric bypass, gastric stapling, gastroplasty, gastric banding, and sleeve gastrectomy. All treatments require medical review and must be preauthorized by the US Family Health Plan. Consultation visits to in-network specialists for consideration of covered obesity treatments do not require preauthorization by the US Family Health Plan but do require a

referral from your PCP. Prescription medications for the treatment of obesity may be covered, but may require authorization. Nutritional counseling for obesity may be covered when certain criteria are met.

Skilled Nursing Care

The US Family Health Plan covers inpatient skilled nursing care in an accredited, contracted skilled nursing facility (SNF) when it is medically necessary. Coverage includes:

- Bed, board, and skilled nursing services in a subacute or rehabilitation facility
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the facility when authorized
- Other medically necessary treatments and services deemed appropriate

NOTE: *Custodial care is not a covered benefit. Custodial care is defined as treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that:*

- *Can be rendered safely and reasonably by a person who is not medically skilled*
- *Are designed mainly to help the patient with the activities of daily living, also known as “essentials of daily living”*

Preventive Care

Here are some covered preventive services; this is not an all-inclusive list. Age and diagnosis criteria/restrictions may apply.

- Annual Physical—an annual physical with an in-network provider. (See Point of Service section.)
- Annual Eye Exam—every 12 months with a participating provider
- Blood Pressure Screening
- Cancer Screenings
- Cervical Cancer Screening—annual PAP test and human papillomavirus (HPV) testing
- Prostate Cancer Screening—annual
- Breast Cancer Screening—breast exams, mammogram (3D mammograms—age and medical criteria may apply) and breast magnetic resonance imaging (MRI)
- Colorectal Cancer Screening—colonoscopy (virtual colonoscopy is generally NOT included)
- Cardiovascular Screening—including echocardiogram and abdominal aortic aneurysm Screening
- Cholesterol Testing
- Hearing Exams—NOT hearing aid exams
- Hepatitis B and C Screening
- Tuberculosis Screening
- Vaccines/Immunizations—(not covered for elective travel)—including human papillomavirus (HPV) vaccine
- Well Woman Exams

Emergency Care

For a life-threatening medical emergency, call 911 or go to the nearest emergency room (ER) immediately. You do not need a referral for emergency care.

An emergency is defined as “the onset of an illness or injury of such a nature that, without receiving prompt medical attention, it puts the beneficiary in jeopardy of sustaining serious impairment or dysfunction; or it presents a significant threat to the beneficiary’s continuing health.”

Examples of qualifying medical emergencies include, but are not limited to:

- Heart attacks and/or chest pains
- Strokes
- Uncontrollable bleeding
- Poisoning
- Severe allergic reactions
- Loss of consciousness
- Convulsions
- Severe motor vehicle accidents
- Sudden or severe breathing difficulty

At the time of the ER visit, retirees and family members of retirees will be asked to pay a copayment. If you are admitted as an inpatient, only the inpatient copayment applies. Active-duty family members and retirees with Medicare Part B pay no copayment for emergency room visits.

Your PCP will provide or coordinate your follow-up care, such as removal of stitches, X-rays, or checking a cast. **Do not return to the emergency room or see the attending physician for follow-up visits without a referral from your PCP and approval from the US Family Health Plan. If you do so, these services may be covered under your Point of Service option, at a higher cost to you.**

Urgent Care

Urgent care is defined as care for an illness or injury that is not immediately life-threatening but requires professional medical 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. You do not need a referral for urgent care.

Examples of an urgent medical situation include, but are not limited to:

- Sprains and broken bones
- Cuts needing stitches
- Common illnesses like urinary tract infections, conjunctivitis, strep throat, ear infections and prolonged common cold/flu symptoms

Out-of-Area Care

When you travel outside the US Family Health Plan service area, whether to go on vacation, attend college, or winter in a warmer climate, only qualified emergency and urgent care are covered. An exception would be care received using the Point of Service (POS) option. (See the “Point of Service” section below.)

Examples of care that will not be covered by the US Family Health Plan while out of the area include:

- Routine office visits and lab work
- Routine treatment for a chronic condition
- Equipment or supplies necessary to treat a chronic condition

Additionally, routine obstetrical care and inpatient labor and delivery services are not covered when a beneficiary chooses to travel outside the US Family Health Plan service area within 30 days of the infant’s expected due date.

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If you are out of the area, including travel outside the United States, and have a qualifying medical emergency, go immediately to the nearest emergency room. You must notify your PCP within 24 hours so that coordination of any necessary follow-up care can occur.

IMPORTANT NOTE ABOUT MEDICARE:

Beneficiaries who also carry Medicare Part B or an approved Medicare Advantage Plan should note that, although the US Family Health Plan cannot cover your routine nonemergency care outside our service area, you cannot use your Medicare to pay for care that is normally covered by the US Family Health Plan (or would be covered if you were in the service area). Intentional use of Medicare outside the US Family Health Plan service area for benefits that are covered by the US Family Health Plan is known as “Medicare Leakage.” Intentional Medicare Leakage results in automatic disenrollment from the US Family Health Plan.

Point of Service Option

THE POINT OF SERVICE OPTION—Choosing to use out-of-network providers when an in-network provider is available

The **Point of Service (POS)** option gives beneficiaries more flexibility to self-refer for medically necessary care. Under the POS option, beneficiaries **may choose** to get medically necessary care without a referral from their PCP, or from out-of-network providers/facilities, even when they can get those services from an in-network provider. **Your out-of-pocket costs will be much higher if you make the choice to use your POS option.**

Question: What are my costs under the POS option?

Answer: **Deductibles**— For outpatient services, you will pay a \$300 (individual) or \$600

(family) deductible before cost sharing begins. For authorized inpatient services, there is no deductible.

Cost shares—Once any applicable deductible is met, you will pay a **50% cost share** of the TRICARE Maximum-Allowable Charge (TMAC) per calendar year (January 1–December 31) for services rendered.

Additional charges—An out-of-network provider or a provider who does not accept Medicare or TRICARE may also bill you for an **additional 15%** over the TMAC.

Example of POS costs

Here is an example to show you how it works. This is a **generic** example, intended to show how out-of-pocket costs can add up when using the POS option. Your actual costs will vary depending on the service provided, etc. Member costs are shown in **bold**.

Provider charge (how much the doctor bills):
\$2,000

TRICARE Maximum-Allowable Charge (TMAC—the amount TRICARE allows us to pay): \$1,000

Outpatient service individual deductible (amount member pays out of pocket): **\$300**

Balance (the TMAC minus the member’s deductible): \$700

POS cost share: **\$350** (50% of \$700 balance)

Plan payment (what we pay): \$350 (50% of \$700 balance)

If provider “balance bills” member for the amount that TRICARE doesn’t cover: 15% of \$1000 = **\$150**

Total member out-of-pocket cost: \$800

Any deductibles or cost shares a member pays for services received through the POS option do **not** apply to the out-of-pocket maximum,

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or “catastrophic cap,” which means there is no maximum limit to these charges.

Per TRICARE, Point of Service determinations are **not** appealable.

The POS Option **does not** apply:

- To newborns and adopted children through the conditional 90 days or the effective date of enrollment, whichever is earlier
- To urgent and emergency care
- If you have other primary health insurance
- If the care being sought is not part of the TRICARE benefit or is determined not to be medically necessary

A directory of in-network health care providers and facilities is available online at MartinsPoint.org/USFHPDirectory. More information about your POS option is available online at: MartinsPoint.org/POSOption.

Please remember, the US Family Health Plan and the TRICARE Prime benefit are intended to help manage and provide continuity of your health care. If you seek care from an in-network provider, depending on your Plan, your out-of-pocket costs could be as low as \$0.

The POS option allows you the choice to seek care outside of the network, but you should be aware of the costs if you do so. If you have any questions, don't hesitate to call Member Services at 1-888-674-8734 (TTY: 711).

TRICARE Young Adult

The TRICARE Young Adult (TYA) program is a premium-based health care plan available for purchase by qualified dependents. TRICARE Young Adult Prime coverage is available for purchase from Martin's Point through the US Family Health Plan. TYA includes medical and pharmacy benefits, but excludes dental coverage.

Who Is Eligible

If you are an adult-aged dependent, you may purchase TYA coverage based on the eligibility established by your uniformed-service sponsor and where you live. (**NOTE: *Special eligibility conditions may exist.***) You may purchase TYA coverage if you are all of the following:

- A dependent of an eligible uniformed-service sponsor
- Unmarried
- At least age 21 (or 23 if previously enrolled in the US Family Health Plan or TRICARE Prime due to a full-time course of study at an approved institution of higher learning and if the sponsor provides at least 50% of your financial support), but have not yet reached age 26. Eligibility for TYA is determined by the branch of service.
- Not eligible to enroll in an employer-sponsored health plan as defined in TYA regulations
- Not otherwise eligible for TRICARE program coverage

Purchasing Coverage

TYA offers open enrollment, so, if you qualify, you may purchase coverage at any time.

The TRICARE Young Adult application is available at <https://martinspoint.org/explore-military-benefits/enrollment>. When applying, you must verify that you are not married and not eligible to

enroll in an employer-sponsored health plan. Your completed application must include the first two months of premium payments, paid by personal check, cashier's check, money order, or credit/debit card. After the initial two-month payment, premiums must be paid in advance by monthly automated payment.

Send your completed application and initial premium payment to:

Martin's Point Health Care
Attn: Enrollment
PO Box 9746
Portland, ME 04104

NOTE: *If you are not already in the Defense Enrollment Eligibility Reporting System (DEERS), your sponsor must add you to the system before starting the application process.*

Enrollment

After enrolling in TYA, you and your sponsor will need to visit a facility that issues uniformed-services identification (ID) cards to obtain an ID card for you. You must bring two forms of ID—one must be an unexpired government-issued ID card containing a picture. Coverage will begin the effective date of your eligibility.

Covered Services

TYA includes medical and pharmacy coverage, but excludes dental coverage. TYA is only available for individuals and is not offered as a family plan. For more information, visit <https://martinspoint.org/explore-military-benefits/usfhp-plans-and-benefits/tricare-young-adult-prime> or call 1-844-522-1412 (TTY: 711).

Ending Coverage

You may choose to end TYA coverage at any time by completing the fields related to terminating coverage on the TRICARE Young Adult application and submitting it to Martin's Point. If you decide to end TYA coverage, you will be locked out from purchasing TYA coverage for one year from the date of termination. There will be no lockout if the coverage is terminated because you gain access to employer-sponsored coverage.

Nonpayment

Your premium payment is due no later than the last day of the month for the next month's coverage. Per TRICARE policy, failure to pay total premium amounts due and any insufficient fund fees owed will result in a termination of coverage. A lockout for the remainder of the calendar year will go into effect.

Change in Status

Your sponsor must always report all family and status changes to DEERS. Your TYA eligibility ends when any of the following occurs:

- You reach age 26
- You get married
- You become eligible for an employer-sponsored health plan as defined in TYA regulations
- You gain other TRICARE coverage
- You lose eligibility because your sponsor ends TRICARE coverage

NOTE: You may not be automatically disenrolled. Please contact Member Services if any of the above are applicable.

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Health Care Benefits

The following chart provides a summary of your covered benefits and copayments/cost shares. See the "Limitations and Exclusions" section below for information about services/items that are not covered under the TRICARE benefit.

If applicable, copayments are due at the time you receive care or pick up prescriptions.

If you use the Martin's Point Mail-Order Pharmacy, your copayment is due when you order your prescription.

Summary of Your Health Care Benefits

NOTE: All fees and copayments/cost shares are subject to change by the Department of Defense.

	Active-Duty Family Members or Retirees and Family Members Who Also Carry Medicare Part B (including Medicare Advantage)	Retirees and Family Members Who Do Not Carry Medicare Part B
Out-of-Pocket Maximums (Catastrophic Cap) (per family)	\$1,000 (active-duty Group A) \$1,256 (active-duty Group B) \$3,000 (retiree with Medicare Part B)	\$3,000 (Group A) \$4,399 (Group B)
COVERED SERVICES	YOUR COST	YOUR COST
Allergy Shots	\$0	\$25 PCP visit \$38 Specialist visit
Annual Physical Examinations and Other Preventive Services (e.g., Pap smears, mammograms, and prostate screening)	\$0	\$0
Diagnostic Tests (e.g., lab work, X-rays, MRIs, CAT scans, PET scans, cardiac tests)	\$0	\$0
Durable Medical Equipment (e.g., wheelchair, walkers, canes)	\$0	20% of the fee negotiated by US Family Health Plan
Emergency Ambulance Services, including ground and air (Note: Benefit limitations apply.)	\$0	\$51: Ground ambulance \$20: Air ambulance
Emergency Room Visits	\$0	\$77 per visit (waived if admitted to the hospital)
Eye Examinations: Routine Annual (In-Network ONLY) Eye Examinations: Medical Reason	\$0 for routine annual visit \$0 for medical reason visit	\$0 for routine annual visit \$38 for medical reason visit
Home Health Care: Skilled nursing, occupational/physical therapy, speech therapy	\$0	\$0
Hospice	\$0	\$193 per admission
Inpatient (Hospitalization: Semi-private room, physician services, general nursing services, meals, drugs, labs, operating room & anesthesia services, diagnostic therapy, blood, etc.)	\$0	\$193 per admission
Maternity	\$0	Hospital: \$193 per admission Birthing Centers: \$77 Home Delivery: \$25 for PCP; \$38 for Specialist (ob/gyn)

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	Active-Duty Family Members or Retirees and Family Members Who Also Carry Medicare Part B (including Medicare Advantage)	Retirees and Family Members Who Do Not Carry Medicare Part B
Out-of-Pocket Maximums (Catastrophic Cap) (per family)	\$1,000 (active-duty Group A) \$1,256 (active-duty Group B) \$3,000 (retiree with Medicare Part B)	\$3,000 (Group A) \$4,399 (Group B)
COVERED SERVICES	YOUR COST	YOUR COST
Medical Supplies (e.g., wound care supplies) (Note: Over-the-counter supplies such as band-aids, saline solution, etc. are not covered.)	\$0	20% cost share
Mental Health: Inpatient	\$0	\$193 per admission
Mental Health: Outpatient	\$0	\$25 per PCP visit \$38 per Specialist visit
Mental Health: Partial hospitalization (up to 60 days per enrollment year)	\$0	\$25 per day by PCP \$38 per day by Specialist
Oncology Treatments (e.g., chemotherapy, radiation treatments, office visits)	\$0	\$38 per visit
Outpatient/Day Surgery (including anesthesia)	\$0	\$77 per procedure
Physical Therapy, Occupational Therapy, Speech Therapy, and Cardiac Rehabilitation	\$0	\$38 per visit
Primary Care Provider Office Visits	\$0	\$25 per visit
Skilled Nursing Facility (rehabilitative facility): Semi-private room, nursing services, meals/special diets, rehabilitative therapies, drugs, supplies, and appliances furnished by the facility (Note: Long-term care and custodial care are NOT covered.)	\$0	\$38 per day
Specialist Office Visits	\$0	\$38 per visit
Substance Abuse Treatment: Inpatient rehabilitation	\$0	\$193 per admission
Substance Abuse Treatment: Inpatient services	\$0	\$193 per admission
Substance Abuse Treatment: Outpatient	\$0	\$25 per PCP visit \$38 per Specialist visit
Urgent Care (Walk-In Clinic)	\$0	\$38 per visit
Vaccinations/Immunizations (Note: These are NOT covered for elective travel.)	\$0	\$0
Well Baby/Well Child Care (including child immunizations)	\$0	\$0

Note: Benefits/costs are subject to change by the Department of Defense. This chart is only a guide. Questions about benefits/costs? Call Member Services at **1-888-674-8734 (TTY: 711)**.

Group A: Sponsor's initial enlistment or appointment occurred before January 1, 2018.

Group B: Sponsor's initial enlistment or appointment occurred on or after January 1, 2018

Prescription Drug Benefit

Martin's Point Mail-Order Pharmacy

Refills for maintenance medications should be obtained through the Martin's Point Mail-Order Pharmacy. Using the Martin's Point Mail-Order Pharmacy can save you time and money. Benefits include:

- Convenient delivery to your home or other temporary address (**Note:** *Some restrictions apply.*)
- Savings of from 66% to 100% on your prescription copayments over the network retail pharmacy (Note: All fees and copayments are subject to change by the Department of Defense.)
- Ability to order up to a 90-day supply, as prescribed (**Note:** *Some restrictions apply.*)
- Free shipping. Talk to your mail-order pharmacy representative to add an email address for shipping notifications.
- A 24-hour toll-free refill telephone line: **1-800-707-9853**
- Request a refill or check the status of a refill: MartinsPoint.org/USFHPRxRefill

You may send your prescriptions or refill information to the Martin's Point Mail-Order Pharmacy using the pharmacy mail-order form, or call the pharmacy, toll-free, at 1-800-707-9853 (TTY: 711) with your prescription refill requests. Within 14 days, you'll receive your medications at your door. Your only cost is the copayment (if one applies).

If you are taking "maintenance medications"—prescription medications on an ongoing basis (such as those for high blood pressure, high cholesterol, diabetes, depression, hormone replacement, or birth control)—we require that you use a the Martin's Point Mail-Order Pharmacy. The Martin's Point Mail-Order Pharmacy is not

intended to be used for acute medications, (short-term medications that you need to begin taking immediately) such as antibiotics. Please allow up to 14 days to receive your order. If you are taking a medication for the first time, you are limited to a 30-day supply. This enables you and your physician to determine whether this medication will have the desired effect and is appropriate for long-term use.

Prescription Drugs Received at a Network Retail Pharmacy

Your pharmacy benefit covers certain prescription drugs filled at network retail pharmacies when prescribed by an authorized US Family Health Plan provider. The copayment fee is per prescription, for up to a 30-day supply or up to the quantity prescribed by the physician, whichever is smaller. Please refer to the Provider Directory on the Caremark website. You may also search for an in-network pharmacy at our website: <https://martinspoint.org/for-membersand-patients/for-us-family-health-planmembers/understand-your-coverage>. Then click "Retail Pharmacy Search" in the right column.

Urgent, One-Time, and Acute-Need Prescriptions

Your prescription drug benefit allows you to use our retail pharmacy network by presenting your US Family Health Plan Member ID Card at participating retail pharmacies for the following reasons:

- One-time and acute-need prescriptions requiring no refills (e.g., antibiotic medications)
- Prescription medications that your doctor requires you to start taking immediately

NOTE: Prescriptions written by dental providers (e.g., DDS, DMD) are not covered unless the associated procedure has been preauthorized by the US Family Health Plan.

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Please remember the following about your network retail pharmacy benefit:

- The prescription drug benefit is only honored at in-network retail pharmacies.
- There is a one-time fill limit for maintenance medications. Maintenance medications are those medications taken regularly to treat a chronic condition, such as high blood pressure, ulcers, or diabetes.
- Maintenance medication refills must be obtained through the Martin's Point Mail-Order Pharmacy.

Quantity Limits

The US Family Health Plan does place quantity limits on some medications. A quantity limit is the maximum-allowable quantity of a drug that may be dispensed in a given time period. Please contact the Martin's Point Mail-Order Pharmacy, toll-free, at 1-800-707-9853 (TTY: 711) for more information.

Generic-Drug Policy

Your prescription drug benefit is a generic-based program. When your provider writes a prescription for a brand-name product for which an FDA-approved generic is available, the prescription will be dispensed with the generic equivalent. If you specifically request a brand-name product when an FDA-approved generic is available, you will be responsible for the full retail cost of the drug.

Generic products dispensed through the pharmacy program are required to have an "A" rating. This means the generic must be both pharmaceutically equivalent (have the same active ingredients in the same dosage form) and therapeutically equivalent (expected to have the same clinical effect and safety profile).

Preferred-Drug Program

The Department of Defense occasionally solicits requests for sole-source drug contracts within a therapeutic class (e.g., cholesterol-lowering agents, acid reducers). When awarded, these drugs become "preferred" drugs.

When a prescription is submitted for a non-"preferred" drug, your physician will be contacted to request a change to a "preferred" drug. If your physician agrees that the "preferred" drug is clinically appropriate, your prescription will be changed to the "preferred" alternative drug.

Payment for Your Medication

- Your copayment is due at the time you order your prescription.
- You may pay by check or money order, or you may authorize billing to your MasterCard, VISA, Discover, or American Express credit card.

Remember, if your physician orders a prescription that will be mailed to you, it is your responsibility to contact the Martin's Point Mail-Order Pharmacy to indicate how payment will be made. Failure to do this will result in a delay in the processing and mailing of your prescription and may result in your needing to obtain a 30-day prescription at a participating network pharmacy at the brand-name or generic copayment.

Coordination of Benefits (COB) for Prescriptions

When you or your covered family members have other health insurance that covers prescriptions, and if the US Family Health Plan recovers any payment from another health insurance plan, we may be able to apply this payment toward all or part of your US Family Health Plan copayment. **(Note: For more information, please refer to the "Coordination of Benefits" section below.)**

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Points to Remember

- Your copayment will be refunded if payment received from your other health insurance plan exceeds your US Family Health Plan prescription copayment.
- If your other insurance prescription copayment equals the retail charge of the medication, the US Family Health Plan will not receive any payment or reimbursement from your other health insurance. Therefore, you will be responsible for paying a copayment (i.e., either your other health insurance copayment or the US Family Health Plan copayment, whichever is less).
- If a deductible needs to be met before your other prescription insurance takes effect, you are responsible for the US Family Health Plan copayment until the US Family Health Plan recovers any payment from your other prescription insurance plan.
- Some insurance prescription plans may limit the supply they will pay for (e.g., a 30-day supply). In this case, in order to refund any copayment associated with the prescription, the pharmacy is required to dispense a 30-day supply of medication. If a deductible has to be met, you will be required to pay your US Family Health Plan copayment for each 30-day supply of medication.
- Your US Family Health Plan pharmacy copayment may be refunded only if your other health insurance is through a third-party prescription card (e.g., Anthem, PCS, Medco-Health). If you have one of these types of drug benefits, let the participating pharmacy know. You will be required to pay the prescription card copayment and then to submit a copy of the receipt plus a copy of your prescription card to the US Family Health Plan for reimbursement. Once we receive the information, your copayment will be refunded as appropriate.

Prescription Drug Limitations/Exclusions

The US Family Health Plan does not cover:

- Drugs not requiring a prescription or over-the-counter items (Over-the-counter drugs, such as insulin, omeprazole, and loratadine, are covered with a prescription.):
 - » All smoking-cessation products are only covered at the Martin's Point Mail-Order Pharmacy.
- Drugs used for cosmetic reasons (e.g., Propecia[®], Renova[®], Rogaine[®], Vaniqa[®])
- Medical supplies (e.g., dressing and antiseptics)
- Homeopathic and herbal preparations
- Food supplements or medical foods
- Experimental drugs (i.e., drugs that cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of their use or proposed use)
- Prescription drugs prescribed for an off-label use that is not generally accepted by the medical community
- Any prescriptions refilled before the previous refill is 80% used
- Prescriptions filled at out-of-network pharmacies, except when part of an emergency treatment
- Prescriptions associated with noncovered TRICARE benefits or nonapproved services

Limitations and Exclusions

It is your PCP's role to refer you for care that they determine to be medically necessary. Please be aware that it is your responsibility to make certain that the care, treatment, diagnostic testing, equipment, supplies, medications, or programs that your PCP refers you for are covered by the US Family Health Plan.

As with most health insurance plans, not all care, treatment, diagnostic testing, equipment, supplies, medications, and programs are covered, even if they are determined to be medically necessary by your PCP or an approved specialist. Examples include vitamins, orthodontics, and chiropractic care. To determine if the care that your PCP refers you for is a covered benefit under the US Family Health Plan, please call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Review of New Technology

The Martin's Point US Family Health Plan reviews TRICARE coverage policy and all regulatory-change-related correspondence on a regular basis. If new products, services, or drugs are added, we are notified by TRICARE. As a health plan with a Department of Defense contract, we are required to provide the same benefits as TRICARE Prime. If we propose to provide additional benefits, we must ensure they meet the criteria specified by TRICARE.

When deciding whether or not to cover a new medical service, both TRICARE and Martin's Point use medical experts to review scientific evidence and information from US government regulators to determine whether the proposed new treatment has been approved as safe and effective in the United States, improves health outcomes as much or more than existing treatments, and can be safely performed outside the research setting.

Services Not Covered Under the US Family Health Plan

General Exclusions

The US Family Health Plan does not provide coverage for:

- Services related to non-covered benefits, e.g., administration of a non-covered drug
- Services provided and charges incurred prior to the effective date of coverage as a member of the US Family Health Plan
- Services provided and charges incurred after the termination date of coverage as a member of the US Family Health Plan
- Care or treatment for conditions that are results of any illegal activity (for example, injuries incurred by a perpetrator who commits any crime, including assault, driving under the influence, and arson)
- Charges or services for which you are not legally required to pay
- Services provided by relatives (by blood, marriage, or legal adoption) or by people ordinarily residing in your household
- Services not referred by and drugs not prescribed by your PCP or the specialist to whom you were referred and authorized to see
- Services not considered medically necessary for your diagnosis and treatment
- Unproven treatments, except Department of Defense (DoD)/National Cancer Institute (NCI) Cancer Prevention and Treatment Clinical Trials Demonstration
- Any mental health or substance abuse services denied or not authorized (if authorization is required) by the Behavioral HealthCare Program.
- Any services provided for employment, licensing, paternity determination, immigration, elective travel, or other administrative reasons (for example, school or college programs)
- Complications due to a treatment or service not covered by the US Family Health Plan (for example, complications resulting from a noncovered plastic surgery procedure or from LASIK surgery.)

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Some Specific Exclusions

- Arch supports
- Acupuncture and acupressure
- Autopsy and postmortem service
- Chiropractic services
- Clinical trials for any diagnosis or medical condition (**Note:** Members with cancer may be eligible for Phase II and Phase III clinical trials sponsored by the National Cancer Institute. For more information, please contact Member Services, toll-free, at **1-888-674-8734, TTY: 711**).
- Cosmetic, plastic, and reconstructive surgery not related to a covered medical condition
- Custodial and long-term care
- Electrolysis
- Exercise equipment, spas, hot tubs, and swimming pools
- Eyeglasses and contact lenses (except for treatment of infantile glaucoma, keratoconus, and other limited medical conditions)
- Foot care (routine), except in connection with systemic diseases affecting the lower extremities
- Foot orthotics (**Note:** Other orthotics may be covered with a qualifying medical condition but require medical review by the US Family Health Plan, as some restrictions apply.)
- Hair transplants
- Homeopathic treatment
- Immunizations and prescribed medications for elective travel
- Massage therapy
- Megavitamins or orthomolecular psychiatric therapy
- Naturopathic services
- Orthodontics
- Orthopedic shoes (covered for diabetics only)
- Over-the-counter drugs or vitamins (except insulin)
- Private hospital rooms (except when medically necessary)
- Radial keratotomy
- Respite care (except as covered under Hospice or ECHO benefits)
- Retirement homes
- Sterilization reversals
- Therapeutic shoes (**Note:** Therapeutic shoes for diabetics may be covered but require medical review by the US Family Health Plan, as some restrictions apply.)
- Transportation for convenience (e.g., including, but not limited to, ambulance transportation home from a facility)
- Treatments for learning disabilities
- Physical exams for employment

This is not an all-inclusive list. Please contact Member Services, toll-free, at **1-888-674-8734 (TTY: 711)** if you have questions about a specific procedure or treatment not listed.

Enrollment Information

All family members are not required to enroll in the US Family Health Plan.

Enrollment Eligibility

To enroll in the US Family Health Plan, you must be an eligible beneficiary of the Military Health System (MHS) and you must also live within the service area of the US Family Health Plan. The service area is determined by ZIP codes.

If you are registered with the Defense Enrollment Eligibility Reporting System (DEERS) and you fit into one of the following categories, you are eligible to enroll in the Plan:

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- Active-duty family members, including spouses and unmarried dependent children (until their 21st birthday, or, if they are full-time students, until their 23rd birthday)
- Retirees, their spouses, and unmarried dependent children (until their 21st birthday, or, if they are full-time students, until their 23rd birthday); unmarried dependent children may be eligible for the TRICARE Young Adult Program after they lose their eligibility for the US Family Health Plan. **(Note: Effective October 1, 2012, anyone who is turning 65 and eligible for Medicare will not be able to enroll in the US Family Health Plan.)**
- Eligible former spouses of active-duty or retired service members who are not remarried
- Survivors of active-duty or retired service members who are not remarried
- National Oceanic Services (NOS) members who retired prior to July 19, 1963, or who have had continuous service since before that date, and their family members
- Retired lighthouse keepers and their family members

Active-duty members of the uniformed services, even if they live in the US Family Health Plan service area, cannot enroll in the US Family Health Plan because they receive services from the military directly. However, the Transitional Assistance Management Program (TAMP) is a special medical entitlement program for certain active-duty military personnel who are involuntarily separated from active duty or for reservists who were on active duty during special contingency operations such as Desert Storm and Operation Joint Endeavor/Operation Iraqi Freedom.

TAMP provides qualifying active-duty personnel and reservists and their family members with full TRICARE benefit including the opportunity to enroll in the US Family Health Plan for a defined

length of time as determined by DEERS. While eligible for TAMP, the sponsor and his/her family members receive the same TRICARE benefit as the US Family Health Plan active-duty benefit. For more information about TAMP and the US Family Health Plan, call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Enrollment Periods

Enrollment in the US Family Health Plan can take place during an annual open enrollment period or after a Qualifying Life Event (QLE) occurs.

Annual Open Enrollment Periods

Open Season—the annual open enrollment period during which any eligible beneficiary may enroll—runs each year from the Monday of the second full week in November to the Monday of the second full week in December. Coverage becomes effective on January 1 of the following year.

Qualifying Life Events (QLEs)

Enrollment is also available if your family has a Qualifying Life Event (QLE). When certain life changes (QLEs) occur for you or your family, you may have the opportunity to change your TRICARE coverage. Depending on your eligibility, a QLE may allow you to enroll in a new TRICARE plan or change your coverage options. If one member in a sponsor's family experiences a QLE, all eligible family members may change their enrollment status during the QLE period.

If you want to enroll in or change your plan after a QLE, you must:

- Make the enrollment changes within 90 days following the QLE
- Pay any enrollment fees or premiums due during that period

QLEs include both family- and military-related changes, including the following:

FAMILY CHANGES—Marriage, divorce, having a baby or adopting, children going to college,

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children becoming adults, becoming Medicare eligible, death in the family, and loss or gain of other insurance

MILITARY CHANGES—Activating, deactivating, deploying, becoming injured on active duty, moving, separating from active duty, and retiring

For more information about QLEs, visit <https://tricare.mil/lifeevents>.

For more information about changes in enrollment due to a QLE, see the “Changes in Enrollment” section below.

Effective Date of Coverage

The effective date of coverage for enrollments made during the annual open enrollment period is January 1 of the following year. The effective date of coverage for enrollments made after a Qualifying Life Event (QLE) is the date the QLE occurred. The effective date of coverage is listed on your US Family Health Plan Member ID Card.

Newborns

For a newborn's coverage to be effective from his or her **date of birth**, the following conditions must be met:

- Another family member must have been enrolled in the Martin's Point US Family Health Plan at the time of the baby's birth.
- Enrollment of your newborn requires **both a completed application and the registering of your child in DEERS within ninety (90) days of his or her date of birth**. Upon your request, your child will be Conditionally Enrolled for their first 90 days until these two conditions are met.
- Failure to meet both of these requirements within the ninety (90) days will result in the disenrollment of your newborn on the 91st day.

We strongly recommend that you fill out, print, and mail the **Enrollment Application (PDF)** found in

the “Enrollment” documents on the Martin's Point US Family Health Plan website or call Member Services at **1-844-522-1412 (TTY: 711)** for assistance with enrolling your newborn.

IMPORTANT: The Beneficiary Web Enrollment (BWE) system, accessible through the TRICARE website, **does not recognize** newborn status and, therefore, will not retroactively enroll your newborn back to his or her date of birth.

If an enrolled member does not want their newborn enrolled in the US Family Health Plan, the member should notify the US Family Health Plan as soon as possible following the birth so that the US Family Health Plan can make note of this in case claims are received from providers.

Costs for services provided to an infant who is not enrolled in the US Family Health Plan within 90 days of his/her date of birth are not the responsibility of the US Family Health Plan. Additionally, the US Family Health Plan does not cover dependents of dependents (e.g., a grandchild).

An Important Note about TRICARE Program Information

At the time of printing, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Change to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact Martin's Point.

Enrollment Fees

There are no enrollment fees for active-duty family members or for beneficiaries who carry Medicare Part B. However, the TRICARE Prime benefit program requires annual enrollment fees for

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retirees, survivors, and family members of military retirees who do not participate in Medicare Part B.

In the initial year of enrollment, new members must pay either the full annual fee or the first quarterly installment of the annual fee at the time of enrollment. Failure to pay the enrollment fee terminates further processing of the enrollment application.

Subsequent quarterly installments are due by the first day of each new quarter. Failure to pay the quarterly installment within 30 days of the due date results in immediate disenrollment from the US Family Health Plan. Members who are disenrolled from the US Family Health Plan for nonpayment are restricted from reenrolling into the US Family Health Plan or any other TRICARE Prime program for the remainder of the calendar year.

The payment options for the enrollment fee are:

- Annual payment—one lump sum paid **only** with a credit or debit card
- Quarterly payment—four equal payments prorated to cover the period until the next calendar quarter for the initial payment and quarterly thereafter (calendar quarters begin on January 1, April 1, July 1, and October 1) also paid **only** using a credit or debit card
- Monthly payment—twelve equal payments paid through an automated, recurring electronic payment either in the form of:
 - » A monthly allotment from military retirement pay; or
 - » A monthly Electronic Funds Transfer (EFTs) from your designated financial institution (which may also include a recurring credit or debit card charge); or
 - » A monthly credit or debit card payment

These are the only acceptable payment methods for the monthly payment option.

To set up an automatic charge to your credit card or bank account, please contact Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Changes of Enrollment

If there are any additions to your family, changes in personal information, or if someone leaves the family through divorce or by death, please update DEERS immediately by contacting your closest RAPIDS office and then let us know by calling Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**. If a new person enters the family, whether by marriage, birth, or adoption, and you wish to enroll him or her in the US Family Health Plan, a completed application must be submitted.

Changes to Your Address

Please let us know if your mailing address within our service area changes for any reason, such as moving to base housing, moving to a new street or town, or acquiring a new street name due to 911 enhancement.

Moving Out of the Service Area

If you move out of our service area, you are no longer eligible for membership in the US Family Health Plan. However, you may be eligible for membership in another TRICARE Prime program. Call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)** before you move and they will explain how to transfer your membership. Please note that eligible students who temporarily move out of the service area can stay enrolled in the US Family Health Plan; however, only qualified emergency care and urgent care is covered while temporarily residing outside of the service area.

If TRICARE Prime is available in your new location, visit the military treatment facility or the local Managed Care Support Contractor and request to transfer into its program. You will be asked to complete an application or official transfer request form, depending on the transfer process

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established by the local TRICARE Prime contractor. The new contractor is responsible for contacting the US Family Health Plan to get your membership transferred. You actually become a member of the TRICARE Prime program in your new location on the day that the servicing contractor receives your application or transfer request form. The US Family Health Plan is obligated to retroactively disenroll you effective midnight the day prior to the effective date of membership in your new TRICARE Prime program. You will have no break in coverage.

Portable Transfer of TRICARE Prime Enrollment to the US Family Health Plan

Members of any TRICARE Prime program who move into the US Family Health Plan service area or who already live within our service area may request transfer of their membership into the US Family Health Plan.

The effective date of coverage by the US Family Health Plan is the actual date that we receive a completed application.

The losing contractor is obligated to retroactively disenroll you effective midnight the day prior to the effective date of membership in the US Family Health Plan. You will have no break in coverage.

Disenrollment

As a member of the US Family Health Plan, you will stay enrolled unless your eligibility changes or you elect to disenroll during your annual re-enrollment period. **Important: If your membership with the US Family Health Plan began on or after October 1, 2012, you will be disenrolled from the plan the last day of the month preceding the month of your 65th birthday.**

If you disenroll or become ineligible for the US Family Health Plan, your coverage ends on the earliest of the following days:

- At midnight on the date you cease to be an eligible beneficiary, including when you move out of the area
- At midnight on the date it is determined that you provided false information to us or permitted someone else to do so
- At midnight on the date all coverage or certain benefits are terminated by modifications of the US Family Health Plan
- At midnight on the date the US Family Health Plan is terminated or amended to terminate coverage with you
- At midnight on the date of death

If you are an inpatient on the date that your coverage is scheduled to end, coverage will continue until the date of your discharge from the hospital.

NOTE: *Please be aware that the US Family Health Plan will not be responsible for charges associated with any service that you receive, including prescriptions, effective midnight of the date of your disenrollment. This is also true for retroactive disenrollments.*

Early Disenrollment

Though a member may request early disenrollment, it is important to understand that there is a moratorium for reenrollment into the US Family Health Plan or any other TRICARE Prime program. Members who disenroll before the completion of the 12-month enrollment period may not reenroll in any other TRICARE Prime program until an open enrollment period or a Qualifying Life Event (QLE) occurs. For appeals information, call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Automatic Disenrollment

Members may be automatically disenrolled in any of the following situations:

- Move out of the service area

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- Intentional use of Medicare/Medicare Advantage plan for benefits covered by the US Family Health Plan
- Intentional use of Medicare for benefits covered by the US Family Health Plan, (see “Medicare Leakage” section below)
- Nonpayment of enrollment fees
- Loss of eligibility for military health benefits
- Lapse of Military ID Card and notification from the Department of Defense to disenroll
(Note: Reenrollment without break in coverage will occur when the US Family Health Plan can verify that the Military ID Card has been reissued within 30 days of the effective date of disenrollment. Your coverage status can be verbally verified by calling Member Services, toll-free, at 1-888-674-8734, TTY: 711.)
- Members diagnosed with end-stage renal disease (ESRD) who also do not carry Medicare Part B will be responsible for all ESRD claims after the initial 90 days of dialysis treatment
- Members who enrolled in the plan on or after October 1, 2012, will be disenrolled the last day of the month preceding their 65th birthday.

Notification of Disenrollment

Upon disenrollment from the US Family Health Plan, you will receive a Disenrollment Letter from us. It is the member’s responsibility to notify the US Family Health Plan, within 30 days of receipt of the letter, if you feel you were disenrolled in error.

What More Should You Know About This Plan?

Exchange of Benefits

Being a member of the US Family Health Plan affects your entitlement to use other government-sponsored health care programs. By enrolling in

the US Family Health Plan, you agree to exchange certain entitlements for US Family Health Plan membership entitlements. As such, you agree not to use the following health care benefits:

- Medicare Part A or Medicare Part B (except for services not routinely covered by the US Family Health Plan, such as chiropractic care)
- TRICARE Select, TRICARE-for-Life (TFL), and other TRICARE Prime programs
- TRICARE Mail-Order Pharmacy
- Military treatment facilities, unless one of the following occurs:
 - » If you experience an emergency and the nearest emergency room is in the military treatment facility
 - » On a space-available basis, you seek services offered by a military treatment facility that are not covered by the US Family Health Plan, such as routine hearing tests

Medicare Parts A and B

Membership in the US Family Health Plan will not cause you to lose your Medicare entitlements. You should pay your monthly Medicare Part B premium; however, you may not use Medicare except in a couple of very specific situations:

- For services that are not covered by the US Family Health Plan, such as chiropractic care
- If you have been diagnosed with end-stage renal disease (ESRD)

When you enroll in Medicare Part B, submit a copy of your Medicare card to the US Family Health Plan. At that time, we will waive your enrollment fees and all copayments, except your prescription copayments.

Important: *If you enrolled in the US Family Health Plan on or after October 1, 2012:* You will be disenrolled when you become eligible for

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Medicare. This will be on the last day of the month that precedes your 65th birthday.

NOTE: *If you were born on the first day of a month: You will be automatically disenrolled from the US Family Health Plan the last day of the month that is two months prior to your birthday. Example: If your birthday is November 1, you will be automatically disenrolled from the US Family Health Plan on September 30. Your Medicare coverage would begin October 1.*

NOTE: *If you enrolled in the US Family Health Plan **prior to October 1, 2012**, and turn 65 or are eligible for Medicare Parts A and B for disability reasons: You are not required to enroll in Medicare Part B when you become eligible. TRICARE rules require all beneficiaries eligible for Medicare Part B to enroll in Medicare Part B in order to retain TRICARE benefits. This is not a requirement for the US Family Health Plan; however, we strongly recommend that you enroll in Medicare Part B for the following reasons:*

- **Delay in Accessing Medicare Part B and TRICARE Benefits:** If you are ever disenrolled for any reason from the US Family Health Plan, you will not be able to access TRICARE benefits until you are enrolled in Medicare Part B. If you decline Medicare Part B when eligible, and then decide to enroll in the future, you will not be able to enroll until the General Enrollment Period. The General Enrollment Period for Medicare Part B is January through March each year, with medical insurance coverage (Medicare Part B) starting on July 1 of the year you sign up. You could be left without medical insurance coverage for an extended period of time, should you decide to disenroll from the US Family Health Plan.

Example: You decline automatic enrollment into Medicare Part B when you become eligible. You move to Florida in May and are disenrolled from the US Family Health Plan. You no longer have access to TRICARE benefits and determine

that you should enroll in Medicare Part B. You will not be able to enroll until the next General Enrollment Period, which begins in January and ends in March. Your effective date of Medicare B coverage would not begin until July. Your only coverage during that 15-month period is Medicare Part A.

- **Penalty in Medicare Part B Premiums:** If you decline Medicare Part B when you initially become eligible and decide to enroll at a later time, your Medicare Part B premium will increase by 10% for each 12-month period that you were originally eligible to enroll in Medicare Part B.

Example: You are 70 years old and have never enrolled in Medicare Part B. You decide you want to enroll in Medicare Part B in January. Your effective date with Medicare Part B will be July 1. Because you were eligible when you turned 65 but declined Medicare Part B, you will be responsible for paying a 10% penalty for each of the five years that you declined Medicare Part B. As such, your Medicare Part B premium will be 50% greater than the standard Medicare Part B premium amount (10% penalty each year x 5 years = 50% increase in your monthly Medicare Part B premium).

- **Limited Coverage for Long-Term Care Facility:** If you become a resident in a long-term care facility, you will no longer be eligible for the US Family Health Plan.
- **Without Medicare Part B, your coverage will be limited to Medicare Part A, until the time that your enrollment becomes effective with Medicare Part B. Without Medicare Part B, you will be responsible for the costs of medical services provided by physicians, labs, etc.**

NOTE: *If you have end-stage renal disease (ESRD), you must enroll in Medicare Part B to maintain your US Family Health Plan eligibility.*

Medicare Leakage

Medicare Leakage is the name given to the money that Medicare pays out when a member of the US Family Health Plan intentionally uses Medicare to pay for services that are routinely covered by the US Family Health Plan. When Medicare-eligible military beneficiaries enroll in the US Family Health Plan, they acknowledge that they may not use Medicare to pay for any health care service that, under normal circumstances, is covered and managed by their US Family Health Plan PCPs and our network of specialists. However, they may use Medicare to pay for services not covered by the US Family Health Plan, such as chiropractic services.

Our contract with the Department of Defense requires us to automatically disenroll members who intentionally use their Medicare for convenience or to obtain services denied as “covered but not medically necessary” by the US Family Health Plan. Members who are disenrolled because they elect to use Medicare rather than the US Family Health Plan cannot reenroll in the US Family Health Plan if over the age of 65. If you are under the age of 65 with Medicare, you may not reenroll until Open Season unless you have a qualifying life event.

State-Funded Insurance—Medicaid Combined with US Family Health Plan Coverage

If you have Medicaid, you cannot choose to use Medicaid first for your medical needs. By federal statute, the US Family Health Plan is your primary insurance carrier and must be billed prior to billing Medicaid for all medical claims.

This does not apply to pharmacy claims. Medicaid pays first on all pharmacy-related claims and US Family Health Plan pays second.

This may impact how and where you can fill your prescriptions. If you live in NH, VT, NY, or PA, you will be required by your state-funded Medicaid insurance to use a local retail pharmacy. US Family

Health Plan members are required to use our Mail-Order Pharmacy for maintenance medications, which means your pharmacy may receive a denial when they run the prescription through your Martin’s Point coverage. Please call Member Services at **1-888-674-8734, TTY: 711** to request a 12 month over ride on all of your maintenance medications which will allow them to be filled and covered at your local pharmacy.

Third-Party Liability and Subrogation

Third-party liability and subrogation is an attempt to recover cost that is paid for care incurred due to an accident or injury that someone else may be responsible for. Our contract with the Department of Defense requires that we assist them in trying to recover these costs.

Members of the US Family Health Plan who suffer an injury or accident that could possibly be covered by a third party (automobile, workers’ compensation, or home and business insurance) are required to complete a Statement of Personal Injury—Possible Third-Party Liability Form. This form will be mailed to you as soon as we are notified of an accident or injury. **(Note: A portion of the form will need to be filled out, even if there is no third-party liability involved.)**

All providers will be informed of the possible third-party involvement and instructed to bill the other insurance carrier for any claims related to the accident or injury until the medical allowance on the policy has been exhausted or until a denial has been received by the US Family Health Plan Claims Department. During this time we will either coordinate benefits with payments being made by the other payers or, if denied, we will pay according to the member’s benefits with the US Family Health Plan. (The provider has 120 days to submit claims to us after a claim has been denied by the other payer. All authorizations should be secured for services which require them in the event of a denial from the other payer.)

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It is the member's responsibility to inform his or her PCP and the US Family Health Plan about the accident and treatment (call Member Services, toll-free, at **1-888-674-8734, TTY: 711**). Failure to report this could result in loss of coverage for care related to this injury and possible disenrollment from the US Family Health Plan.

Private Commercial Health Insurance Plans and Coordination of Benefits (COB)

Some US Family Health Plan members also have private commercial health insurance plans. These other health insurance policies may be a benefit the sponsor earned while working in a civilian job, or the family may be covered under a spouse's/ sponsor's employee benefit plan. Regardless of the reason why someone has other health insurance, federal law requires that all health care providers bill commercial insurance first, as the patient's "primary payor," before billing any federally sponsored health care plan such as Medicare, Medicaid, TRICARE, or the US Family Health Plan. So, even though your health care services are managed by the US Family Health Plan, your PCP and the specialists to whom you are referred must bill your private commercial health insurance policy first.

To abide by this federal law, we are obligated to ask you about your other health insurance. We ask about other health insurance on the enrollment application and when you come in to see your doctor. We also periodically request verification of other health insurance through mailings and when you call Member Services. By collecting this information, the US Family Health Plan can coordinate the benefits of your private insurance policy with those of the US Family Health Plan. This is known as "coordination of benefits" or COB.

The COB provision does not deny or reduce any benefits to which you are entitled. It is intended to ensure that duplicate payments are not made.

All of the health care expenses covered by the US Family Health Plan are subject to this provision.

Collection of Primary Health Insurance Copayments

If you have other primary insurance that also has a copayment plan, the provider may collect the primary insurance copayment from you at the time of service. You are responsible for paying primary insurance copayments.

Medicare Advantage Plans as Other Health Insurance

Medicare Advantage plans are federally funded plans just like the US Family Health Plan—the difference is who is doing the funding. For the US Family Health Plan, the funding is provided by the Department of Defense. For a Medicare Advantage plan, the funding is provided by Medicare. **Because both programs are federally funded, beneficiaries cannot use their Medicare for services covered by the US Family Health Plan.**

Insurance Changes

It is the member's responsibility to inform the US Family Health Plan about any insurance changes for any member of the family enrolled with the US Family Health Plan. Up-to-date insurance information ensures proper payment of claims and prevents delays and/or reprocessing of claims due to incorrect or outdated information. Notification of any changes can be made by calling Member Services at **1-888-674-8734 (TTY: 711)**.

Processing Claims for Members with Other Primary Health Insurance

If you have other primary insurance, your provider is required to bill your primary insurance carrier first. The actual provider of care coordinates your benefits and bills the US Family Health Plan as your secondary payor. In processing those claims, a copayment will not be charged from the US

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Family Health Plan if your private commercial insurance pays charges for that date of service in an amount that is equal to or more than your applicable copayment. Cost shares will not apply if the other health insurance covered the service; this includes if no payment was made by the other health insurance, but the total allowed amount went to cost share (copay, coinsurance, and/or deductible). The US Family Health Plan needs a copy of the explanation of benefits (EOB) that your private insurance sends to the provider before the US Family Health Plan pays anything more to that provider. Any claim submitted to us as the secondary payor without this EOB will be denied.

Please note that federal law requires you to provide us with any information that will enable us to coordinate payment for your health care services with any other health insurance you may have. Remember that, if you have commercial health insurance, the commercial health insurance is your primary payor and must be billed first.

Please call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)** if you have any questions concerning other health insurance and its coordination with your US Family Health Plan benefit.

Catastrophic Loss Protection Benefit (Catastrophic Cap)

As a US Family Health Plan member, you have a catastrophic loss protection limit (or catastrophic cap) for your health care costs. This means there is a limit to your out-of-pocket expenses.

The catastrophic cap for active-duty families is \$1,000 for Group A and \$1,256 for Group B. The catastrophic cap is \$3,000 for retirees in Group A, and \$4,399 for retirees in Group B. Out-of-pocket expenses that contribute toward your cap include copayments (including pharmacy copays), premiums, and cost shares, excluding those incurred under the Point of Service option (see note below). Once your catastrophic cap has been

met, you and your covered family members will not have to pay any more out-of-pocket expenses for the remainder of the calendar year. **You will receive Member ID Cards that indicate “Max OOP” has been met with an end date of 12/31 of the current calendar year, once reported from DEERS.**

IMPORTANT NOTE: Point of Service (POS) Exclusion—Any deductibles or cost shares/balance bills a member pays for services received through the POS option do **not** count toward the catastrophic cap. Even if you reach your catastrophic cap for your other costs, you will still be responsible for any POS costs you and your covered family members incur. There is no maximum annual limit to these charges.

Balance Billing

Balance billing occurs when a health care provider (e.g., doctor, therapist, or laboratory) bills you for the balance of the amount not paid to them by the US Family Health Plan for the health care services you received. Since most of the health care services you receive are provided directly by an affiliated or contracted network provider, balance billing should not routinely occur. However, when you receive health care services from an out-of-network provider, such as emergency services out of the area, you risk being billed for the balance (“balance billed”) because we do not readily know whether or not the out-of-network provider is a TRICARE-participating provider.

Congress modified the TRICARE law to protect you from having to pay balance bills to non-TRICARE-participating providers for amounts greater than 115% of the TRICARE Maximum Allowable Charge (TMAC). When the US Family Health Plan receives a claim for services received outside the US Family Health Plan network, we pay that provider the TMAC rate (100% TMAC). Since many nonparticipating providers may be unfamiliar with the TRICARE law, they may not realize that

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they should not balance bill our members. The US Family Health Plan sends out an explanation of the TRICARE law to nonparticipating providers with our authorization letters. However, if you receive what appears to be a balance bill for more than your appropriate copayment, **do not ignore it**. Instead, we recommend you take the following actions:

- Call the provider's billing office immediately and request clarification of the charges on the bill.
- If the provider's office says it is your copayment, but the copayment does not match the appropriate copayment listed in the Summary of Benefits listed in this Member Handbook, advise them of the error.
- If they indicate that it is the balance of the amount that your insurance (the US Family Health Plan) did not pay, remind them that you are a member of a TRICARE Prime program and cannot, by law, be balance billed.
- If they insist that the US Family Health Plan has not paid the appropriate amount, take the name of the person with whom you spoke and call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**, for assistance.

We will research the claim payment and coordinate any further action that may be needed.

We strongly recommend that you use US Family Health Plan network providers for all services other than emergency care. However, if you must use an out-of-network provider for a non-emergency service, always ask up front if they participate in TRICARE. You stand a much greater chance of receiving a balance bill from a non-TRICARE-participating provider than you do from a TRICARE-participating provider. If they do not participate, always make sure that they are certified Medicare providers. Medicare providers can lose their certification if they continue to balance bill TRICARE Prime members.

Finally, reimbursement to you will be at the maximum amount allowed by TRICARE and not for the amount of the billed charges. You may use a TRICARE provider that does not participate with the US Family Health Plan for non-emergency care, but it will be covered at the Point of Service rate, which may result in a significant financial cost to you (see "Point of Service" section above). The US Family Health Plan will work with you and the out-of-network provider to ensure that you are reimbursed for all fees that you paid, except for applicable copayments.

Grievance (Feedback) and Appeals Process

Grievance (Feedback) Process

Martin's Point Health Care appreciates member feedback. We continually strive to improve the experience, care, and services that we provide to our members.

Any US Family Health Plan beneficiary, sponsor, parent, guardian, or other representative who is dissatisfied with personnel, service, or quality of care can offer feedback by contacting Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**. Every effort will be made to resolve the complaint to your satisfaction during your initial call. If your complaint is not resolved to your satisfaction, you may request a formal grievance be filed on your behalf.

A grievance may be submitted over the phone, in writing, or in person. Once received, the grievance will be documented in our customer feedback system and forwarded to our Service Excellence Department where it will be reviewed and researched. You will receive a written response to your grievance within 30 calendar days from the date the grievance was received. If additional time is needed, members will be notified of the

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reason for the delay in writing. If your grievance is related to quality of care, the written response will be limited to a confirmation that the case was investigated. A quality of care investigation is a protected internal process where the investigation results and associated corrective action steps are confidential and therefore cannot be shared with members or their families.

Confidentiality is an important aspect of the grievance process. The member is assured that information regarding a grievance will be held in confidence by the Plan throughout the investigation and resolution.

YOU MAY SUBMIT A FORMAL GRIEVANCE, IN WRITING, TO THE FOLLOWING ADDRESS:

Martin's Point US Family Health Plan
Attn: Grievance Department
PO Box 9746
Portland, ME 04104

For further information on the grievance process, please call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Appeals Process

Members who are not satisfied with medical decisions made by the US Family Health Plan or who disagree with the US Family Health Plan decision to deny an authorization or claim, may pursue the formal appeals process.

The Martin's Point US Family Health Plan intends to provide appeal notices in a culturally and linguistically appropriate manner. Martin's Point monitors US Census data for each service area annually to determine whether 10% or more of the population in each county speaks a language other than English. When the population in the county speaking a language other than English exceeds 10%, Martin's Point will add language to the appeal notice informing members in that language how to obtain assistance in understanding the appeal notice.

There are two main categories of appeals: Factual and Medical Necessity.

A **factual appeal** is a request to reconsider a claim or authorization request that has been denied for any of the following reasons:

- The requested service is not a covered benefit under the TRICARE program. (e.g. chiropractic)
- Determinations related to coverage based on limitations contained in the 32 CFR 199, the TRICARE Policy Manual (TPM), and other TRICARE guidance

Factual appeals must be filed, in writing, within 90 calendar days after the date of the notice of the initial denial determination in order to be accepted for review by the US Family Health Plan. A written request for appeal must be received—by mail, fax, or by email—before the expiration of the appeal filing deadline, unless it can be shown to the satisfaction of the US Family Health Plan that timely filing of the request was not possible due to extraordinary circumstances over which the appealing party had no practical control. A determination by the US Family Health Plan that extraordinary circumstances do not exist is not appealable.

Medical-necessity appeals are requests to reconsider an authorization that has been denied for either of the following reasons and must be filed, in writing, within 90 calendar days after the date of the initial determination:

- Service is a covered benefit, but the member's condition does not meet medical-necessity standards
- Services extend beyond what is considered to be medically necessary (e.g., extended hospital stay)

Expedited appeals: (Preadmission/concurrent) Expedited appeals must be medical-necessity appeals and be submitted prior to the service being delivered. They must be filed within three

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(3) calendar days after the date of the mailing of the initial denial determination. An appeal can be expedited for the following reasons:

- In the opinion of the practitioner, the member's health or ability to function could be seriously harmed by waiting for the standard appeals process, and/or
- Continuing coverage for inpatient or skilled nursing level of care has been denied.

Concurrent appeals: The member must be a patient in the facility on the date of the appeal filing.

Appeals may be submitted by a member, the member's appointed representative, the parent of a minor, or a provider (if the member has signed an "Appointment of Representative" statement authorizing the provider to act on his or her behalf).

The appeal letter should include the member's name, address, telephone number, sponsor's name, the decision being appealed, and the specific reason(s) a determination should be reversed. Please include copies of any other documents that are related to your appeal request.

Member appeals should be mailed to:

Martin's Point US Family Health Plan
 Attn: Appeals Specialist
 PO Box 8832
 Portland, ME 04104

Once an appeal letter is received, the US Family Health Plan will mail you an acknowledgment

letter confirming receipt and stating when a final determination of your appeal request will be made, following TRICARE guidelines.

The US Family Health Plan will issue a written determination letter that will include the Independent Review Entity (IRE) decision (approval or denial), the citation and quotation of relevant authority, and the reasons for the IRE decision. The letter will additionally provide the member with an explanation and finding relative to the member's financial liability under hold harmless or waiver of liability provisions, as applicable, and will provide the member with further appeal rights and instructions, if applicable.

For further information on the appeals process, call Member Services, toll-free, at **1-888-674-8734 (TTY: 711)**.

Level Two Appeals: If the member is not satisfied with the outcome of the Level One determination and has Level Two appeal rights in their determination letter, the member may submit an additional letter to request that the issue be further reviewed and reconsidered.

The member will need to send a copy of the Level One determination letter along with his/her appeal letter to:

- The Defense Health Agency (DHA) for **factual-determination** cases
- TRICARE Quality Monitoring Contractor (TQMC) for **medical-necessity** cases.

Addresses for the DHA and TQMC will be included in the Level One denial letters.

Appeal Type	Appeal Decision Timeframes
Medical & Factual Appeals Level One	<p>A Preservice Determination will be made within 30 calendar days from the date your appeal was received.</p> <p>A Postservice Determination will be made within 60 calendar days from the date your appeal was received.</p>

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Concurrent Review (Member is Inpatient in a Facility)	The TQMC shall complete a reconsideration determination for a concurrent review initial determination within two working days and shall notify all parties and US Family Health Plan of the determination within three working days after the receipt of the reconsideration request from US Family Health Plan to the TQMC.
Medical-Necessity Appeal: Expedited	Within three (3) working days of receipt of a request from a beneficiary for an expedited appeal.

Definition of Terms

Appeal

Formal process by which a member may request a reversal of a medical decision made by the US Family Health Plan or a decision to deny an authorization request or claim.

Authorization

Approval by the US Family Health Plan for a member to receive a service because it is both medically necessary and a covered benefit.

Balance Billing

Occurs when a health care provider bills you for the balance of the amount not paid to them by the US Family Health Plan for the health care services you received.

Catastrophic Cap

A cost “cap” or upper limit on out-of-pocket expenses a member is required to pay for US Family Health Plan-covered services.

Copayment

The flat fee you are required to pay a provider at the time of service.

Defense Enrollment Eligibility Reporting System (DEERS)

The worldwide computerized data bank that lists all TRICARE-eligible beneficiaries.

Durable Medical Equipment (DME)

Medical equipment such as wheelchairs, hospital beds, oxygen, and respirators. Most items are covered when medically necessary.

Emergency Care

Care for a medical emergency. A medical emergency consists of an illness or injury of such a nature that, without receiving prompt medical attention, it puts the member in jeopardy of sustaining serious impairment or dysfunction; or it presents a significant threat to the member’s continuing health. Examples include heart attacks and/or chest pains, uncontrollable bleeding, and loss of consciousness.

Grievance

Feedback lodged by a member dissatisfied with personnel, service, or quality of care received.

Group A

Sponsor’s initial enlistment or appointment occurred before January 1, 2018.

Group B

Sponsor’s initial enlistment or appointment occurred on or after January 1, 2018.

Maintenance Medication

Medications taken on a regular basis to treat a chronic condition (e.g., high blood pressure, high cholesterol, ulcers, and diabetes).

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A TRICARE Prime benefit administered in the Maine, New Hampshire, northern Massachusetts,

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Vermont, upstate New York, and northern Pennsylvania areas by Martin's Point Health Care. The US Family Health Plan is a managed-care plan, designed to provide comprehensive medical benefits to enrolled beneficiaries at a low out-of-pocket cost.

Medically Necessary Care

Care that is consistent with the condition, illness, or injury of the patient; is in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is provided; is not provided for the convenience of the patient; and is cost-effective treatment for the injury or condition of the patient.

Medicare Leakage

Money that Medicare pays out when a member of the US Family Health Plan intentionally uses Medicare to pay for services that are routinely covered by the US Family Health Plan.

Open Enrollment

The yearly period when non-active-duty beneficiaries can enroll in or change their TRICARE enrolled plan coverage for the following calendar program year. The open enrollment period for TRICARE begins on the Monday of the second full week in November to the Monday of the second full week in December of each calendar year.

Out-of-Area Care

Care received when traveling outside the US Family Health Plan service area.

Primary Care Provider (PCP)

Primary care provider who sees you for all of your routine health needs, monitors the medications you receive, refers you for tests or special services when needed, and maintains your medical records.

Qualifying Life Event (QLE)

A family- or military-related change in a beneficiary's situation, like getting married, having

a baby, losing health coverage, or deploying, that allows a beneficiary to enroll in or change their TRICARE health plan coverage outside of the annual open enrollment period.

Referral

A PCP's verification that the services being recommended for you are medically appropriate or medically necessary. (Note: PCP referrals do not imply or guarantee payment by the US Family Health Plan.)

Service Area

Area, as defined by ZIP codes, approved by the DoD from which military beneficiaries may enroll into the US Family Health Plan.

Transitional Assistance Management Program (TAMP)

Transitional health care benefits available for certain categories of service members released from active duty, such as a member who is involuntarily separated from active duty or a reserve component member who is separated from active duty and who was called up or ordered in support of a contingency operation for an active-duty period of more than 30 days.

TRICARE Prime

This benefit provides the most comprehensive coverage for health care benefits at the lowest cost. Each member has a civilian primary care provider who manages all the individual's health care. The US Family Health Plan is a TRICARE Prime benefit.

TRICARE Select

The name for the health care option formerly known as STANDARD. Under Tricare Select, eligible beneficiaries may choose any physician they want and the government will pay a percentage of the cost after a deductible is met.

Urgent Care

Care for an illness or injury that is not immediately life-threatening but requires professional medical

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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. Examples include a sprained ankle, cuts needing stitches, and severe abdominal pain.

Notes

Martin's Point US Family Health Plan

For over 40 years, the US Family Health Plan has been an integral part of the military health care system. Our plan is available to military beneficiaries in six areas across the country. In each, the Department of Defense has designated a health care provider to manage the plan. In northern New England, the US Family Health Plan has always been administered by Martin's Point Health Care, a locally owned and operated not-for-profit health care organization. We now serve members in Maine, New Hampshire, Vermont, upstate New York, northern and western Pennsylvania, and northeast Ohio.



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