

# TRICARE Fundamentals Course

## Glossary of Terms

# 16

Participant Guide

### References

[www.tricare.mil/mybenefit/Glossary](http://www.tricare.mil/mybenefit/Glossary)



### **20th-of-the-Month Rule**

The effective date of certain TRICARE programs is determined by the date the enrollment application is received by the appropriate contractor. If received by the 20th of the month, coverage begins on the first day of the next month. If the form is received after the 20th of the month, then coverage begins on the first day of the second month following receipt of the application. Please note that the application must be received by the 20th of the month, not merely postmarked by the 20th of the month.

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### **Active Duty Service Member (ADSM)**

A person currently serving in one of the seven uniformed services of the United States under a call or order that does not specify a period of 30 days or less.

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### **Adopted Child**

A child taken into one's own family by legal process. In the case of adoption, TRICARE eligibility begins at 12:01 a.m. the day of the final adoption decree. The child is also eligible when placed in a home by the court system.

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### **All-Inclusive Per Diem Rate**

The TMA-determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient.

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### **Allowable Charge**

The TRICARE-determined level of payment to physicians and other categories of individual professional providers based on one of the approved reimbursement methods set forth in the TRICARE Reimbursement Manual (TRM). As used by TRICARE, the allowable charge shall be the lowest of: The billed charge, the prevailing charge, or the maximum allowable prevailing charge.

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### **Appeal**

A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact.

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### **Authorization for Care**

The determination that requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit, and that the treatment will be cost-shared by DoD through its contract.

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### **Balance Billing**

A term used to describe when a provider bills a beneficiary for the difference between billed charges and the TRICARE allowable charge after TRICARE (and other health insurance) has paid everything it's going to pay. Network and participating providers are prohibited from balance billing. By law, non-participating providers may charge up to 15 percent above the TRICARE allowable charge.

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### **Benefit**

The TRICARE benefit consists of those services, payment amounts, cost-shares and copayments authorized by Public Law (PL) 89-614, 32 CFR 199 and the TRICARE Policy Manual (TPM).

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### **Beneficiary**

A person who, by law, is eligible for TRICARE benefits as set forth in 32 CFR 199.3. Beneficiaries include: ADSMs and their families, retired service members and their families, certain National Guard and Reserve members and their families, survivors and widows, certain unremarried former spouses, and Medal of Honor recipients and their families. Family members include spouses and children (biological, adopted or step) up to age 26.

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### **Beneficiary Counseling and Assistance Coordinator (BCAC)**

Persons who serve as beneficiary advocates at military treatment facilities (MTFs) and TRICARE Regional Area Offices, who are available to answer questions, help solve health care-related problems and assist beneficiaries in obtaining medical care through TRICARE.

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**Billed Charge**

The total cost of care without discounts or reduced fees from a provider.

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**Catastrophic Cap**

The maximum out-of-pocket expenses that the TRICARE beneficiary is responsible for in a given fiscal year (October 1- September 30). The catastrophic cap for active duty service families is \$1,000, and the catastrophic cap for all other TRICARE-eligible persons is \$3,000. For beneficiaries enrolled in a Prime option, point of service cost shares and deductibles do not apply to the catastrophic cap. The beneficiary cost share will remain at 50 percent of the TRICARE allowable charge even after the catastrophic cap has been reached.

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**Claim**

Any request for payment for health care services rendered which is received from a beneficiary, a beneficiary's representative, or a network or non-network provider by a contractor on any TRICARE-approved claim form or other approved electronic medium. This includes requests for reimbursement of a dispensed pharmaceutical agents or diabetic supply items.

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**Clinical Preventive Services**

Services such as health screenings and examinations, often conducted at regular intervals, which are meant to keep beneficiaries healthy or detect health problems in a timely manner. They include such things as mammograms, cholesterol testing, colorectal cancer exams, prostate cancer exams, blood pressure readings and pap smears.

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**Computer/Electronic Accommodations Program (CAP)**

The Federal Government's centrally funded reasonable accommodations program for employees with disabilities in the Department of Defense and throughout the Federal Government. CAP provides assistive technologies and accommodations to ensure that persons with disabilities and wounded service members have equal access to the information environment and opportunities throughout the Department of Defense and the Federal Government.

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**Contingency Operation**

A military operation that results in the call or order to, or retention of, active duty of members of the uniformed services under section 688 12301, 12304, 12305 or 12306 of Title 10, Chapter 15 of Title 10 or any other provision of law during a war or during a national emergency declared by the President or Congress. Written calls or orders to active duty specify if they are in support of a contingency operation; determined by the service.

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**Continued Health Care Benefit Program (CHCBP)**

A premium-based health care program that offers temporary transitional health coverage for 18 to 36 months after TRICARE eligibility ends for certain former beneficiaries. Beneficiaries may purchase CHCBP within 60 days of loss of eligibility and will be covered as if they had TRICARE Standard benefits.

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**Coordination of Benefits**

A system to acquire collection of other health insurance benefits before making any TRICARE benefit payment, except for Medicaid, in compliance with requirements specified in 32 CFR 199 and the TRICARE Reimbursement Manual (TRM).

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**Copayment**

The fixed amount a TRICARE Prime enrollee (not including ADFMs) pays for care in the civilian provider network. TRICARE Prime active duty family members are not required to pay copayments for health care services.

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**Cost Share**

The amount a beneficiary must pay for covered inpatient and outpatient services (other than the deductible, the annual TRICARE Prime enrollment fee, the balance billing amount, or disallowed amounts) as set forth in 32 CFR 199.4, 199.5, and 199.17. Under TRICARE, cost-shares are expressed as either coinsurance or copayment.

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**Debt Collection Assistance Officer (DCAO)**

Persons located at military treatment facilities and TRICARE Regional Offices who assist in resolving TRICARE-related collection actions. DCAOs work a beneficiary case if the beneficiary has a negative credit rating or was sent to a collection agency.

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**Deductible**

The statutory requirement for payment by the beneficiary of an initial specified dollar amount of the TRICARE-determined allowable costs or charges for covered outpatient services or supplies provided in any one fiscal year.

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

A system operated by the Department of Defense used to reflect beneficiary eligibility. Beneficiaries are responsible for maintaining the accuracy of their DEERS records and getting information updated in the system, as necessary.

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**Defense Manpower Data Center (DMDC)**

The office that manages the DEERS database and provides customer service for beneficiaries who are trying to establish, maintain or determine their eligibility for TRICARE. The DMDC also distributes certificates of creditable coverage to beneficiaries upon loss of eligibility.

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**Dental Treatment Facility (DTF)**

Military facilities that provide dental care primarily for active duty service members; DTFs may see other beneficiaries based on capacity and capability.

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**DoD Benefit Number**

A unique 11-digit family member identifier that ties a family member to the sponsor and identifies the cardholder as one who has DoD benefits (such as health care and base exchanges services).

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**DoD Identification Number**

A 10-digit electronic DoD identification number that replaces the sponsor's SSN on the military ID and the Common Access Card (CAC).

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**Double Coverage**

Enrollment by a TRICARE beneficiary in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's TRICARE benefits.

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**Emergency Services**

Medical services provided for a sudden or unexpected medical, dental, or psychiatric condition, or the sudden worsening of a chronic (ongoing) condition that is threatening to life, limb, or sight and needs immediate medical treatment, or which has painful symptoms that need immediate relief to stop a beneficiary's suffering.

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**Enrollee**

A TRICARE beneficiary who has elected coverage under TRICARE Prime, TRICARE Prime Remote, TRICARE Young Adult Prime, TRICARE Prime Remote for Active Duty Family Members, the US Family Health Plan, TRICARE Overseas Program Prime or TRICARE Overseas Program Prime Remote.

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**Enrollment Fees**

The amount required to be paid by some categories of beneficiaries to enroll in and receive the benefits of TRICARE Prime or other special TRICARE programs.

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**The Exceptional Family Member Program (EFMP)**

Identifies active duty family members with special medical and/or educational needs, documents required services, and involves the personnel community, medical commands and the educational system in providing required services. Registration in EFMP is mandatory upon identification of an active duty family member with special needs. This helps to ensure that military families are stationed in geographical areas where the family member's needs can be met. EFMP registration is especially important when family members are being screened for approval to accompany their sponsor to an overseas location on permanent change of station orders.

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**Explanation of Benefits (EOB)**

A statement, prepared insurance carriers, health care organizations, and TRICARE, informing beneficiaries and providers of actions taken on a claim for health care coverage.

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**Exclusion**

Exclusion from participation as a provider or entity under TRICARE means that items, services, and/or supplies furnished will not be reimbursed under TRICARE.

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**Extended Care Health Option (ECHO)**

ECHO is a supplemental program to the TRICARE basic program and provides eligible active duty family members with an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition, such as moderate or severe mental retardation, a serious physical disability or an extraordinary physical or psychological condition such that the beneficiary is homebound.

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**Fee For Service (FFS)**

A method of paying providers service-by-service. Beneficiaries generally pay a cost share under a fee-for-service provider. TRICARE Standard is a fee-for-service option.

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**Fit For Duty**

Medical and/or dental status of an ADSM, as determined by the ADSM's service.

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**Formulary**

A listing of pharmaceuticals and other authorized supplies to be dispensed with appropriate prescriber's order from a particular point of service. The formulary for any TRICARE contract is managed by the DoD Pharmacy and Therapeutics (P&T) Committee, with clinical guidance from the DoD Pharmacoeconomic Center (PEC). Applicable formulary information may be viewed on the TRICARE web site at: [tricare.osd.mil/pharmacy](http://tricare.osd.mil/pharmacy).

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**Grievance**

A written complaint on a non-appealable issue which deals primarily with a perceived failure of a network provider, the Health Care Finder (HCF), or contractor or subcontractor, to furnish the level or quality of care expected by a beneficiary.

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**Health Care Finder (HCF)**

Health Care Finders (HCFs) are health care professionals employed by the regional contractors, generally registered nurses, who can help find needed care for services that require prior authorization. HCFs work with primary care managers to locate the specialty care nearest to the beneficiary. HCFs can also assist with making medical appointments at military treatment facilities.

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**Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was introduced to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

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**Health Maintenance Organization (HMO)**

A health plan in which a fixed premium for an assortment of medical services, usually including primary and preventive care, is paid by the member. The primary purpose of an HMO is to coordinate care to eliminate unnecessary care and costs. HMOs typically have copayments rather than cost shares. The Prime options are similar to HMOs.

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**Host Nation Provider**

A hospital, clinic, laboratory, individual doctor or provider licensed to practice or deliver health care in a foreign country.

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**Medicaid**

Medical benefits authorized under the Title XIX of the Social Security Act provided to welfare recipients and the medically indigent through programs administered by the various states.

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**Medicare**

Medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons or persons with end stage renal disease or amyotrophic lateral sclerosis, through a national program administered by the Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Bureau.

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**Medicare Part A**

The part of Medicare that covers inpatient stays, to include hospice and skilled nursing facility care.

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**Medicare Part B**

The part of Medicare that covers outpatient services and products, such as doctor's services, outpatient hospital care and other medical services that Part A does not cover, such as physical and occupational therapy. Other examples include x-rays, medical equipment or limited ambulance service. Purchase is optional and affects TRICARE eligibility.

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**Medicare Part C**

Also known as the Medicare Advantage Plan, provides all of Medicare Part A and Part B coverage, and may offer vision, hearing, dental and/or health and wellness coverage.

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**Medicare Part D**

A prescription drug program available through Medicare-approved private insurance companies.

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**Medical Summary Notice (MSN)**

After receiving a Medicare-covered service, beneficiaries will be sent a Medicare Summary Notice (MSN) by mail every three months. The notice shows all of the beneficiary's services and/or supplies that providers and suppliers billed to Medicare during that three month period, what Medicare paid, and what the beneficiary may owe the provider. This notice is not a bill.

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**Military Medical Support Office (MMSO)**

The joint services organization responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty. MMSO is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. The Service Points of Contact (SPOCs) for Army, Navy, Marine Corps, and Air Force ADSMs are assigned to the MMSO.

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**Military Treatment Facility (MTF)**

A military hospital or clinic usually located on a military installation..

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**National Defense Authorization Act (NDAA)**

Formerly established and funds TRICARE in public law. The NDAA is under the jurisdiction of the Senate and House Armed Services Committees and provides statutory direction across all DoD programs by establishing, changing or eliminating programs and activities such as civilian health care services. TRICARE occasionally adds new services to its offerings.

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**Negotiated Rate**

The negotiated or discounted rate that network providers agree to accept for covered services versus the usual TRICARE allowable charge.

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**Network Pharmacy**

Retail pharmacies that serve TRICARE beneficiaries through a contractual agreement with the pharmacy contractor.

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**Network Provider**

A professional or institutional provider who has a contractual relationship with the TRICARE regional contractor to provide care at a negotiated rate. A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries, and typically administers care to TRICARE Prime beneficiaries and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option). A network provider accepts the negotiated rate as payment in full for services rendered.

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**Non-Network Provider**

Non-network providers do not have a signed agreement with regional contractors and still have to be TRICARE authorized for TRICARE to pay on the claim.

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**Non-Participating Provider**

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

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**Other Health Insurance (OHI)**

Primary coverage other than TRICARE health insurance (not including supplemental mental Health Care Provider [HCP]). OHI is acquired through an employer, entitlement program or other source. Under federal law, TRICARE is the secondary payer to all other health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service or other programs or plans as identified by the TRICARE Management Activity.

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**Out-of-Pocket Costs**

The amount of money a beneficiary must pay. This includes any enrollment fees, cost shares, deductibles, copayments and all extra expenses incurred.

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**Participating Provider**

An authorized provider or institutional provider who agrees to accept payment directly from TRICARE and to accept the TRICARE allowable charge plus applicable cost shares paid by the beneficiary as payment in full for services. Providers may choose to participate on a claim-by-claim basis.

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**Point of Service (POS)**

The POS option allows Prime option enrollees to self-refer for non-emergency care to any TRICARE-authorized provider. However, POS has higher out-of-pocket costs for care.

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**Preferred Provider Organization (PPO)**

An organization of providers who, through contractual agreements with a contractor, have agreed to provide services to beneficiaries at reduced rates and to file claims on behalf of the beneficiary. A membership allows a substantial discount below the regularly charged rates of the designated professionals partnered with the organization.

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**Primary Care Manager (PCM)**

An MTF provider, team of providers or a civilian network provider to whom a beneficiary is assigned for primary care services (at the time of enrollment in TRICARE Prime). Enrolled beneficiaries agree to initially seek all non-emergency, non-mental health care services from their PCMs.

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**Prime Service Area (PSA)**

A geographic area where TRICARE Prime benefits are offered. Regional contractors are required to establish a Prime services provider at MTF and Base Realignment and Closure (BRAC) locations.

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**Prior Authorization**

A process of reviewing certain medical, surgical and behavioral health services to ensure medical necessity and appropriateness of care prior to services being rendered, or within 24 hours of an emergency admission. Services requiring prior authorization may vary from region to region.

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**Professional Fees**

Charges for medical professional services that hospitals or third-party payers require to be separately identified on an inpatient billing form.

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**Provider**

A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies in accordance with 32 CFR 199.

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**Provider Network**

An organization of providers with which the contractor has made contractual or other arrangements. These providers must accept assignment of claims and submit claims on behalf of the beneficiary.

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**Referral**

The process of sending a beneficiary to another professional provider for consultation or a health care service that the referring provider believes is necessary but is not prepared or qualified to provide.

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**Region**

A geographic area determined by the Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

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**Regional Contractor**

A TRICARE civilian health care partner who provides health care services and support in each of the TRICARE regions. The regional contractors help combine the services available at military treatment facilities and those offered by the TRICARE network of civilian hospitals and providers to meet the health care needs of beneficiaries within the region.

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**Routine Care**

Includes general office visits for the treatment of symptoms, chronic or acute illnesses, diseases and follow-up care for an ongoing medical condition including preventive care. Also known as primary care.

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**Service Point of Contact (SPOC)**

The Uniformed Services office or individual responsible for coordinating civilian health care for ADSMs who receive care under the Supplemental Health Care Program and the TRICARE Prime Remote Program. The SPOC reviews requests for specialty and inpatient care to determine the impact on the ADSM's fitness for duty; determines whether the ADSM shall receive care related to fitness for duty at a medical MTF or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for the ADSMs. The SPOC is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness-for duty and/or retention on active duty. SPOCs for the Army, Navy/Marines, and Air Force are assigned to the Military Medical Support Office (MMSO).

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**Specialty Care**

Specialized medical services provided by a specialist.

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**Split Enrollment**

Refers to multiple family members enrolled in TRICARE Prime under different regional contractors, including Managed Care Support Contractors (MCSCs) (stateside and overseas) and U.S. Family Health Plan (USFHP) designated providers.

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**Sponsor**

The active duty service member or retiree through whom family members are eligible for TRICARE.

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**Supplemental Care**

Medical care received by ADSMs of the Uniformed Services and other designated patients pursuant to an MTF referral (MTF referred care). Supplemental Health Care also includes specific episodes of ADSM non-referred civilian care, both emergent and authorized non-emergent care (non-MTF referred care) approved by the service or SPOC.

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**Survivor**

A TRICARE-eligible family member whose sponsor, at the time of death, was on active duty for 30 consecutive days or more. A family member's eligibility for survivor status is determined by the sponsor's service personnel office. Three years following the sponsor's death, surviving spouses convert to survivor status, and receive TRICARE benefits as a retiree family member.

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**Transitional Assistance Management Program (TAMP)**

Transitional health care for certain uniformed service members (and eligible family members) who separate from active duty.

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**TRICARE**

The DoD's managed health care program for ADSMs, service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's DC system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan.

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**Transitional Survivor**

A TRICARE-eligible family member whose sponsor, at the time of death, was on active duty for 30 consecutive days or more. Transitional survivors are eligible to receive the same health care benefits as active duty family members under TRICARE Prime programs for as long as they maintain TRICARE eligibility. Spouses of the deceased sponsor are considered transitional survivors for three years from the date of the sponsor's death. Eligible dependent children (including qualifying students over 18) of the deceased sponsor remain transitional survivors, as long as they remain eligible for TRICARE.

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**Transitional Care for Service Related Conditions (TCSRC)**

The Transitional Care for Service-Related Conditions benefit provides extended transitional health care coverage to former active duty service members with certain service-related conditions. The TCSRC coverage period is 180 days from the date the diagnosed condition is validated by a Department of Defense physician. Family members are not eligible for this benefit.

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**TRICARE Adjunctive Dental Care**

Dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease.

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**TRICARE Area Office (TAO)**

The office responsible for the development and execution of an integrated plan for the delivery of health care within TRICARE overseas regions, including Eurasia-Africa, Latin America/Canada, and the Pacific.

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**TRICARE Allowable Charge**

The maximum amount TRICARE pays for services. By law, the TRICARE allowable charge matches Medicare rates whenever practical.

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**TRICARE Assistance Program (TRIAP)**

Program that uses audio-visual features to provide online access to behavioral health care counseling for short-term, non-medical issues.

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**TRICARE Area Office (TAO)**

The office responsible for the development and execution of an integrated plan for the delivery of health care within the TRICARE overseas regions, including Eurasia-Africa, Latin America/Canada, and the Pacific.

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**TRICARE Authorized Provider**

A provider who meets TRICARE's licensing and certification requirements and is certified to provide care to TRICARE beneficiaries. There are two types of TRICARE authorized providers: network and non-network.

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**TRICARE Contractor**

An organization with which TMA enters into a contract for delivery of and/or processing of payment for health care services through contracted providers and for processing of claims for health care received from non-network providers and for performance of related support activities.

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**TRICARE Dental Program (TDP)**

A voluntary premium-based dental insurance program available to eligible active duty family members, other select members and to members of the National Guard and Reserve and/or their families.

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**TRICARE Extra**

A PPO-like option, provided as part of the TRICARE program under 32 CFR 199.17, where Standard beneficiaries may choose to receive care in facilities of the uniformed services or from special civilian network providers (with reduced cost-sharing), or from any other TRICARE-authorized provider (with standard cost-sharing).

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**TRICARE for Life (TFL)**

TRICARE for Life combines TRICARE Standard coverage with Medicare Part A and Medicare Part B to provide wrap-around medical coverage to beneficiaries worldwide who are eligible for Medicare and TRICARE. These are also known as dual-eligible beneficiaries. TRICARE beneficiaries entitled to premium-free Medicare Part A are required by federal law to have Medicare Part B to remain TRICARE eligible (with some exceptions).

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**TRICARE Management Activity (TMA)**

The DoD organization responsible for managing the TRICARE contracts and day-to-day operations of the TRICARE plan.

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**TRICARE Overseas Program (TOP)**

The Department of Defense's health care program in all geographic areas and territorial waters outside of the 50 United States and the District of Columbia.

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**TRICARE Overseas Program-Prime (TOP Prime)**

TOP Prime offers the benefits of TRICARE Prime in overseas military treatment facility locations. TOP Prime enrollees are assigned a Primary Care Manager who delivers and/or manages routine and urgent medical care and coordinates care with the overseas contractor as needed. TOP Prime enrollees pay no copayments, cost shares or deductibles for care rendered by the Primary Care Manager or for authorized services rendered by a purchased care/host nation provider. TOP Prime is only available to ADSMs and command-sponsored family members.

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**TRICARE Overseas Program-Prime Remote (TOP Prime Remote)**

Offers the benefits of TRICARE Prime to active duty service members permanently assigned to designated remote overseas locations, and to their eligible family members. The TOP contractor has networks of licensed, purchased care/host nation providers in these remote overseas locations to deliver health care to TOP Prime Remote enrollees.

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**TRICARE Plus**

A primary care enrollment program offered at select MTFs. All beneficiaries eligible for care at MTFs (except those enrolled in TRICARE Prime or a health maintenance organization) may seek enrollment for primary care at select MTFs where enrollment capacity exists.

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**TRICARE Prime**

An HMO-like option, provided as part of the TRICARE program under 32 CFR 199.17, where beneficiaries elect to enroll in a voluntary enrollment program, which provides TRICARE Standard benefits and enhanced primary and preventive benefits with nominal beneficiary cost-sharing. TRICARE Prime requires beneficiaries to use a PCM located at either the MTF or from the contractor's network, except when beneficiaries are exercising their freedom of choice under the Point of Service Option.

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**TRICARE Prime Remote (TPR)**

A TRICARE Prime option that provides health care coverage through civilian network or TRICARE-authorized providers for uniformed service members who are assigned to duty stations and reside in remote areas, typically 50 or more miles from a military treatment facility. TPR requires enrollment.

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**TRICARE Prime Remote for Active Duty Family Members (TPRADFM)**

A TRICARE Prime option that provides health care coverage through civilian network or TRICARE-authorized providers for family members of uniformed service members who are assigned to duty stations and reside in designated remote areas, typically 50 or more miles from a military treatment facility. TPRADFM requires enrollment; family members must reside with the sponsor (with some exceptions).

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**TRICARE Regional Office (TRO)**

A division of the TRICARE Management Activity which oversees the integrated health care delivery system in the three United States-based TRICARE regions: North, South and West.

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**TRICARE Regulation**

32 CFR 199. This regulation prescribes guidelines and policies for the administration of the TRICARE Program for the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA. It includes the guidelines and policies for the administration of the TRICARE Program.

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**TRICARE Reserve Select (TRS)**

A premium-based health care plan that qualified Selected Reserve members may purchase for themselves and eligible family members. Offers TRICARE Standard benefits.

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**TRICARE Retired Reserve (TRR)**

A premium-based, worldwide health plan that qualified Retired Reserve members may purchase for themselves and eligible family members. Offers TRICARE Standard benefits.

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**TRICARE Retiree Dental Program (TRDP)**

A voluntary dental insurance program available for purchase by retired service members and their eligible family members.

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**TRICARE Service Center (TSC)**

A customer service center operated by the regional contractors and TRICARE Area Offices in each TRICARE region or overseas area. The TSC can help with specialty care authorizations and can provide general TRICARE and claim-processing information.

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**TRICARE Standard**

A fee-for-service option that allows beneficiaries to seek care from any TRICARE-authorized provider. Beneficiaries are responsible for payment of an annual deductible and cost shares, and may be responsible for other costs. There is no fee for enrollment.

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**TRICARE Young Adult (TYA) Program**

Premium-based program that extends TRICARE coverage to certain family members who have lost or will lose TRICARE eligibility due to age.

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**Uniform Formulary**

A list of TRICARE-covered prescription medications that is categorized into three tiers: Tier 1 (Formulary-Generic), Tier 2 (Formulary-Brand Name), and Tier 3 (Non-Formulary).

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**Uniformed Services**

The seven uniformed services of the United States are: U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the United States Public Health Service and the Commissioned Corps of the National Oceanic and Atmospheric Administration. TRICARE is available to eligible beneficiaries from any of the uniformed services. The services determine TRICARE eligibility.

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**Uniformed Services Employment and Reemployment Rights Act (USERRA)**

USERRA provides employment/reemployment protection to uniformed service members who perform military service.

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**Urgent Care**

Medically necessary services required for illnesses or injuries that will not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

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**US Family Health Plan (USFHP)**

A TRICARE Prime option available in six geographic locations across the United States that offers benefits to active duty family members, retirees and their eligible family members, survivors, certain former spouses and other eligible beneficiaries, including those 65 years of age and over, regardless of whether or not they participate in Medicare Part B. USFHP is similar to a Prime option.

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