

TRICARE Fundamentals Course

Other TRICARE Programs

6

Participant Guide

References

10 USC § 1079 (d)-(f)
32 CFR §§ 199.5, 6, 8
TRICARE Operations Manual, 2002 and 2008, Chapter 6
TRICARE Policy Manual, 2002 and 2008, Chapter 9
<http://www.militaryhomefront.dod.mil>
<http://www.usfhp.com>
<http://www.TRICARE.mil/CAP/WSM>
<http://www.tricare.mil/tmaprivacy>



Brainteaser

What do you see in the picture below?



Module Objectives



- State the purpose of TRICARE Plus
- Describe the Extended Care Health Option (ECHO)
- State the purpose of the Computer/Electronic Accommodations Program (CAP)
- Explain how the US Family Health Plan mirrors TRICARE Prime

1.0 TRICARE Plus

TRICARE Plus is a primary care enrollment program offered at select military treatment facilities (MTFs). Although TRICARE Plus isn't a health care plan, it offers primary care at the MTF with an assigned Primary Care Manager (PCM) to enrolled TRICARE Standard and TRICARE for Life (TFL) beneficiaries, and dependent parents/parents-in-law.

MTF commanders may limit enrollment based on capability and capacity. Continued enrollment in TRICARE Plus is determined by the MTF commander on a case-by-case basis.

1.1 Eligibility

Eligibility is limited to TRICARE Standard and TFL beneficiaries, dependent parents and parents-in-law.

Beneficiaries enrolled in a Prime option (stateside or overseas), a civilian health maintenance organization (HMO), or Medicare HMO are not eligible.

1.2 Enrollment

- There are no enrollment fees or cards associated with TRICARE Plus. Eligible beneficiaries must complete a *TRICARE Plus Enrollment Application* (DD Form 2853).
- The MTF validates eligibility in DEERS
- Once approved, the TRICARE Plus enrollment form is forwarded to the regional contractor
- The regional contractor enters the TRICARE Plus enrollment into the Defense Online Enrollment System (DOES). The TRICARE Plus enrollment is then reflected in DEERS
- A TRICARE Plus enrollment indicator appears in the MTF's medical appointment system allowing MTF staff to schedule appointments for TRICARE Plus enrollees

1.3 Disenrollment

- TRICARE Plus enrollees may disenroll at any time by submitting a *TRICARE Plus Disenrollment Request* (DD Form 2854).
- The MTF sends the disenrollment request form to the regional contractor for processing and recording in DEERS.

1.4 Portability

Unlike TRICARE Prime, TRICARE Plus isn't a portable health care plan. Beneficiaries who choose to disenroll from TRICARE Plus at one MTF aren't guaranteed access to primary care services or enrollment in TRICARE Plus at another.

1.5 Specialty Care

Enrollment in TRICARE Plus doesn't guarantee access to specialty care within the MTF. TRICARE Plus enrollees may be referred to a civilian TRICARE-authorized provider, if eligible, or use Medicare or other health insurance, as applicable. The MTF isn't responsible for any costs associated with care outside the MTF.

TRICARE Standard/Extra, Medicare, or other health insurance (OHI) rules apply, as well as applicable cost shares and deductibles.

TRICARE Plus doesn't affect other TRICARE benefits or existing programs.

2.0 Exceptional Family Member Program

- 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 DoD educational system to provide required service to the family.

- An exceptional family member is defined as an authorized family member residing with the sponsor who may require special medical or educational services based on a diagnosed physical, intellectual, or emotional handicap. An authorized family member may be a spouse, child, stepchild, adopted child, or foster child.
- Special medical or educational needs may include medical, mental health, developmental or educational requirements, wheelchair accessibility, adaptive equipment, assistive technology devices, and associated services.
- Enrollment in EFMP is mandated by the service when an active duty family member with qualifying special needs is identified.
 - The sponsor, or an authorized person acting on the sponsor's behalf, must enroll the qualified family member in the service's EFMP by completing a DD 2792, *Exceptional Family Member Medical Summary* and DD 2792-1, *Exceptional Family Member Special Education/Early Intervention Summary*.
 - This may be waived for National Guard and Reserve members. (See 3.4)
- Enrollment in EFMP helps ensure that families are stationed in geographical areas where the family members' needs can be met. This is especially important when family members are being screened for approval to accompany the sponsor to an overseas location on permanent change of station order.
- The U.S. Public Health Service (USPHS) and National Oceanic and Atmospheric Administration (NOAA) don't have an EFMP.

3.0 Extended Care Health Option Program

The Extended Care Health Option (ECHO) is a supplemental program to the basic TRICARE Program. It provides qualified active duty family members with an additional financial resource for services and supplies designed to assist in the reduction of the disabling effects of the family member's qualifying condition.

3.1 ECHO and TRICARE Eligibility Status

- If a sponsor or provider believes a family member may qualify for ECHO services, the sponsor should speak with the family member's PCM or primary care provider, case manager, regional contractor, or TRICARE Area Office (TAO) to receive an eligibility determination. The following family members are eligible.
 - A spouse, dependent child, or an unmarried person whose sponsor is an active duty member of a uniformed service of the United States, including members of the National Guard or Reserve on federal orders written for more than 30 consecutive days.
 - A spouse, dependent child, or an unmarried person whose sponsor is a former member of a uniformed service of the United States and the spouse, child, or unmarried person is a victim of physical or emotional abuse. Benefits are limited to the period that the abused dependent is receiving transitional compensation.
 - A Transitional Survivor. This is the surviving spouse, for up to three years from the sponsor's death and surviving dependent children until they age out at age 21 or 23 (See *DEERS*).
 - An ECHO-qualified spouse, dependent child, or unmarried person who is eligible for continued TRICARE medical benefits through the Transitional Assistance Management Program (TAMP).
- Each regional contractor or TAO determines eligibility for ECHO. If they determine the beneficiary isn't eligible for ECHO, the decision is regarded as a factual determination and **isn't** appealable (See *Claims and Appeals*).

3.2 ECHO Qualification Determination

Qualification is based on the evidence of specific mental or physical disabilities and enrollment in EFMP, where applicable.

The family member may need to see a TRICARE-authorized provider to get the necessary testing, screening, and exams to determine and document the qualifying disability and the need for specialty services.

- If enrolled in TRICARE Prime/TPRADFM/a Prime-option (stateside or overseas), or the US Family Health Plan, the family member must first see his/her PCM for routine care and to get referrals for any necessary testing, screening, and exams.
- If using TRICARE Standard, the family member doesn't need referrals unless required for certain services, as verified by the regional contractor or overseas TRICARE Area Office (TAO).

3.3 ECHO Qualifying Conditions

- An extraordinary physical or psychological condition, defined as a complex physical or psychological clinical condition of such severity that it results in the beneficiary being homebound.
- Multiple disabilities, where the cumulative effect of disabilities involves two or more separate body systems, none of which is individually an ECHO qualifying condition, will be used to establish a qualifying condition in lieu of the qualifying conditions.
- Neuromuscular developmental conditions or other conditions that are expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability in infants or toddlers under age three.

3.4 Registration

The sponsor or other authorized persons acting on behalf of the family member may be required to submit the following documents to the regional contractor or TAO responsible for administering the ECHO Program in their geographical area:

- Proof the sponsor is an active duty service member in one of the uniformed services
- Medical records of qualifying conditions
- Proof from the sponsor's branch of service the family member seeking ECHO registration is enrolled in the EFMP (Guard and Reserve, Coast Guard, Public Health Service, National Oceanic and Atmospheric Administration). This requirement may be waived when either the sponsor's service doesn't provide the EFMP, the beneficiary is a transitional survivor, or the beneficiary resides with a custodial parent who is not the active duty sponsor.

To avoid delay of ECHO services due to a delay in the EFMP enrollment process, the regional contractor or TAO may grant provisional ECHO status for a 90-day period.

3.5 ECHO Benefits

3.5.1 Services Covered Under ECHO

- Medical and rehabilitative services
- Durable equipment, including adaptation and maintenance
- Training to use assistive technology devices
- Assistive services, such as those from a qualified interpreter or translator
- Special education
- Institutional care when a residential environment is required
- Transportation for institutionalized beneficiaries to receive authorized ECHO benefits
- In-home respite care services
- ECHO respite care. ECHO family members are eligible for 16 hours of respite care per month in any month during which the family member receives other authorized ECHO benefits

3.5.2 Services Not Available Under ECHO

- Inpatient care for medical or surgical treatment of an acute illness or an acute exacerbation of the qualifying condition
- Structural changes to living space and permanent fixtures, including changes necessary to accommodate

installation of equipment or to facilitate entrance or exit

- Dental care and orthodontic treatment
- Certain durable medical equipment and maintenance for beneficiary-owned equipment
- Homemaker services that provide assistance with household chores, except those provided by the ECHO Home Health Care benefit

3.5.3 ECHO Benefit Authorization

- ECHO benefits are authorized when:
 - The family member is registered in ECHO
 - The requested service/item is an allowable ECHO benefit
 - The requested service/item meets the public facility use requirement, when applicable
- The authorization specifies the requested services by type, scope, frequency, duration, dates, amounts, requirements, limitations, provider name and address, and all other information necessary to provide exact identification of approved benefits.
- Authorizations remain in effect until the regional contractor or TAO determines that:
 - The beneficiary is no longer eligible for ECHO..
 - The authorized ECHO service or item is no longer appropriate or required by the family member
 - The authorized ECHO service or item becomes a benefit through the basic TRICARE program, as established by law and/or policy
- All ECHO services, supplies, and equipment must be received from a TRICARE-authorized provider. If the family member changes providers, they must obtain a new benefit authorization from the regional contractor or TAO
- Beneficiaries may appeal the denial of ECHO services and supplies

4.0 ECHO Costs

ECHO has no deductibles or enrollment fees. The family may incur costs for services associated with determining an ECHO qualifying condition(s) (See 3.3).

Beneficiaries may incur cost shares for health services which:

- Establish qualifying conditions
- Confirm the severity of the disabling effects of a qualifying condition
- Measure the extent of functional loss

For example, the sponsor of a beneficiary who uses TRICARE Standard/Extra to receive diagnostic services that result in a diagnosis that is an ECHO-qualifying condition is liable for cost shares and deductibles associated with the diagnostic services. These cost shares and deductibles are not reimbursable under the ECHO program.

4.1 Cost Shares

Although ECHO allowable charges aren't subject to deductibles, a monthly cost share must be paid during the months registered family members receive ECHO benefits. ECHO cost shares don't count towards the family's catastrophic cap.

Cost shares are based on the sponsor's pay grade

Sponsor Pay Grade	Sponsor Cost Share	Sponsor Pay Grade	Sponsor Cost Share
E-1 to E-5	\$25	CWO-5, O-5	\$65
E-6	\$30	O-6	\$75
E-7, O-1	\$35	O-7	\$100
E-8, O-2	\$40	O-8	\$150
E-9, CWO-1, CWO-2, O-3	\$45	O-9	\$200
CWO-3, CWO-4, O-4	\$50	O-10	\$250

4.2 Government's Cost Share Limit

The maximum amount the government pays toward ECHO benefits (excluding the ECHO Home Health Care benefit) is \$36,000 per registered family member per fiscal year.

4.3 Claims for Benefits with Prior Authorization

All ECHO benefits must be authorized by the regional contractor ECHO case manager, or overseas TAO before any services, supplies, or equipment are received.

- When family members file claims for ECHO-authorized care, they or their sponsor should use:
 - Patient's Request for Medical Payment* (DD Form 2642)
 - A copy of the authorization the beneficiary received from the regional contractor, ECHO case manager, or overseas TAO should accompany the claim form.

Claims should be sent to the TRICARE claims processing contractor for the region where the family member lives.

4.4 ECHO Resources

For more information about ECHO or for a variety of support and counseling services, visit tricare.mil/echo.

5.0 Uniformed Services Family Health Plan

The Uniformed Services Family Health Plan (USFHP) is a TRICARE Prime option available through networks of community-based, not-for-profit health care systems in six areas of the United States. To enroll, eligible beneficiaries must be registered in DEERS and live within one of the designated USFHP service areas.

5.1 USFHP Designated Providers

There are five organizations in different regions throughout the United States that sponsor the US Family Health Plan.

The US Family Health Plan sponsoring organizations and covered regions are:

**Pacific Medical Centers
(PacMed Clinics)**

Serving the Puget Sound area of
Washington State
1-888-958-7347

CHRISTUS Health

Serving southeast Texas and
southwest Louisiana
1-800-678-7347

Martin's Point Health Care

Serving Maine, New Hampshire,
Vermont, upstate and western
New York, and the northern tier of
Pennsylvania
1-888-241-4556

Johns Hopkins Medicine

Serving central Maryland,
Washington DC, and parts of
Pennsylvania, Virginia, and West
Virginia
1-800-808-7347

Brighton Marine Health Center

Serving Massachusetts (including
Cape Cod), Rhode Island and
northern Connecticut
1-800-818-8589

5.2 Eligibility

- Active duty service members aren't eligible for USFHP enrollment.
- Beneficiaries must live within the USFHP service area as determined by zip code. Eligible beneficiaries include:
 - Active duty family members (ADFM), and unmarried dependent children until they age out. (See *DEERS*)
 - Retired service members, their spouses, and unmarried dependent children (until they age out).
 - Eligible unremarried former spouses of active duty or retired service members.
 - Certain former active duty service members, including National Guard/Reserve members and their eligible family members during TAMP.

5.3 Enrollment

Enrollment is open all year.

- There are no enrollment fees for ADFMs or Medicare-eligible beneficiaries who purchase Medicare Part B.
- All others pay an annual enrollment fee as follows for new FY 2012 enrollees:
 - Individual enrollment: \$260 annually
 - Family enrollment: \$520 annually
- Once a beneficiary is enrolled in the EFMP, the ECHO coordinator for their region registers the family member into ECHO and assigns them an ECHO Case Manager. The ECHO case manager assists the family member with all authorizations for care and continued eligibility for ECHO.

To enroll, eligible beneficiaries must complete DD Form 2876, *TRICARE Prime Enrollment Application and PCM Change Form*. They must include an initial 3-month payment, payable by check, electronic funds transfer, or allotment.

5.4 USFHP Coverage

- USFHP is an organized system of health care delivery that relies on primary care managers (PCMs) to arrange for all of an enrollee's health care needs with specific speciality providers and hospitals. USFHP offers plan flexibility where enrollees choose their PCM. Family members may have different PCMs. PCMs may be changed upon request.
- Covered benefits are available only from USFHP-approved providers, except during a medical emergency.
- USFHP enrollees must get referrals for care not provided by their PCM and use USFHP network providers and facilities for speciality services.

- USFHP offers a Point of Service option where enrollees may self-refer for specialty care (See *TRICARE Options*).

5.5 Costs

USFHP handles payment for covered services. There are no claim forms when USFHP-approved providers are used; enrollees are only responsible for the applicable copay.

5.6 Exchange of Benefits

Enrollment in USFHP affects the beneficiary's entitlement to use other government-sponsored health care programs. By enrolling, the beneficiary agrees not to use the following health care benefits:

- TRICARE Standard/Extra, TFL, and other TRICARE programs
- TRICARE Pharmacy Program:
 - Home delivery, retail network and MTF pharmacies
- MTF care, with the following exceptions:
 - When the beneficiary experiences an emergency and the nearest emergency room is a MTF.
 - When the beneficiary receives a prescription from a dentist for dental care not covered by USFHP, a military pharmacy may fill the dental prescription.
 - Enrollees may seek services offered by a MTF that are not covered by the USFHP, such as routine hearing tests, on a space-available basis.
- Medicare Part A or Medicare Part B (except for services not routinely covered under USFHP, such as chiropractic care)

5.7 Medicare-Eligible Enrollees

- Purchase of Medicare Part B isn't required to become a USFHP enrollee. However, DoD highly encourages Medicare-eligible beneficiaries to purchase Part B when first available to avoid incurring higher Medicare Part B premiums due to delayed enrollment penalties.
- If a member disenrolls from USFHP, those with Medicare Part B still have an opportunity to access services under Medicare Part B and TRICARE for Life (TFL).
- If a member disenrolls from USFHP without having Medicare Part B, they must apply for Medicare Part B before they can obtain TFL coverage; they may have a break in Medicare and TRICARE coverage until Medicare Part B takes effect, as well as pay a higher Medicare Part B premium.

5.8 Portability

- When enrollees move within their current USFHP's zip code-defined service area, they should notify their USFHP-designated provider of their new address.
 - If an enrollee wants to change their PCM based on their new address, they should contact their USFHP-designated provider to receive a new membership card with the new PCM's name and phone number.
- If they move to another area in the country where the USFHP is available, their enrollment may be transferred.
- If they move to an area where USFHP is not available and they qualify for TRICARE Prime or Prime Remote enrollment, they can transfer their enrollment to the new location; otherwise, they revert to TRICARE Standard or TRICARE for Life, depending on their Medicare status.

5.9 Accessing Medical Care While on Vacation

For medical emergencies, USFHP enrollees should go to the nearest appropriate civilian medical facility or MTF. Enrollees, or an authorized representative should call the USFHP provider's toll-free number (located on the back of the USFHP enrollment card) or their PCM within 24 hours, to facilitate USFHP coverage of the service. The bill should be sent to the address listed on the enrollee's USFHP enrollment card.

5.10 Prescription Coverage

Copayments for prescription medications through the USFHP retail pharmacy network are:

- \$5 for generic medications for a 30-day supply
- \$12 for brand name medications for a 30-day supply
- \$25 for non-formulary medications for a 30-day supply

USFHP also has a home delivery pharmacy option which allows enrollees to receive a 90-day supply for most prescription medications at the same cost as the TRICARE home delivery program (see *Pharmacy* for rates.)

For more information on USFHP eligibility and enrollment, please visit: usfhp.com

5.11 Comparing Plans

Beneficiaries may compare USFHP to other TRICARE plans by visiting tricare.mil/mybenefit/home/overview/ComparePlans

6.0 Computer/Electronic Accommodations Program

The Computer/Electronic Accommodations Program (CAP) is the federal government's centrally funded reasonable accommodations program for employees with disabilities in the Department of Defense (DoD) and throughout the federal government.

CAP's mission is to provide assistive technologies and accommodations to ensure that people with disabilities and wounded service members (WSMs) have equal access to the information environment and opportunities throughout DoD and the Federal government. CAP is helping to make the federal government the model employer for people with disabilities by eliminating the costs of assistive technology and accommodation solutions.

The Defense Authorization Act of 2000 granted CAP the authority to expand its services to agencies outside of DoD. CAP has formal partnership agreements with 66 Federal agencies.

In 2004, CAP launched its Wounded Service Member Initiative to support WSMs in their recovery and rehabilitation by equipping them with the appropriate assistive technologies, thereby empowering them for future employment opportunities.

On October 17, 2006, Public Law 109-364 authorized WSMs to retain assistive technology and services provided by CAP when they separate from active duty service.

6.1 Eligibility

- Disabled employees who work for the DoD or one of the 66 federal agencies that have a partnership with CAP.
- ADSMs with limitations resulting from injury or illness sustained while on active duty.

6.2 CAP Services

- Assistive technology to increase access to the computer and telecommunications environment
- Individualized needs assessments
- Demonstration and evaluation of assistive technology
- Installation, integration, and training
- Disability education and awareness
- CAP is available to provide support to WSMs during the following phases:
 - **Phase 1: Recovery and Rehabilitation:** CAP provides assistive technology to support the recovery and rehabilitation of WSMs at military treatment facilities (MTFs) around the world.
 - **Phase 2: Transition:** CAP works closely with therapists, providers, case managers, and military liaisons

to provide the appropriate assistive technologies to WSMs during their recovery process.

- **Phase 3: Employment:** Active duty service members may retain assistive technologies provided to them as personal property when they separate from active duty. CAP provides free workplace accommodations to separated service members who are in a federal internship program, or who return to the Federal government as civilian employees.

6.3 CAP Web Sites

For more information on CAP, please visit:

- cap.mil/ (support for federal civilian employees with disabilities)
- cap.mil/wsm/ (support for wounded service members)

Module Objectives



Summary

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- **Describe the Extended Care Health Option (ECHO)**
- **State the purpose of the Computer/Electronic Accommodations Program (CAP)**
- **Explain how the US Family Health Plan mirrors TRICARE Prime**