US FAMILY HEALTH PLAN | TRICARE®

2027 Member Handbook



800.67.USFHP
USFHPenroll.com

CHRISTUS Health®

MC8517

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WELCOME TO CHRISTUS HEALTH US FAMILY HEALTH PLAN!

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

ABOUT US

CHRISTUS Health has been providing health care to military families for over 30 years as a nonprofit organization offering primary care services in San Antonio, Southeast Texas and Southwest Louisiana. We also provide health plans to those eligible, including US Family Health Plan, a TRICARE Prime® option offered through a Department of Defense contract.

US Family Health Plan provides access to medical benefits for retirees from the uniformed services, their family members, qualified former spouses and active-duty family beneficiaries of the uniformed services: The Army, Navy, Air Force, Marine Corps, Coast Guard, Space Force, Public Health Service Commissioned Corps and the Oceanic and Atmospheric Administration Commissioned Officer Corps. US Family Health Plan also provides access to the same benefits for beneficiaries of the National Guard | Reserve and their families.

A network of primary care providers, specialists, hospitals and pharmacies within our designated service area provides medical services to eligible beneficiaries.

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 primary care provider who will coordinate your medical care.

HOW THE PLAN WORKS

As your health plan administrator, the staff at US Family Health Plan wants to help ensure that you understand your military health care benefits and that you always receive the health care services you need.

We hope this Member Handbook will help you understand the following:

- The role of your primary care provider (PCP)
- How to obtain health care services
- The services that are covered by TRICARE Prime and US Family Health Plan
- The services that are not covered by TRICARE Prime and 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

WELCOME TO CHRISTUS HEALTH US FAMILY HEALTH PLAN! (CONT.)

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 Mon. - Fri., 8 a.m. - 5 p.m. to help you find the answers you need. Member Services can be reached by calling **800.67.USFHP (800.678.7347); TTY 711.**

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 program are continually made as public law and/or federal regulations are amended. For the most recent information, contact CHRISTUS Health US Family Health Plan Member Services.



QUICK REFERENCE TELEPHONE NUMBERS

EMERGENCIES AND AFTER HOURS

Call 911 for emergencies. Notify your primary care provider within 24 hours of your emergency room visit so all follow-up care can be arranged.

URGENT CARE (INCLUDING EVENINGS, WEEKENDS, HOLIDAYS, ETC.)

You can see an urgent care provider without calling your primary care provider, but you should call your primary care provider to let him/her know what happened, especially if you need follow-up care. The telephone number for your primary care provider is printed on the front of your Member Identification (ID) Card.

24-HOUR NURSE LINE: 800.455.9355

SPECIALTY CARE

If you need access to a specialist, you do not need a referral from your primary care provider. Call an in-network specialist for an appointment. If you need help finding a specialist, call your primary care provider first or search for a provider in the USFHP Provider Directory at www.christushealthplan.org/find-a-provider. The telephone number is printed on the front of your Member ID Card.

MENTAL HEALTH

US Family Health Plan **800.67.USFHP (800.678.7347); TTY 711**
NOTE: For more information regarding mental health services, see Page 17.

US FAMILY HEALTH PLAN

Member Services: **800.67.USFHP (800.678.7347); TTY 711**

MAIL-ORDER PHARMACY (VytlOne Mail-Order Pharmacy): **800.687.0707**

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)

Manpower Data Center Support Office: **800.538.9552**
Fax: **800.336.4416**

INTERPRETER SERVICES

Interpreter Services are available through Member Services, **800.67.USFHP (800.678.7347); TTY 711.** You can request any language you need and an interpreter will be brought on the line.

MEMBER RIGHTS & 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 beneficiary of the US Family Health Plan.

Our notification of Member Rights and Responsibilities is available at CHRISTUShealthplan.org/privacy-and-patient-rights, as well as here in your Member Handbook.

MEMBER RIGHTS

As a CHRISTUS Health US Family Health Plan beneficiary, you have the right to:

- Receive considerate and respectful care, with recognition of your personal dignity and privacy at all times
- Receive information about USFHP, our services and your rights and responsibilities as our beneficiary
- Receive information about covered benefits and cost sharing
- Have a candid discussion of all medically necessary treatment options, regardless of the cost of benefits coverage
- 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.
- Understand an explanation of the diagnosis, treatment and prognosis of your health condition
- Participate in decisions involving your health care, including mutually agreed-upon goals, to the highest 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.
- 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
- You have the right to file grievances and appeals, as outlines in the "Grievance and Appeals Process" section of this Member Handbook
- Request that ongoing benefits be continued during appeals (although you may have to pay for the continued benefits if our decision is upheld in the appeal)
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Receive information about our provider and health care facilities, including information about the composition of our network.
- 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
- To participate with practitioners in making decisions about your health care and question the adequacy of the care being provided

MEMBER RIGHTS & RESPONSIBILITIES (CONT.)

- To have candid discussions of appropriate or medically necessary treatment options for your conditions, regardless of the cost or benefit coverage
- Receive a second opinion from another doctor in USFHP's network if you disagree with your doctor's opinion about the services you need. Contact Member Services for help with this
- Make recommendations regarding the organization's member rights and responsibilities policy

MEMBER RESPONSIBILITIES

As a US Family Health Plan beneficiary, you are responsible for:

- Carrying your member ID card with you at all times and knowing your eligibility status with your US Family Health Plan. If you lose your card, please call Member Services or log in to your Member Portal account to print a new ID card.
- Following the plan's prior authorization guidelines and policies.
- Becoming knowledgeable about your plan coverage and options
- Providing your health plan, primary care provider and other health care providers complete information to provide the needed care, to the best of your knowledge, regarding your medical history and other matters relating to your health.
- 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 following all instructions of care provided by your providers, 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.
- Understanding your health problems and participating in developing mutually agreed upon treatment goals, to the highest degree possible. Becoming involved in specific health care decisions.
- Being considerate of the rights of other patients, and of US Family Health Plan personnel and network providers.
- Being respectful of the property of other persons and facilities.
- Following provider facility rules and regulations concerning patient conduct.
- Reporting wrongdoing and fraud to appropriate resources or legal authorities.

US FAMILY HEALTH PLAN MEMBER ID CARD

All beneficiaries of 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 when copays and your primacy care provider remain the same. If you recently enrolled in the US Family Health plan and have not received your US Family Health Plan Member ID Card, please call Member Services, toll-free, and let us know that you are still waiting for your card.

A sample Member ID Card is shown below. You will notice that the card provides 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 primary care provider
- Your copayment responsibilities for office visits, emergency room visits, and inpatient hospital
- Instructions and telephone numbers for medical emergencies. If you are a parent, we suggest that you keep your children's card 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.

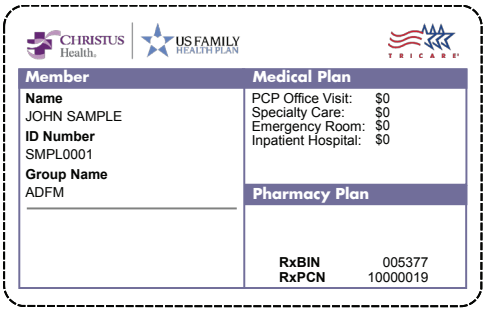
If you lose or damage your card, please call Member Services and we will send you a replacement Member ID Card.

SAMPLE ID CARD

In case of emergency, seek care immediately.

Please refer to important numbers listed on the back of your card. Claims should be sent to the address listed on the back of your card.

Please review your Member ID Card for accuracy. If any information is incorrect, call Member Services and a corrected card will be sent to you within two (2) weeks.





MAIL-ORDER PHARMACY: 800.687.0707

24-HOUR NURSE LINE: 800.455.9355

US FAMILY HEALTH PLAN MEMBER ID CARD (CONT.)

PROVIDERS SEND CLAIMS TO:

US FAMILY HEALTH PLAN AT CHRISTUS HEALTH
PO Box 561505
Dallas, TX 75356

PROVIDER INQUIRY: 800.67.USFHP (800.678.7347); TTY 711

Present your Member ID Card each time you receive care or fill a prescription. This ID Card lets the clinic staff and hospital know what your copayment is and where to send the bill for the services you receive.



PRIMARY CARE PROVIDER

CHOOSING YOUR PRIMARY CARE PROVIDER

US Family Health Plan beneficiaries are required to select a primary care provider. Each enrolled family member should also select a primary care provider with whom he or she is comfortable.

If you or an enrolled family member ever wishes to choose a different primary care provider, simply call Member Services. They will update your information and send you a new Member ID Card listing your new primary care provider. You can also change your primary care provider through your online Member Portal, found at christushealthmember.healthtrioconnect.com.

You are free to change your primary care provider at any time during your membership. Please ensure that you notify Member Services or update your online portal if you change your primary care provider. Visit CHRISTUShealthplan.org/find-a-provider for a directory of participating providers.

ROLE OF YOUR PRIMARY CARE PROVIDER

Your primary care provider and his/her team are the key to accessing services that will meet your health care needs. He or she sees you for all your routine health needs, monitors the medications you receive, orders tests or special services such as physical therapy when needed and maintains your medical records. If you have a complex problem, your primary care provider may refer you to one of our many qualified network specialists. Your primary care provider and the specialist will work together as a team to meet your health care needs.

There are many advantages to choosing a designated primary care provider:

- You only have one office to call whenever you need care.
- Your medical records are kept in one secure place.
- Your primary care provider has a good working relationship with the specialists and hospitals that he/she recommends for care.
- Your medications can be monitored for adverse interactions.
- You develop a trusting relationship with your primary care provider over time and he/she becomes familiar with your medical history and personal needs/preferences.
- Your primary care provider and his/her staff can help you navigate the complex world of health care.
- A primary care team led by your primary care clinician will provide the highest quality care for you. Your designated PCP may not always be available for urgent or even routine care, so other team members, including other physicians in the practice, nurse practitioners or physician assistants, with access to your records usually are made available. Knowing the other team members will be helpful to you.

PRIMARY CARE PROVIDER (CONT.)

Your primary care provider's office will submit claims to us for any services you receive. You should not receive a bill (other than your copay) for most routine and preventative care received from your primary care provider. If you do receive a bill from your primary care provider for anything other than your copayment or authorized cost share, please contact Member Services, toll free **800.67.USFHP (800.678.7347); TTY 711.**

CHANGING YOUR PRIMARY CARE PROVIDER

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

- If you are currently taking medications daily, obtain a 90-day supply from your former provider (before you change your primary care provider) to ensure you do not run out prior to your first visit with your new PCP.
- Call your new PCP's office to inquire about its process for establishing a patient-provider relationship.
- Call your former primary care provider's office and request a transfer of your medical records to the office of your new PCP.
- Call Member Services to update your PCP and issue a new ID Card or update the information online and download your new ID Card.

SPECIALTY CARE

Some services may require authorization by US Family Health Plan. Please see the "Authorizations" section for more information on Page 20.

IMPORTANT! Before you receive services, please make sure to check whether the provider/facility is in the US Family Health plan network. To find out if a provider or facility is in our network, check our online directory at CHRISTUShealthplan.org/find-a-provider or you may call Member Services, toll-free.

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 (POS) benefit at a much higher cost to you. (See "Point of Service" section on Page 25.)

We highly recommend that beneficiaries call Member Services for coverage/cost information when considering if you should use an out-of-network provider.

PRIMARY CARE PROVIDER (CONT.)

CONTINUITY OF CARE

If you are following a treatment plan prescribed by a specialty provider 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 PCP as soon as possible.
- In circumstances where self-referral is warranted, please communicate with your primary care provider as soon as possible in order to maintain continuity of care.
- Some specialty services also require authorizations (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.

IMPORTANT: If the specialist is not in the US Family Health Plan network, additional authorization may be required in order for the service to be covered at the in-network 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 preauthorization from US Family Health Plan, these services will be covered at the POS benefit level, a much higher cost to you. (See "Point of Service" section on Page 25.)

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.

HOSPITAL ADMISSIONS

If you require a planned hospitalization, your PCP or specialist will make the necessary arrangements for you at a network facility. Your PCP or another network provider will coordinate your hospital care.

If you are admitted to the 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 US Family Health Plan by calling Member Services, toll-free **800.67.USFHP (800.678.7347); TTY 711.**

You may also use our online directory at CHRISTUShealthplan.org/find-a-provider to check provider/facility network participation.

Directories are subject to change and are updated on a regular basis.

COVERED SERVICES

Some services may be referred by your primary care provider, and many services require medical review and a preauthorization letter from US Family Health Plan prior to receiving the service. If you have any questions regarding these benefits, please call Member Services.

Please visit tricare.mil/costs to view a summary of your covered benefits and copayments/cost sharing. A list of limitations and exclusions to the TRICARE benefit begins on Page 25.

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

If you use the USFHP Mail-Order Pharmacy through VytlOne, 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 annually by the Department of Defense.

You are in Group A if your or your military sponsor's initial enlistment or appointment began before Jan. 1, 2018.

You are in Group B if your or your military sponsor's initial enlistment or appointment began on or after Jan. 1, 2018.

COVERED SERVICES (CONT.)

COPAYMENTS FOR COVERED SERVICES

Visit tricare.mil/costs for all TRICARE cost-shares and copayment information.

Note: Benefits and costs are subject to change by the Department of Defense. If you have any questions about a particular benefit or cost, contact Member Services.

DENTAL CARE IN SUPPORT OF A MEDICAL CONDITION

Medically related dental services and oral surgery require authorization by the plan. Prescriptions for dental or oral surgery services are only covered for authorized services.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Rental or purchase of medically necessary durable medical equipment (DME) must be ordered by your primary care provider.

- 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 authorization by 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.

COVERED SERVICES (CONT.)

FAMILY PLANNING

Family Planning Services are covered through Conduent. Services are designated as covered by TRICARE.

These covered services may include:

- Contraceptive implants (e.g. Norplant)
- Diaphragms (as well as the measurement for them)
- Intrauterine devices (IUDs)
- Sterilization procedures (including tubal ligation and vasectomy)
- Surgical treatments for a diagnosis of infertility

For more information, please contact Member Services, toll-free, at **800.678.7347.**

HOME HEALTH CARE

Prior to receiving home health services, a provider must certify that you qualify for such services and he or she 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.

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 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 US Family Health Plan. 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: Primary care providers or specialists using established medical criteria make eligibility determination and referrals to approved hospice care providers.

COVERED SERVICES (CONT.)

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

US Family Health Plan covers outpatient and inpatient care related to the treatment of diagnosed mental health or substance abuse conditions. Some additional programs and resources available to you include:

- **After Deployment:** Do you need help after your deployment? Military OneSource confidential counseling is available to help support the reunion and reintegration process. Military OneSource counseling: **800.342.9647**
- **inTransition:** Transferring to a new location or separating from active duty? InTransition coaches are skilled counselors who understand military culture and who maintain privacy. They can help you connect to a new provider, find services for you in your new location and monitor your transition. https://www.health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health Center-of-Excellence/inTransition
- **Military Crisis Line:** You can call, chat online or send a text message to reach a trained professional at any time. Call **988** and press 1, or text **838255** to speak with someone if you experience a crisis or are concerned about someone experiencing a crisis.
- **Substance Abuse and Mental Health Services Administration Crisis Line:** 24/7 free and confidential treatment referral and information about mental and substance use disorders, prevention, and recovery. **1.800.662.HELP (4357)**, www.samhsa.gov

For additional information about the mental health benefit or to obtain names of in-network mental health professionals, please contact Member Services or use our online provider directory.

OBESITY TREATMENT

The following types of surgical treatment for obesity are covered: gastric bypass, gastric stapling, gastroplasty, gastric banding and sleeve gastrectomy. All treatments require medical review and must be preauthorized by US Family Health Plan.

Consultation visits to in-network specialists for consideration of covered obesity treatments do not require preauthorization by US Family Health Plan but do require a referral from your primary care provider.

Please note that prescriptions and nonprescription medications are not covered for weight loss or the treatment of obesity. Nutritional counseling for obesity is only covered as part of a bariatric surgical program. Participation in weight-loss programs or clinics are also excluded from coverage.

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 by an in-network provider
- 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 of services or where such treatment or services are provided, it is designed mainly to help the patient with the activities of daily living, also known as “essentials of daily living.”

COVERED SERVICES (CONT.)

EMERGENCY CARE

For a life-threatening medical emergency, call 911 or go to the nearest civilian emergency room (ER) immediately.

An emergency is defined as "the onset of an illness or injury of such a nature that, without receiving prompt medical attention, the individual is in jeopardy of sustaining serious impairment or dysfunction or that presents a significant threat to the individual's continuing health."

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

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

At the time of the ER visit, US Family Health Plan beneficiaries 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 do not pay a copayment for emergency room visits.

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.

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

- Cuts needing stitches
- Flu, fever, nausea
- Severe abdominal pain
- Sprains and broken bones

COVERED SERVICES (CONT.)

OUT-OF-AREA CARE

When you travel outside the US Family Health Plan service area, only qualified emergency and urgent care are covered. An exception would be care received using the POS option. (See the "Point of Service" section below.)

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

- Equipment or supplies necessary to treat a chronic condition
- Follow-up care related to a covered emergency situation
- Routine office visits and lab work
- Routine treatment for a chronic condition

Additionally, routine obstetrical care and inpatient labor and delivery services are not covered as an in-network benefit when a beneficiary chooses to travel outside the US Family Health Plan service area within thirty (30) days of her expected due date. Such services will be rendered, but the beneficiary will pay the out-of-network cost.

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 primary care provider 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 should note that, although US Family Health Plan cannot cover your routine non-emergency care outside our service area, you cannot use your Medicare to pay for care that is normally covered by US Family Health Plan (or would be covered if you were in the service area). Intentional use of Medicare outside US Family Health Plan service area for benefits that are covered by US Family Health Plan is known as "Medicare Leakage." **Intentional Medicare Leakage results in automatic disenrollment from US Family Health Plan.**

AUTHORIZATIONS

AUTHORIZATIONS

Certain services require an authorization. These types of services need to be reviewed first to make sure that they are covered by the 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

An authorization denial will be mailed to you and to the referring provider. Although the authorization takes approximately three days, the authorization letter will arrive in the mail within five business days.

Please feel free to call Member Services for the status of your authorization.

NOTE: All requests for out-of-network services are reviewed by 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 authorized to be covered at the in-network benefit level. Preauthorized inpatient admissions are subject to change over time based upon the government's assessment of the efficacy of the review. The changes will include adding to removing admissions or procedures.

AUTHORIZATIONS (CONT.)

COMMON AUTHORIZATION QUESTIONS

Question: Do I need an authorization from US Family Health Plan for every service?
Answer: Not necessarily. Some referred services, such as diagnostic testing (e.g., X-rays), never require authorization by the US Family Health Plan. Other referred services, such as office consultations and visits, do not require authorizations by the US Family Health Plan if those services are provided by an in-network provider. Some services, like inpatient hospital services, always require 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?
Answer: To find out which services require authorization prior to delivery you may do the following:

- Visit CHRISTUShealthplan.org/provider/prior-authorization for a list of services that require authorization (This list is subject to change so check back often.)
- Call Member Services, toll-free
- Ask your primary care provider to find out, on your behalf
- For preauthorization of mental and substance abuse services, please call Member Services

Question: What if I want to receive services from a provider NOT in the US Family Health Plan provider network?
Answer: In some cases, US Family Health Plan may authorize an out-of-network provider to deliver the medically necessary, covered service. If such authorization is granted, the service will be covered at the in-network benefit level.

However, if you choose to receive medically necessary, covered services from an out-of-network provider and have not received advanced authorization from US Family Health Plan 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.)

Question: How do I find out which providers are in the US Family Health Plan network?
Answer: Both you and your primary care provider are responsible for ensuring that the specialist to whom you are referred is an in-network practitioner. To find a health care provider in your area, visit our website at CHRISTUShealthplan.org or contact Member Services.

SERVICES NOT COVERED UNDER US FAMILY HEALTH PLAN

LIMITATIONS AND EXCLUSIONS

Please be aware that it is your responsibility to make certain that the care, treatment, diagnostic testing, equipment, supplies, medications or programs are covered by 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 primary care provider or an approved specialist. Examples include vitamins, orthodontics and chiropractic care. To determine if a service is a covered benefit under US Family Health Plan, please call Member Services.

GENERAL EXCLUSIONS

US Family Health Plan does not provide coverage for:

- Any mental health or substance abuse services denied or not authorized by USFHP
- Any services provided for employment, licensing, paternity determination, immigration, elective travel or other administrative reasons (for example, school or college programs)
- 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
- Complications due to a treatment or service not covered by US Family Health Plan (for example, complications resulting from a non-covered plastic surgery procedure and from a radial keratotomy)
- Services and drugs not prescribed by your primary care provider or the specialist to whom you were authorized to see
- Services not considered medically necessary for your diagnosis and treatment
- Services provided and charges incurred after the termination date of coverage as a beneficiary of the US Family Health Plan
- Services provided and charges incurred prior to the effective date of coverage as a beneficiary of the US Family Health Plan
- Services provided by relatives (by blood, marriage or legal adoption) or by people ordinarily residing in your household
- Unproven treatments, except Department of Defense (DoD)/National Cancer Institute (NCI) Cancer Prevention and Treatment Clinical Trials Demonstration

SERVICES NOT COVERED UNDER US FAMILY HEALTH PLAN (CONT.)

SOME SPECIFIC EXCLUSIONS

- Abortions (elective)
- Arch supports
- Acupuncture and acupressure
- Artificial insemination
- Autopsy and postmortem services
- Aversion therapy in connection with alcoholism
- Contraceptives (over-the-counter)
- Chiropractic services
- Clinical trials for any diagnosis or medical condition (**Note:** Beneficiaries 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.)
- 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)
- Food, food substitutes and supplements outside a hospital, with the exception of medically necessary foods
- 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 US Family Health Plan, as some restrictions apply.)
- Hair transplants
- Hearing aids and batteries (except for eligible active-duty beneficiaries through the Extended Care Health Options (ECHO) Program and eligible active-duty beneficiaries with a profound hearing loss)
- Hearing examinations (except when required for the diagnosis and treatment of an auditory condition). (Note: Hearing aids are not covered when prescribed unless for treatment of an auditory condition for those active-duty beneficiaries enrolled in the ECHO Program.)
- Homeopathic treatment
- Immunizations and prescribed medications for elective travel
- In vitro fertilization
- Massage therapy
- Megavitamins or orthomolecular psychiatric therapy
- Naturopathic services
- Orthodontics
- Orthopedic shoes (covered for diabetics only)
- Over-the-counter drugs or vitamins (except insulin)
- Physical exams for employment
- Private hospital rooms (except when medically necessary)

SERVICES NOT COVERED UNDER US FAMILY HEALTH PLAN (CONT.)

SOME SPECIFIC EXCLUSIONS (CONT.)

- Radial keratotomy
- Respite care (except as covered under Hospice or ECHO benefits)
- Retirement homes
- Sex therapy, sexual counseling, sexual behavioral modification or sex change procedures
- Sterilization reversals
- Therapeutic shoes (Note: Therapeutic shoes for diabetics may be covered but require medical review by US Family Health Plan, as some restrictions apply.)
- Treatments for learning disabilities
- Weight control (e.g., weight programs and medications for weight control)

This is not an all-inclusive list. Please contact Member Services, toll-free, if you have questions about a specific procedure or treatment not listed.

REVIEW OF NEW TECHNOLOGY

CHRISTUS Health 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 CHRISTUS Health 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.

POINT OF SERVICE

Point of Service (POS) is when a beneficiary chooses to use out-of-network providers when an in-network provider is available.

US Family Health Plan beneficiaries usually get their health care from in-network providers with very low out of pocket costs. The POS benefit gives beneficiaries more flexibility in their choice of provider. Under the POS option, beneficiaries may choose to get medically necessary care from out-of-network providers/facilities, even when they can get those services from an in-network provider.

In order for POS coverage to apply, *the care provided must be a TRICARE-covered benefit.* While the POS option provides some coverage for unauthorized out-of-network care, your out-of-pocket costs will be much higher if you make the choice to use the POS option.

Question: What are my costs under the POS option?
Answer: Please visit tricare.mil/costs for POS pricing specifics.

NOTE: Out-of-pocket costs under the Point of Service option are not applied to the catastrophic cap.

POINT OF SERVICE (CONT.)

Any deductibles or cost shares a beneficiary pays for services received through the POS benefit do not apply to the out-of-pocket maximum, or "catastrophic cap," which means there is no maximum limit to these charges (see Page 52 for more information).

Per TRICARE, Point of Service determinations are not appealable. Point of Service (POS) option does NOT apply to the following:

- Active-duty service members
- Referrals (If you have a referral and/or authorization, your costs are the same as network costs.)
- Newborn or adopted child (until enrolled in USFHP)
  - Children are covered by USFHP for 90 days (120 days overseas) after birth or adoption as long as one other family member is enrolled. The point-of-service option won't apply to children during this time or until the date the contractor receives the enrollment form.
- Use of other health insurance (OHI) as primary coverage
- Use of the following types of care:
  - Emergency care
  - Preventive care from a network provider in your region
  - Urgent care, in some cases
  - Outpatient mental health care without PCP referral
  - Substance use disorder (SUD) visits
  - Ancillary services

More information about your POS benefit option is available online: tricare.mil/Costs/POS

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, do not hesitate to call Member Services at **1.800.678.7347.**

TRICARE YOUNG ADULT

The TRICARE Young Adult (TYA) program is a premium-based health plan available for purchase by qualified dependents. TRICARE Young Adult Prime coverage is available for purchase from CHRISTUS Health 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 qualified applicants may purchase coverage at any time.

Visit CHRISTUShealthplan.org for the TRICARE Young Adult enrollment form. 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.

YOU CAN CALL MEMBER SERVICES, OR SEND YOUR COMPLETED APPLICATION AND INITIAL PREMIUM PAYMENT TO:

CHRISTUS HEALTH USFHP
Attn: Enrollment
PO Box 169001
Irving, TX 75016

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.

TRICARE YOUNG ADULT (CONT.)

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 tricare.mil/Plans/HealthPlans/TYA or call Member Services.

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 enrollment form and submitting it to CHRISTUS Health US Family Health Plan. If you decide to end TYA coverage, you will be locked out from purchasing TYA coverage for one (1) 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. Failure to pay total premium amounts due and any insufficient fund fees owed will result in a termination of coverage. A 12-month TYA purchase lockout will go into effect.

CHANGE IN STATUS

Your sponsor must always report all family and status changes to DEERS. Your TYA coverage 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.

MEDICAL MANAGEMENT

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 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.
- 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 US Family Health Plan. Rest assured that USFHP 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.
- US Family Health Plan 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 to encourage decisions that result in underutilization of services or benefits.

NON-EMERGENCY ELECTIVE HOSPITAL ADMISSIONS

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 US Family Health Plan. It is important to note that without receiving proper preauthorization from USFHP, 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 primary care provider within 24 hours of admission.

MEDICAL MANAGEMENT (CONT.)

24-HOUR NURSE LINE

The Nurse Line is available 24 hours a day, 7 days a week. The nurse can help beneficiaries with questions or help beneficiaries decide what to do about their health needs. Nurse Line is toll free at **800.455.9355**.

MEDICAL MANAGEMENT

We encourage our beneficiaries to take an active role in their health care. If they need extra support, we provide resources like regular Care Management, Complex Care Management and Disease Management. These services can help beneficiaries take control of certain health issues and work collaboratively with representatives of our health plan Medical Management team. These services are provided by the health plan at no cost to CHRISTUS Health Plan's beneficiaries who qualify.

CARE MANAGEMENT

Care Management is a program that assists beneficiaries who need help with their health care needs. Care managers coordinate care, manage transitions between levels of care and work collaboratively with a beneficiary's current providers to identify the best personal care plan possible. Complex Care Management can help beneficiaries with multiple chronic conditions or multiple acute conditions regain optimum health or improved functionality, in the right setting and in a cost-effective manner.

DISEASE MANAGEMENT

Disease Management can assist beneficiaries with management of conditions such as diabetes, asthma, lung disease, heart disease and adult and pediatric asthma. Disease Management provides education and support to beneficiaries to help them understand and manage their conditions.

A health coach or care manager will help you better understand your chronic conditions and help you manage ongoing medical problems by providing education, resolving healthcare gaps and sharing tools for improving your health. They will also help with medication management and provide guidance on steps that you can take each day on your way to feeling better.

The beneficiary of the health plan has the right to self-refer to any of the programs. We encourage our provider network to identify and engage beneficiaries with the health plan's Care Management Services. Please fax your patient referrals to **800.277.4926** or call our Care Management team at **800.446.1730**. These programs are voluntary, and beneficiaries can opt out at any given time.

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 (DoD) 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 beneficiary, 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 to determine coverage.

EXTENDED CARE HEALTH OPTION (ECHO) PROGRAM

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 for active-duty family members only with specific qualifying physical, developmental and/or mental conditions. 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. Please contact Member Services for referral to Care Management.

AUTISM CARE DEMONSTRATION

The CHRISTUS Health plan Comprehensive Autism Care Demonstration (ACD) covers applied behavior analysis (ABA) services. Under the ACD, ABA services are authorized to target the core symptoms of autism spectrum disorder (ASD).

The ACD began on July 25, 2014. It is currently authorized to run through December 31, 2028.

Does your child qualify for the ACD?

To qualify for the ACD, your child must be:

- Enrolled in a TRICARE health plan (CHRISTUS Health plan)
- Diagnosed with ASD by an approved provider

US FAMILY HEALTH PLAN SPECIAL PROGRAMS (CONT.)

Are you an active-duty service member (ADSM)?
ADSMs with a child diagnosed with ASD **must** enroll in your service branch's Exceptional Family Member Program. Your child must also enroll in the Extended Care Health Option (ECHO).

- Exceptional Family Member Program: https://www.militaryonesource.mil/special-needs/efmp/
- Extended Care Health Option (ECHO): https://tricare.mil/Plans/SpecialPrograms/ECHO

Is ACD available overseas?
Yes. However, it's only available in very few locations overseas. ABA services overseas are only authorized for the sole provider model. Tiered ABA services aren't authorized overseas, except in U.S. territories. Please contact your regional call center when seeking ABA services. They'll walk you through the process.

HOW THE ACD WORKS

Follow the steps below to get started.

1 Get diagnosed

Your child must be diagnosed by an approved diagnosing provider, which includes either:

- A primary care physician in the following specialties:
  - Family practice
  - Pediatrics
  - Pediatrics nurse practitioners
- Board-certified or board-eligible physicians in the following disciplines:
  - Licensed clinical psychology, doctoral level
  - Doctors of Nursing Practice, meeting certain criteria
  - Developmental behavioral pediatrics
  - Neurodevelopmental pediatrics
  - Pediatric neurology
  - Adult or child psychiatry

2 Get a referral and pre-authorization

- Your child must get a referral to the ACD and a pre-authorization for all ABA services. All TRICARE plans require this.
- Your child's diagnosing provider will submit a referral to your US Family Health Plan (USFHP) provider for authorization.
- Your child will get an authorization letter for six months of ABA services.
  - A new referral from your ASD diagnosing provider is required every two years.

US FAMILY HEALTH PLAN SPECIAL PROGRAMS (CONT.)

Are you requesting ABA services for the first time?

- You'll get an authorization letter for your child from your USFHP provider. This authorization covers your child's ABA assessment.
- Your provider will complete your child's ABA assessment. Then, your provider will develop your child's treatment plan.
- You'll get an authorization letter for six months of ABA services. Your child's provider will request reauthorization every six months.

**ABA services are only available in locations with board certified behavior analysts.*

3 **Complete outcome measures**

- You and your child's provider team must complete four baseline outcome measures before your child can get ABA services. This will help monitor your child's progress. The four measures are the:
  - Pervasive Developmental Disorder Behavior Inventory
  - Vineland Adaptive Behavior Scales
  - Social Responsiveness Scale
  - Parent Stress Index or Stress Index for Parents of Adolescents
- You must complete the four outcome measures every six months or every 12 months. The frequency depends on the measure.

4 **Schedule an appointment**

When you get your child's authorization letter:

- Schedule your child's ABA assessment appointment. Your child's authorization letter gives you the provider's contact information.
- If you'd like to see a different provider, contact your USFHP designated provider: CHRISTUS Health 1.800.678.7347

Your authorized ABA supervisor:

- Oversees your child's ABA treatment program
- Helps you to develop goals; these goals are for your participation in your child's ABA treatment plan.
- Updates your child's treatment plan; this will be done before your child's next authorization period.

PRESCRIPTION DRUG BENEFIT

COMPREHENSIVE PHARMACY BENEFIT

Your prescription drug benefit covers prescription drugs filled at network pharmacies when prescribed by an authorized US Family Health Plan provider. Prescription copayments vary depending on what type of medication it is (formulary generic, formulary brand name or non-formulary) and whether you are using a retail network pharmacy or the mail-order pharmacy.

PRESCRIPTIONS

Prescriptions can be filled at a local VytlOne Pharmacy (designated provider), a network pharmacy or the VytlOne Mail Order pharmacy.

The local VytlOne Pharmacy locations are:

- **VytlOne** – Clear Lake (Houston)

Nationwide network pharmacies include:

- Brookshire Brothers
- CVS (freestanding or inside Target)
- H-E-B
- Market Basket
- Sam's Club
- Costco
- Walmart

The network pharmacies can be used for first time and urgent care fills only. Prescriptions filled at a network pharmacy are limited to a maximum of 30-day supply. A 90-day supply can only be obtained by VytlOne Mail Order Pharmacy and the walk-in VytlOne Pharmacy.

The copayments using Mail Order remain the lowest copayments available. In addition to lower copayments, you can fill up to a 90-day supply of medication using Mail Order. This can save you over $720 per prescription per year in copayments. If you are not using mail order, call VytlOne customer service toll free at 866.408.2459 and ask how to move your prescriptions over.

Beneficiaries are responsible for a copayment to the pharmacy for each prescription filled or refilled. There is no copayment for drugs administered by a health-care professional. Please visit tricare.mil/costs to view copayments according to the type of pharmacy and formulary status.

PRESCRIPTION DRUG BENEFIT (CONT.)

NETWORK PHARMACIES

US Family Health Plan offers 15,000 network pharmacies nationwide for your convenience. When filling a prescription, always present your US Family Health Plan Member ID card along with the prescription.

VYTLONE MAIL-ORDER PHARMACIES

Use VytlOne Mail-Order Pharmacy for your maintenance medications. Maintenance medications are those medications taken regularly to treat a chronic condition, such as diabetes, high blood pressure or asthma. You will get up to a 90-day supply of medication for a lower copayment than you would for a 30-day supply at a retail network pharmacy.

Using the VytlOne Pharmacy Mail-Order Pharmacy can save you time and money for all your prescription needs. Benefits include:

- A 24-hour toll-free refill telephone line
- VytlOne App found on the App Store and Google Play
- Ability to order up to a 90-day supply, as prescribed (Note: Some restrictions apply.)
- Convenient delivery to your home — no need to drive to the pharmacy and wait in lines
- Delivery to a temporary address while traveling
- Free shipping
- Online account to view prescription history
- Savings up to 64% on your prescription copayments over the network retail pharmacy (**Note**: All fees and copayments are subject to change by the Department of Defense.)
- Web refills using the web address: vytlone.com

NEW PRESCRIPTIONS CAN BE MAILED TO THE PHARMACY OR SENT DIRECTLY FROM YOUR PROVIDER.

VYTLONE MAIL-ORDER PHARMACY
P.O. Box 32050
Amarillo, TX 79120

Refills can be ordered by telephone **866.408.2459**, 24 hours a day; online via your member portal or by using the VytlOne App. Within 14 days, you will receive your medications at your door. Make sure you have payment on file before ordering your prescriptions. Your only cost is the copayment (if one applies).

PRESCRIPTION DRUG BENEFIT (CONT.)

FORMULARY

The US Family Health Plan prescription drug formulary is established by the Department of Defense (DoD), Pharmacy and Therapeutic Committee (a group of military providers and pharmacists) and approved by the Director of Defense Health Agency (DHA).

The TRICARE Formulary is a list of generic and brand-name prescription drugs. It includes preferred generic drugs (Tier 1); preferred brand drugs (Tier 2); non-formulary brand, non-formulary generic drugs (Tier 3); and non-covered drugs (Tier 4). These categories follow industry standards. They depend on the medical effectiveness and cost effectiveness of a drug compared to other similar drugs. Visit tricare.mil/CoveredServices/Pharmacy/Drugs to get additional information about the DoD Pharmacy and Therapeutics review and a list of formulary drugs.

GENERIC DRUG POLICY

Generic drugs are chemically identical to their branded counterparts. They are made with the same active ingredients and produce the same effects as their brand name equivalents. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as brand name drugs. The FDA also requires that all drugs including generic drugs be safe and effective. Generic drugs usually cost less than brand name drugs. You can save money on your copay by choosing generic drugs when applicable.

DoD's policy on generic drugs requires the pharmacy to substitute generic medications for brand-name medications when a generic equivalent is available. Brand-name drugs with a generic equivalent may be dispensed only if your provider submits a medical necessity request and approval is granted by USFHP. In those cases, you will pay the brand-name copay. If you insist on having a prescription filled with a brand name drug when a generic equivalent is available, and medical necessity for the brand name drug has not been established, you will be responsible for the entire cost of the prescription.

Visit the TRICARE Formulary website at tricare.mil/CoveredServices/Pharmacy/Drugs to determine a drug's eligibility for medical necessity.

PRESCRIPTION DRUG BENEFIT (CONT.)

QUANTITY LIMITS

The Department of Defense Pharmacy and Therapeutics Committee has established quantity limits for certain medications. If your medical condition warrants use of quantities greater than the listed quantity limit for your medication, your provider may submit a Prior authorization request for use of the higher quantity. Your physician must provide medical justification for use of the higher quantity. To determine if there is a quantity limit on a medication you take, use the TRICARE Formulary Search tool at tricare.mil/CoveredServices/Pharmacy/Drugs to view drug specific information.

TO INITIATE A QUANTITY LIMIT PRIOR AUTHORIZATION YOUR PROVIDER MUST COMPLETE AND FAX THE PRIOR AUTHORIZATION FORM TO THE VYTLONE:

320 South Polk - Suite 200
Amarillo, TX 79101
Fax: **844.370.6203**
Phone: **800.687.0707**

PRESCRIPTION DRUG LIMITATIONS/EXCLUSIONS

US Family Health Plan does not cover:

- Any prescriptions refilled before the previous refill is 80% used
- Drugs used for cosmetic reasons (e.g., Propecia, Renova, Rogaine, Vaniqa)
- 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)
- Food supplements
- Homeopathic and herbal preparations
- Medical supplies (e.g., dressing and antiseptics)
- Over-the-counter drugs (except when approved for the formulary)
- Prescription drugs prescribed for an off-label use that is not generally accepted by the medical community
- Prescriptions associated with non-covered TRICARE benefits or non-approved services

PRESCRIPTION DRUG BENEFIT (CONT.)

PRESCRIPTION DRUG RECALLS

CHRISTUS Health US Family Health Plan cares about your safety. When VytlOne is notified by the Food and Drug Administration (FDA) about a Class I, Class II or voluntary drug recall, on behalf of USFHP, they promptly notify affected beneficiaries and their prescribing providers by mail.

For Class I recalls, situations where there is reasonable probability of a serious adverse health consequences caused by a medication, beneficiaries and prescribers will be notified within 10 business days of health plan notification by the FDA.

For Class II recalls, where a medication may cause temporary or medically reversible adverse health consequences, or in the case of a drug withdrawal from the market by a manufacturer, beneficiaries and prescribers are notified within thirty (30) calendar days of health plan notification by the FDA.

Beneficiaries who receive recall notices are urged to contact their prescriber for further instructions. More information can be found at fda.gov regarding drug recalls, market withdrawals and safety information.

ENHANCEMENT PROGRAM

In place of formal benefits, US Family Health Plan offers an enhancement program to supplement your benefits.

This is not insurance: This is a supplemental discount.

TRANSPORTATION ENHANCEMENT

SafeRide Health provides 24 round-trips (48 one-way trips) every calendar year. Transportation to medical services covered by the plan include:

- Appointments
- Dialysis
- Hospital admissions
- Medical procedure

Transport may be by rideshare or non-emergency ambulance through SafeRide Health. Call Member Services to schedule with SafeRide today at **800.678.7347.**

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

Complementary and alternative medicine (CAM) includes treatment not defined as standard medicine. CAM treatment options are not covered benefits under the plan and TRICARE. We do offer discounts on these services to plan beneficiaries through a partnership.

Show your plan Member ID card at participating providers to get up to 50% off CAM services:

- Acupuncture
- Chiropractic services
- Holistic providers
- Massage therapy
- Nutritional counseling
- Tai chi
- Yoga
- And more...

To locate a program in your area, visit USFHP.wholehealthmd.com.

Scan the QR code to join now.

ENHANCEMENT PROGRAM (CONT.)

DENTEGRA DISCOUNT DENTAL PLAN

We're bringing you discounted dental services as a CHRISTUS Health US Family Health Plan beneficiary, to help you maintain your smile, your total health and your budget.

What's a discount dental plan? It works like a membership plan. As a beneficiary of CHRISTUS Health US Family Health Plan, you receive discounts for dental services from Dentegra network providers. It's not dental insurance. Your Dentegra discount plan is a convenient way to protect your oral health while reducing your expenses.

Features of your discount dental plan:

- Reliable savings: Dentegra negotiated discounts with general dentists and specialists that average between 30%-40% in savings for you. Discounts are available on hundreds of dental services, including cleanings, exams, x-rays, crowns, fillings, veneers, implants, teeth whitening and more.
- Network of top-notch providers: You have the freedom to choose any Dentegra provider in the nation. There are more than 25,000 general dentists and specialists in the Dentegra network nationwide.
- Check if your provider is in the Dentegra network, or search for a network provider at Dentegra.com.
- Easy to use: You can start using your discounts after your US Family Health Plan effective date. Just show your USFHP Member ID card and Dentegra discount plan membership card to your Dentegra provider. Then pay your provider when you receive services.

ENHANCEMENT PROGRAM (CONT.)

AMPLIFON HEARING HEALTH CARE DISCOUNT PROGRAM

CHRISTUS Health US Family Health Plan has partnered with Amplifon Hearing Health Care, which is dedicated to helping you restore the sounds of your life. Our program provides beneficiaries and their families with custom hearing solutions from the top ten brands, expert care from a location near you and significant savings negotiated on your behalf.

With Amplifon, CHRISTUS Health US Family Health Plan beneficiaries enjoy:

- Risk-free 60-day trial period with 100% money back guarantee.
- Aftercare program — 1-year follow-up care, 2 years free batteries and 3-year warranty**
- Convenient locations near you — 5,600 providers nationwide
- Wide product selection from the leading brands including Miracle-Ear, Oticon, Phonak, ReSound, Rexton, Signia, Sonic Innovations, Starkey, Unitron and Widex

It's easy to activate your discounts:

1. Call **866.211.6050** or visit amplifonusa.com/christushealthusfhp. Amplifon's friendly and knowledgeable patient care advocates will help you find a hearing care provider near you.
2. The patient care advocate will explain the Amplifon program and assist you in making an appointment.
3. Amplifon will send you and your provider the necessary information to activate your Amplifon program.

***Some exclusions apply. A deductible may apply for a one-time claim for loss and damage for hearing aid purchased via the Amplifon Hearing Care discount program.*

ENHANCEMENT PROGRAM (CONT.)

GROUP VISION SERVICE (GVS) VISION PLAN

We're bringing you discounted vision services as a CHRISTUS Health US Family Health Plan beneficiary, to help you maintain your vision acuity, your total health and your budget.

What's a discount vision plan? It works like a membership plan. As a beneficiary of USFHP, you receive discounts for optical services from network providers. It's not vision insurance. Your GVS discount plan is a convenient way to protect your visual health while reducing your expenses.

Features of your discount vision plan:

- Reliable savings: GVS negotiated discounts with private practice and retail providers that average between 30%-40% in savings for you. Discounts are available on exams, lenses, frames, lens options, even Lasik surgery when you visit a GVS provider.
- Network of top-notch providers: You have the freedom to choose any GVS provider in the nation. There are more than 92,000 optometrists and ophthalmologists available in the GVS network.
- Check if your provider is in the GVS network, or visit gvsmd.com to search for a network provider.
- Easy to use: You can start using your discounts after your US Family Health Plan effective date.

ENROLLMENT INFORMATION

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

ENROLLMENT ELIGIBILITY

To enroll in 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 US Family Health Plan. The service area is determined by ZIP codes.

US Family Health Plan is available to the following beneficiaries who live in the designated service area:

- 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 Oct. 1, 2012, anyone who is turning 65 and eligible for Medicare will not be able to enroll in USFHP.)
- Family Members of Activated National Guard/Reserve members
- Non-activated National Guard/Reserve members and their families who qualify for care under the Transitional Assistance Management Program
- Retired National Guard/Reserve members at age 60 and their families
- Survivors
- Medal of Honor recipients and their families
- Qualified former spouses

Active-duty members of the uniformed services, even if they live in the US Family Health Plan service area, cannot enroll in 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.

The Transitional Assistance Management Program (TAMP) provides qualifying active-duty personnel and reservists and their family members with full TRICARE benefit including the opportunity to enroll in US Family Health Plan for a defined length of time as determined by DEERS. TAMP provides 180 days of health care benefits after regular TRICARE benefits end. These benefits help with your transition. You also you don't have to pay any premiums for TAMP.

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 US Family Health Plan, call Member Services.

ENROLLMENT INFORMATION (CONT.)

NEWBORNS

Beneficiary has 90 days to officially enroll the newborn or adoptee to the Prime option, or 120 days overseas.. If the newborn or adoptee is formally enrolled in Prime within the 90/120-day period, the effective date of enrollment will be the first of the month following the date of birth or adoption.

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 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 90 days of his or her date of birth (120 days overseas). Upon your request, your child will be Conditionally Enrolled for their first 90/120 days until these two conditions are met.
- Failure to meet both of these requirements within the 90/120 day period will result in the contractor processing all claims as a non-enrolled beneficiary, applying the appropriate TRICARE cost-shares and deductibles.

We strongly recommend that you fill out, print, and mail the Enrollment Application (PDF) found in the "Enrollment" documents on the CHRISTUS Health US Family Health Plan website or call Member Services 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 mother does not want her newborn enrolled in US Family Health Plan, the mother should notify US Family Health Plan as soon as possible following the birth so that the US Family Health Plan can make the appropriate changes in DEERS.

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. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact CHRISTUS Health US Family Health Plan.

ENROLLMENT INFORMATION (CONT.)

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

In the initial year of enrollment, new beneficiaries 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 US Family Health Plan. Beneficiaries who are disenrolled from US Family Health Plan for nonpayment have to wait until TRICARE Open Season (each fall, beginning on the Monday of the second full week in November to the Monday of the second full week in December) or have a Qualifying Life Event.

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 fiscal quarter for the initial payment and quarterly thereafter (fiscal 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: An allotment from retirement pay; or Electronic Funds Transfer (EFTs) from your designated financial institution (which may also include a recurring credit or debit card charge); these are the only acceptable payment methods for the monthly payment option
- For payment options, such as automatic charges to your credit card or bank account, please contact Member Services. There is also an option for monthly allotment from military retiree pay.

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. 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 enhancements.

ENROLLMENT INFORMATION (CONT.)

MOVING OUT OF THE SERVICE AREA

If you move out of our service area, you are no longer eligible for enrollment in US Family Health Plan. However, you may be eligible to enroll in another TRICARE program. Call Member Services before you move and they will explain how to transfer your enrollment. Please note that eligible students who temporarily move out of the service area can stay enrolled in US Family Health Plan. However, only qualified emergency care and urgent care are covered while temporarily residing outside of the service area.

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

PORTABLE TRANSFER OF TRICARE PRIME ENROLLMENT TO US FAMILY HEALTH PLAN

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

The effective date of coverage by US Family Health Plan is the actual date that we receive a completed enrollment form. The losing contractor is obligated to retroactively disenroll you effective midnight the day prior to the effective date of enrollment in US Family Health Plan. You will have no break in coverage.

DISENROLLMENT

As a beneficiary of US Family Health Plan, you will automatically stay enrolled unless you elect to disenroll during your annual re-enrollment period.

Important: If your enrollment with US Family Health Plan began on or prior to Oct. 1, 2012, you will be disenrolled from the plan on the last day of the month preceding the month of your 65th birthday.

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 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 disenrollment.

AUTOMATIC DISENROLLMENT

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

- Intentional use of Medicare for benefits covered by US Family Health Plan, known as Medicare Leakage (see Page 58)
- 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

Beneficiaries can request reinstatement within 90 days of their disenrollment date (the last paid-through date) and pay all past due fees.

NOTIFICATION OF DISENROLLMENT

Disenrollment requests must be initiated by the sponsor, spouse, other legal guardian of the beneficiary, or an eligible beneficiary 18 or older. Beneficiaries will automatically be disenrolled when the appropriate enrollment fee payment is not received by the 30th calendar day following the last paid-through date.

FRAUD, WASTE AND ABUSE

PREVENTING IDENTITY THEFT AND PROTECTING PERSONAL HEALTH INFORMATION

Follow these "Best Practices" to protect your identity, personal health information and financial information.

1. **Phone calls:** Never share your Personal Health Information, such as your ID number, especially over the phone, unless you are certain the caller is a legitimate health care professional. Limit the information you provide, using only the minimum necessary information. Unless you're completely certain, a "Best Practice" is to take down the caller's name, phone number, name of the business and return the call after you verify the information. Only answer health-related questions.
2. **Verification of the caller's identity:** Ask the caller for the address where they are located, which should match a familiar location. Ask the caller for their supervisor's name. The information the caller provides can be verified by:
   a) Recognizing the phone number
   b) Performing a Google search on the phone number and business name
   c) Calling the main number of the business, and then being transferred to the original caller
3. **Ask questions:** Ask questions before you provide your personal information. Ask the caller to send you an email requesting the information needed, but do not reply to the email. At a minimum, ask the caller to provide you with their email address. The email address should end with a recognizable health care business name, such as "@CHRISTUSHealth.org". If a caller is rushing you, sounds agitated, frustrated or you feel uncomfortable in any way, immediately terminate the call.
4. **Payments by phone:** Did you have the treatment for which the caller is requesting payment? If the caller is a bill collector, ask them to mail you full information about the bill, which they are required to do. Call Member Services or the Special Investigations Unit for assistance, to confirm the bill is legitimate. Avoid making payments by phone, giving out a credit card number, or any banking information. Make the payment online via the business website, to confirm legitimacy. If you do make a payment by phone, a credit card is the best way, since most cards have 100% fraud protection, and no funds will be removed from your checking account. Avoid giving out a combination of information so someone can commit identity theft, i.e. Driver's license number, home address, Social Security number, banking information, credit card numbers with the 3-digit code on the back of the card or family members' names.
5. **If identity theft occurs:** Call the credit reporting bureaus and inform them of the identity theft. These three credit reporting bureaus, Transunion, Experian and Equifax will provide protections to prevent unauthorized banking, credit or loan accounts opened in your name. Call to inform your bank and other financial institutions and seek guidance.

FRAUD, WASTE AND ABUSE (CONT.)

FOLLOW THE LAW — HEALTH CARE RULES AND LAWS

Reporting unusual treatment or unauthorized billing: Please make a report with the Special Investigations Unit if any unusual or suspicious health care related activity occurs, i.e. you receive a bill for treatment you didn't receive, someone else used your ID to seek treatment, a Provider performs unauthorized treatment or medically unnecessary equipment. The CHP Special Investigations Unit (SIU) promptly and thoroughly investigates all reports of fraud, waste and abuse to detect if non-compliance is occurring. Please report any non-compliance. If preferred, you may remain anonymous. The options for reporting are:

- **Fraud, Waste and Abuse HOT LINE:** 855.771.8072
- CHRISTUS Health Plan main phone: 469.282.2000
- Dedicated email: fraudreporting@christushealth.org
- Secure fax: 210.766.8849
- Mail to: CHRISTUS Health Plan, Special Investigations Unit, 5101 N. O'Connor Blvd., Irving, TX 75039

BREAKING THE LAW — FRAUD, WASTE AND ABUSE (FWA) — INVESTIGATIONS AND REPORTING

DETECTION: Governing agencies and regulatory bodies require that CHP endeavor to detect fraud, waste and abuse, involving providers or beneficiaries within the health plan network. The CHP Special Investigations Unit (SIU) monitors, reviews and analyzes claims activity, to verify compliance with regulatory standards. To advocate for the highest and best health care for beneficiaries, CHP endorses treatment that is medically necessary, evidence based, provided by the proper specialist, at the right time, for the appropriate duration, in the most suitable location, at a reasonable cost. If these standards are not followed, there is a higher likelihood of an unfavorable impact on beneficiaries, generating preventable health care costs and the possibility a report will be made to the Special Investigations Unit.

SPECIAL INVESTIGATIONS UNIT (SIU): The SIU promptly and thoroughly investigates all reports of fraud, waste and abuse to detect if non-compliance is occurring by beneficiaries or providers. Beneficiaries must never misuse their benefits such as loaning their Member ID or card to anyone or receiving medically unnecessary treatment for compensation from a dishonest provider. When any non-compliance is confirmed, a referral is sent to law enforcement, governing agencies and regulatory officials. The SIU performs data analysis, medical record reviews, conducts personal interviews, performs audits and collaborates with health care providers to detect fraud, waste or abuse. As required by regulatory agencies, CHRISTUS makes reports to and cooperates with federal, state and local law enforcement.

FRAUD, WASTE AND ABUSE (CONT.)

EXAMPLES: Below are several examples of non-compliance, which may be considered fraud, waste or abuse.

MEMBER NON-COMPLIANCE	DESCRIPTION
Unnecessary treatment	Beneficiary knowingly seeks and receives medically unnecessary treatment or equipment
Cash for treatment	Accepting cash, gift cards or other benefits in exchange for unnecessary treatment
Misuse of member ID	Selling, loaning out or borrowing a Member ID, for unauthorized use
Caravan care	Joining a group transported to one or more providers for unnecessary treatment
Over utilization	Treatment that is not necessary to the extent rendered
Overcharging	Using an unneeded item or service priced unusually high or unreasonable
Non-covered services	Receiving non-covered services and pretending they are covered
Non-cooperation	Refusal to furnish or allow access to records or being uncooperative
Unauthorized services	Receiving unnecessary equipment, supplies and services not specifically prescribed
Repetitive billing	Receiving ongoing, unnecessary treatment or equipment

FRAUD, WASTE AND ABUSE (CONT.)

REPORTING

Report any possible violations to the Special Investigations Unit,
Fraud, Waste and Abuse HOT LINE: 855.771.8072

ENFORCEMENT

To comply with federal agency requirements, all laws and statutes, CHRISTUS monitors beneficiary and provider claims activity and reports non-compliance to authorities as appropriate authorities. Beneficiaries or providers who break the law can be charged using the following federal and state laws:

False Claims Act, 31 U.S.C. §§ 3729 – 3733,
42 C.F.R. §§422.503, 423.504(b)(4)(vi), etc.

The Anti-Kickback Statute
Statute: 42 U.S.C. § 1320a–7b(b)
Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law
Statute: 42 U.S.C. § 1395nn
Regulations: 42 C.F.R. §§ 411.350–.389

The Exclusion Authorities
Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5
Regulations: 42 C.F.R. pts. 1001 (OIG)
and 1002 (State agencies)

The Civil Monetary Penalties Law
Statute: 42 U.S.C. § 1320a–7a
Regulations: 42 C.F.R. pt. 1003

Criminal Health Care Fraud Statute
Statute: 18 U.S.C. §§ 1347, 1349

More information on these laws: https://oig.hhs.gov/

Review Office of Inspector General enforcement actions:
http://oig.hhs.gov/fraud/enforcementactions.asp

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN?

EXCHANGE OF BENEFITS

Being a beneficiary of US Family Health Plan affects your entitlement to use other government-sponsored health care programs. By enrolling in US Family Health Plan, you agree to exchange certain entitlements for US Family Health Plan beneficiary 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 US Family Health Plan, such as chiropractic care)
- TRICARE Select, TRICARE For Life (TFL) and other TRICARE Prime programs
- TRICARE Mail-Order Pharmacy
- Military hospitals or clinics unless one of the following occurs:
  - If you experience an emergency and the nearest emergency room is in the military hospital or clinic.
  - If space is available, you seek services offered by a military hospital or clinic that are not covered by US Family Health Plan, such as routine hearing tests.

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

MEDICARE PARTS A AND B

Enrollment in 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 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 US Family Health Plan. At that time, we will waive your enrollment fees and all copayments, except your prescription copayments.

As a beneficiary of US Family Health Plan, 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 eligibility.

This is not a requirement for 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 US Family Health Plan, you are not eligible for TRICARE For Life 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 US Family Health Plan. You are no longer eligible for coverage under TRICARE 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 Part 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).

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

- 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 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 beneficiary of US Family Health Plan intentionally uses Medicare to pay for services that are routinely covered by US Family Health Plan. When Medicare-eligible military beneficiaries enroll in 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 PCP and our network of specialists.

However, they may use Medicare to pay for services not covered by US Family Health Plan, such as chiropractic services. Our contract with the Department of Defense requires us to automatically disenroll beneficiaries who intentionally use their Medicare for convenience or to obtain services denied as "covered but not medically necessary" by US Family Health Plan.

Beneficiaries who are disenrolled because they elect to use Medicare rather than US Family Health Plan cannot reenroll in US Family Health Plan for at least twelve (12) months, starting from the disenrollment date. Disenrollment will not be retroactively applied in order to make the beneficiary eligible for Medicare benefits on the date of the Medicare Leakage.

STATE-FUNDED INSURANCE — MEDICAID COMBINED WITH US FAMILY HEALTH PLAN COVERAGE

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

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

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.

Beneficiaries of 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 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 US Family Health Plan.

The provider has one hundred twenty (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.

All confirmed third-party liability cases will be processed according to the procedures outlined by the individual service branch's Judge Advocate Generals (JAG) offices.

It is the beneficiary's responsibility to inform his or her PCP and US Family Health Plan about the accident and treatment. Failure to report this could result in loss of coverage for care related to this injury and possible disenrollment from US Family Health Plan.

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

PRIVATE COMMERCIAL HEALTH INSURANCE PLANS AND COORDINATION OF BENEFITS (COB)

Some US Family Health Plan beneficiaries 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, federal law requires that all health care providers bill commercial insurance first, as the patient's "primary payer," before billing any federally sponsored health care plan such as Medicare, Medicaid, TRICARE or US Family Health Plan. Even though US Family Health Plan manages your health care services, 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 provider. We also periodically request verification of other health insurance through mailings and when you call Member Services. By collecting this information, US Family Health Plan can coordinate the benefits of your private insurance policy with those of 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 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 US Family Health Plan — the difference is who is doing the funding. For 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 be enrolled in both types of plans.

If you are in a Medicare Advantage plan, your membership in that plan may affect your enrollment eligibility in US Family Health Plan. It is extremely important that you contact Member Services as soon as possible so we can discuss your options.

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

INSURANCE CHANGES

It is the beneficiary's responsibility to inform US Family Health Plan about any insurance changes for any member of the family enrolled with 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.

PROCESSING CLAIMS FOR BENEFICIARIES 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 US Family Health Plan as your secondary payer.

In processing those claims, a copayment will not be charged from US 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. If your private commercial insurance uses the entire charged amount for that date of service toward meeting your annual deductible, you are required to pay your US Family Health Plan copayment. US Family Health Plan needs a copy of the explanation of benefits (EOB) that your private insurance sends to the provider before US Family Health Plan pays anything more to that provider. Any claim submitted to us as the secondary payer 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 payer and must be billed first.

Please call Member Services 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 beneficiary, 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.

Out-of-pocket expenses that contribute toward your cap include enrollment fees, copayments (including pharmacy copays) and cost shares. 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 new Member ID Cards that indicate "Max OOP" has been met with an end date of 12/31 (Dec. 31) of the current calendar year.

By visiting tricare.mil/costs, you can find your catastrophic cap.

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

BALANCE BILLING

A TRICARE network provider agrees to accept the rates and terms of payment specified in its agreement with US Family Health Plan as payment for a covered service. Participating non-network providers who accept assignment on the claim agree to accept the TRICARE allowable amount as payment in full for a covered service. These providers may not bill TRICARE beneficiaries more than this amount for covered services. Both network and non-network providers can seek applicable copays and cost-shares directly from the beneficiaries.

Non-network providers who do not accept assignment or do not "participate" on a claim do not have to accept the TRICARE allowable amount and may bill you for up to 15% above the TRICARE allowable amount. If the billed amount is less than the TRICARE allowable amount, TRICARE reimburses the billed amount.

If a TRICARE beneficiary has Other Health Insurance (OHI), the provider must bill the OHI first. After the OHI pays, TRICARE pays the remaining billed amount up to the TRICARE allowable amount for covered services. Providers may not collect more than the billed charge from the OHI (the primary payer) and TRICARE combined. OHI and TRICARE payments may not exceed the beneficiary's liability.

Medicare's balance-billing limitations apply to TRICARE. Noncompliance with balance-billing requirements may affect a provider's TRICARE and/or Medicare status. Balance-billing limitations only apply to TRICARE-covered services.

Providers may not bill beneficiaries for administrative expenses, including collection fees, to collect TRICARE payment. In addition, network and participating non-network providers cannot bill beneficiaries for non-covered services unless the beneficiary agrees in advance and in writing to pay for these services up front. At that point, the provider is not obligated to file a claim to TRICARE if the TRICARE specific waiver is in place and the non-covered service is confirmed prior to the date of service.

However, if you receive what appears to be a balance bill for more than your appropriate co-payment, 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 co-payment, but the copayment does not match the appropriate co-payment advise them of the error.
- If they indicate that it is the balance of the amount that your insurance (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 US Family Health Plan has not paid the appropriate amount, take the name of the person with whom you spoke and call Member Services.

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

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

BALANCE BILLING (CONT.)

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 US Family Health Plan for non-emergency or urgent 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" on Page 25). 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.

PARTICIPATING/IN-NETWORK CLAIMS AND REIMBURSEMENTS

Beneficiaries of the CHRISTUS Health US Family Health Plan should never receive a claim or a bill from a participating provider for a covered service except for their applicable copays. Participating providers are required to bill the plan directly for all covered services provided to beneficiaries. If you should receive a claim or a bill in error, call Member Services and ask the representative to contact the provider to correct the error.

OUT-OF-AREA CLAIMS AND REIMBURSEMENTS

If you are traveling outside the service area and require urgent or emergent care, the provider should bill USFHP at the address shown on the back of your Member ID card. However, some providers (especially if they are outside the United States) may require immediate payment from you.

To obtain reimbursement for out-of-area services as described above, you must submit a completed USFHP OOA and RX Reimbursement Form and the required documentation within 365 days of the date of service, at the address indicated below. Requests submitted after 365 days will be denied. This form can be found on CHRISTUShealthplan.org or by calling Member Services at the number on the back of your ID card.

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

NON-PARTICIPATING/OUT-OF-NETWORK CLAIMS AND REIMBURSEMENTS FOR MEDICAL SERVICES

In most cases, the provider of medical services should bill USFHP at the address shown on the back of your Member ID card. However, some out-of-network providers may require immediate payment from you.

To obtain reimbursement for covered out-of-network services, you must submit a completed USFHP Medical Reimbursement Form and required documentation within 365 days of the date of service. Requests submitted after 365 days will be denied. This form can be found on our website: CHRISTUSHealthPlan.org or by calling Member Services at the number on the back of your ID card.

Claims will be reimbursed for covered services at the TRICARE allowable amount, minus your cost share, or at billed charges, whichever is lesser. The Point of Service (POS) benefit applies to covered out-of-pocket services received by an out-of-network provider.

Note: The POS benefit has a higher out-of-pocket cost for covered services than if you had chosen an in-network provider. (50% of total costs applies after the POS deductible is met for formulary and non-formulary covered drugs.) Additionally, the provider has the legal right to charge up to 15% more than the TRICARE allowable charge. Any charges above the allowable charge are your responsibility and will not be reimbursed by USFHP.

WHAT MORE SHOULD YOU KNOW ABOUT THIS PLAN? (CONT.)

PRIVACY AND CONFIDENTIALITY

It is the policy of CHRISTUS Health and US Family Health Plan (USFHP) to protect the privacy and security rights of all of its health plan beneficiaries; to maintain the confidentiality of health plan information (oral, written and electronic); and to comply with all applicable federal and state privacy and security laws and regulations, including those under the Health Insurance Portability and Accountability Act (HIPAA).

Information provided to the plan is kept confidential and will only be used by the plan for such purposes as but not limited to:

- Care coordination
- Claims processing
- Coordination of benefits with other plans
- Subrogation of claims, review of a disputed claim
- Program integrity activities (examples: investigation of fraud, waste, abuse, or privacy theft)
- Quality improvement activities
- Other health care operations and/or payment purpose

To ensure responsible maintenance of your Protected Health Information (PHI), the plan has implemented internal policies and procedures to address how we further protect, secure and limit use and disclosure of your oral, written and electronic health plan information. USFHP verifies the identities of both the beneficiary and requestor prior to responding to a request for a beneficiary's PHI.

The plan secures and limits access to hardcopy and electronic files. Electronic data is password protected. Internal controls are in place to ensure that only the health plan associates have access to information required to perform their specific job functions. All health plan associates have gone through rigorous training prior to handling PHI.

GRIEVANCE AND APPEALS PROCESS

GRIEVANCE PROCESS

We continually strive to improve the experience, care and services that we provide to our beneficiaries. Any beneficiary who is dissatisfied with personnel, service or quality of care can offer feedback by contacting Member Services, toll-free. 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. Your grievance will be forwarded for review and will be acknowledged within five working days of receipt. All grievances will be resolved within 30 calendar days. If additional time is needed, a letter will be sent to the beneficiary noting this, with an explanation for the delay and the estimated date of completion.

Confidentiality is an important aspect of the grievance procedure. The beneficiary 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:

CHRISTUS HEALTH US FAMILY HEALTH PLAN
Attn: Grievances
PO Box 169009
Irving, TX 75016

APPEALS PROCESS

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

CHRISTUS Health US Family Health Plan intends to provide appeal notices in a culturally and linguistically appropriate manner. CHRISTUS Health 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%, CHRISTUS Health will add language to the appeal notice informing beneficiaries in that language how to obtain assistance in understanding the appeal notice.

GRIEVANCE AND APPEALS PROCESS (CONT.)

TYPES OF APPEALS

There are two main categories of appeals: factual and medical necessity. These types of 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 US Family Health Plan. A written request for appeal must be received — by mail, fax or email — before the expiration of the appeal filing deadline, unless it can be shown to the satisfaction of 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 US Family Health Plan that extraordinary circumstances do not exist is not appealable.

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 care).
- Determinations related to coverage based on limitations contained in Title 32 CFR 199, the TRICARE Policy Manual (TPM) and other TRICARE guidance.

Medical necessity appeals are requests to reconsider an authorization that has been denied for either of the following reasons:

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

There are two types of medical necessity appeals: **expedited** and **concurrent** appeals.

Expedited appeals must be submitted prior to the service being delivered. They must be filed within three (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 provider, the beneficiary's health or ability to function could be seriously harmed by waiting for the standard appeals process.
- Continuing coverage for inpatient or skilled nursing level of care has been denied.

GRIEVANCE AND APPEALS PROCESS (CONT.)

Concurrent appeals require the beneficiary to be a patient in the facility on the date of the appeal filing. Appeals may be submitted by a beneficiary, the beneficiary's appointed representative, the parent of a minor or a provider (if the beneficiary has signed an "Appointment of Representative" statement authorizing the provider to act on his or her behalf) along with a signed HIPAA disclosure form on file.

The appeal letter should include the beneficiary'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.

BENEFICIARY APPEALS SHOULD BE MAILED TO:

CHRISTUS HEALTH US FAMILY HEALTH PLAN
Attn: Medical Appeals
PO Box 169009
Irving, TX 75016
Fax: **866.416.2840**

Once an appeal letter is received, 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.

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

For further information on the appeals process, call Member Services.

Level 2 appeals: If the beneficiary is not satisfied with the outcome of the Level I determination and has Level 2 appeal rights in their determination letter, the beneficiary may submit an additional letter to request that the issue be further reviewed and reconsidered.

The beneficiary will need to send a copy of the Level I 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 I denial letter.

GRIEVANCE AND APPEALS PROCESS (CONT.)

APPEAL DECISION TIMEFRAMES

APPEAL TYPE	APPEAL DECISION TIMEFRAMES
Medical necessity and factual Appeals Level I	A pre-service determination will be made within 30 calendar days from the date your appeal was received. A post-service determination will be made within 60 calendar days from the date your appeal was received.
Medical necessity appeal: Concurrent	The TQMC shall complete a reconsideration determination for a concurrent review initial determination within two (2) working days and shall notify all parties and USFHP of the determination within three (3) working days after receipt of the reconsideration request from USFHP to the TQMC.
Medical necessity appeal: Expedited	Within three (3) working days of receipt of a request from a beneficiary for an expedited appeal.

DEFINITIONS

Adverse determination: A determination by a health maintenance organization (HMO) or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are not appropriate. The adverse determination, i.e., denial of a requested covered service, including type or level of service, which includes:

- Denial in whole or the service
- Denial in part of a service, i.e., has been limited, reduced, suspended or terminated
- Denial in whole or part of payment for a covered service
- Failure by the health plan to provide a service in a timely manner as defined by federal and/or state regulations
- Failure to act within timeframes for the health plan's prior authorization review process

Allowable charge: The maximum amount TRICARE will authorize for medical and other health services furnished by physicians, medical groups, professional providers, independent laboratories, suppliers of ambulance services and suppliers of durable medical equipment, prostheses, orthotics and supplies.

Appeal: The formal process by which a beneficiary or his/her authorized representative requests a review of the health plan's or delegated contractor's adverse determination of a covered service due to lack of medical necessity. The appeal (reconsideration process) consists of a review of the evidence of findings upon which it was based and any other evidence the parties submit or the health plan or regulatory agency obtains. A standard appeal resolution is made within 30 calendar days of receiving the request for the appeal.

Authorization: Approval by US Family Health Plan for a beneficiary 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 US Family Health Plan for the health care services you received.

Beneficiary: A recipient of insurance benefits.

- Who meets each of the enrollment and eligibility requirements described in this policy
- Who has been properly enrolled in coverage with the plan.
- For whom the plan has received any required premium for the enrolled coverage

Benefit: The health care items or services covered under a health plan.

Brand name drug: A drug sold under a specific, trademarked brand name, available by prescription or over the counter.

Catastrophic cap: A cost "cap" or upper limit on out-of-pocket expenses a beneficiary is required to pay for US Family Health Plan covered services. Visit tricare.mil/costs to find limits.

Coinsurance: A percentage of costs for a covered benefit the beneficiary pays after the deductible is met.

DEFINITIONS (CONT.)

Complaint (grievance): Any dispute or expressed level of dissatisfaction, either verbally or in writing, by a beneficiary or beneficiary's authorized representative with the health plan or a delegated contractor's processes other than an action associated with the disposition of a claim, i.e., adverse determination of a benefit.

Continuity of care: Term used to describe the process that allows an individual to continue to receive medical care from his or her current health care provider if he or she is currently involved in an active, covered treatment plan that if interrupted, could seriously affect the health of the beneficiary.

Coordination of benefits (COB): An insurance claims review process used when two or more carriers insure a beneficiary. The process determines the liability of each carrier in order to eliminate duplication of payments.

Copayment: The flat fee you are required to pay at the time of service (e.g., $20 for an office visit).

Covered services: Health care services and items a beneficiary is entitled to receive under their health plan.

Defense Enrollment Eligibility Reporting System (DEERS): A database of information on uniformed services members (sponsors), U.S.-sponsored foreign military, DoD and uniformed services civilians, other personnel as directed by the DoD and their family members.

Department of Defense (DoD): An executive branch of the federal government charged with coordinating and supervising all agencies and functions of the government concerned directly with national security and the United States Armed Forces.

Dependent: A child or other person claimed by another for a personal tax exemption.

DoD Managed Care Contract: The contract between US Family Health Plan and the Department of Defense (DoD) under which certain covered services are to be provided to or arranged for beneficiaries.

Disenroll or disenrollment: The process of ending membership in the plan. Disenrollment may be voluntary (member's own choice) or involuntary (not their own choice).

Durable medical equipment (DME): Medical equipment such as, but not limited to, wheelchairs, hospital beds, oxygen and respirators. Most items are covered when medically necessary.

Effective date: 12:01 a.m. of the date on which coverage begins.

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, the beneficiary is in jeopardy of sustaining serious impairment or dysfunction or that presents a significant threat to the beneficiary's continuing health. Examples include heart attacks and/or chest pains, uncontrollable bleeding and loss of consciousness.

DEFINITIONS (CONT.)

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his/her condition, sickness or injury is of such a nature that failure to receive immediate medical attention could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of pregnant women, serious jeopardy to the health of the fetus

Explanation of benefits (EOB): A statement sent to covered individuals by a health plan explaining services provided, amount billed and payments made to the provider and the amount the patient is responsible for.

Follow-up care: The contact with or re-examination of a patient at prescribed intervals following diagnosis or during a course of treatment.

Formulary: A list of prescription drugs chosen and covered by a health plan with prescription drug benefits. The DoD Pharmacy & Therapeutics (P&T) Committee (a body of military physicians and pharmacists) and approved by the Director of the Defense Health Agency (DHA) establishes a uniform formulary, which is a list of covered generic and brand name drugs. This formulary also contains a third category of drugs that are non-formulary and a fourth category of drugs that are non-covered. Prescriptions for non-formulary drugs are dispensed at a higher copay. The formulary is updated on a quarterly basis.

Generic drug: A drug with the same active-ingredient formula as a brand name drug without a trademarked name. Generic drugs usually cost less than brand name drugs.

Grievance: Feedback lodged by a beneficiary dissatisfied with personnel, service or quality of care received.

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. This act protects privacy and regulates the use of protected health information (PHI).

Home health care: A home health agency is a public or private agency that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy, in the home. The home health care program provides skilled professional services to beneficiaries upon receiving prior orders by the attending physician and authorization by the UM/CM Department. Requests for continuation of services will be reviewed on an ongoing basis to determine medical necessity. Custodial care is a non-covered benefit.

In-network: Care received from a participating provider.

DEFINITIONS (CONT.)

Inpatient: A patient who is admitted to a hospital that requires at least one overnight stay.

Insurance: A method of providing money to pay for specific types of losses which may occur. Insurance is a contract between one party and another. The policy states what types of losses are covered, what amounts will be paid for each loss and for all losses and under what conditions.

Limits: Quantity or monetary thresholds associated with a particular benefit.

Mail-order pharmacy: A pharmacy that delivers drugs to patients through the mail directly to their homes, rather than requiring patients to show up at the pharmacy to pick up prescriptions.

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

Maximum out-of-pocket: A set amount capping what a beneficiary can spend on deductibles, coinsurance and copays for the plan year. After the maximum is met, the plan covers 100% of expenses.

Medical necessity: Services that are sufficient in amount, duration and scope to achieve their purpose, are in accordance with accepted standards of practice in the medical community of the area in which the services are rendered and are furnished in the most appropriate setting. A service is medically necessary when it (1) prevents, diagnoses or treats a physical or mental health injury; (2) is necessary to achieve age-appropriate growth and development; (3) minimizes the progress of disability; or (4) is necessary to attain, maintain or regain functional capacity. A service is not considered reasonable and medically necessary if it can be omitted without adversely affecting the beneficiary's condition or the quality of medical care rendered.

Medicare: Title XVIII of the Social Security Act and all amendments thereto.

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

Member ID card: Identification card issued to beneficiaries upon enrollment in a health plan.

Member Services: A department within our plan responsible for answering a beneficiary's questions about their enrollment, benefits, grievances and appeals.

Network pharmacy: A network pharmacy is a pharmacy where beneficiaries of the plan can get their prescription drug benefits. In most cases, their prescriptions are covered only if they are filled at one of the contracted network pharmacies.

Network provider: Provider is the general term used for doctors, other health care professionals, hospitals and other health care facilities that are licensed or certified to provide health care services. They are network providers when they have an agreement with the plan to accept plan payment as payment in full, and in some cases to coordinate as well as provide covered services to beneficiaries of the plan.

Out-of-network: Care received when traveling outside the CHRISTUS Health US Family Health Plan service area.

DEFINITIONS (CONT.)

Outpatient: Services that do not necessitate an overnight hospitalization, but visit to a hospital, clinic or associated facility for diagnosis or treatment.

Outpatient hospital: A place to receive covered services while not an inpatient. Services considered outpatient include, but are not limited to, services in an emergency room regardless of whether the beneficiary is subsequently admitted as an Inpatient in a hospital.

Plan: The health benefit plan established by CHRISTUS Health US Family Health Plan and selected by the beneficiary to provide health care services to beneficiaries, as it exists on the effective date of this policy or as subsequently amended as provided herein.

Prescription drugs: Drugs for which sale or legal dispensing requires the order of a provider with legal authority to prescribe drugs.

Primary care provider (PCP): 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.

Protected Health Information (PHI): Protected health information is any individually identifiable health information that relates to a patient's past, present or future physical or mental health and related health care services. PHI may include, but is not limited to, demographics, documentation of symptoms, examination and test results, diagnoses and treatments. Personal information that is protected by federal privacy policy.

Provider directory: A comprehensive listing of all participating providers in a health plan.

Service area: A geographic area approved by the DoD, within which an eligible individual (and any dependents) may enroll in US Family Health Plan.

Skilled nursing facility (SNF): A place that:

1. Legally operates as a skilled nursing facility
2. Primarily engages in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a physician
3. Provides continuous 24-hour a day nursing service by or under the supervision of a licensed practical nurse (LPN)
4. Maintains a daily medical record on each patient
5. Provides rehabilitation services, such as physical, occupational and speech therapy, and may provide other multidisciplinary services, such as respiratory therapy, dietician/nutrition services, and medical social work

Specialist: A physician who provides covered services for a specific disease or part of the body. Examples include internists who care for diseases of internal organs in adults; oncologists who care for patients with cancer; cardiologists who care for patients with heart conditions; and orthopedists who care for patients with certain bone, joint or muscle conditions and psychiatrists who care for beneficiaries with mental illness and disorders.

Summary of benefits: An easy-to-read summary that lets potential beneficiaries make apples-to-apples comparisons of costs and coverage between health plans. Prospective beneficiaries can compare options based on price, benefits and other features that may be important to them.

DEFINITIONS (CONT.)

Termination date: 11:59 p.m. on the last day of the month for which premiums were paid and the date that the beneficiary's coverage ends.

Termination of coverage: The cancellation or non-renewal of coverage provided by a health care plan to a grievant but does not include a voluntary termination by a grievant or termination of a health benefits plan that does not contain a renewal provision.

Transitional Assistance Management Program (TAMP): TAMP provides 180 days of transitional health care benefits to help certain service members and their family members transition to civilian life. For more information, visit tricare.mil/tamp.

TRICARE: Formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), TRICARE is a health care program of the United States Department of Defense Military Health System that provides civilian health benefits for military personnel, military retirees and their dependents, including some members of the reserve component.

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

Urgent care: Medically necessary health care services provided in emergencies or after a PCP's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention.

Utilization Management: A set of techniques used by or on behalf of purchasers of health care benefits to assure the appropriateness of care, and to manage the services provided to support improved health by completing case-by-case assessments of care given which is based on accepted standards of practice.



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