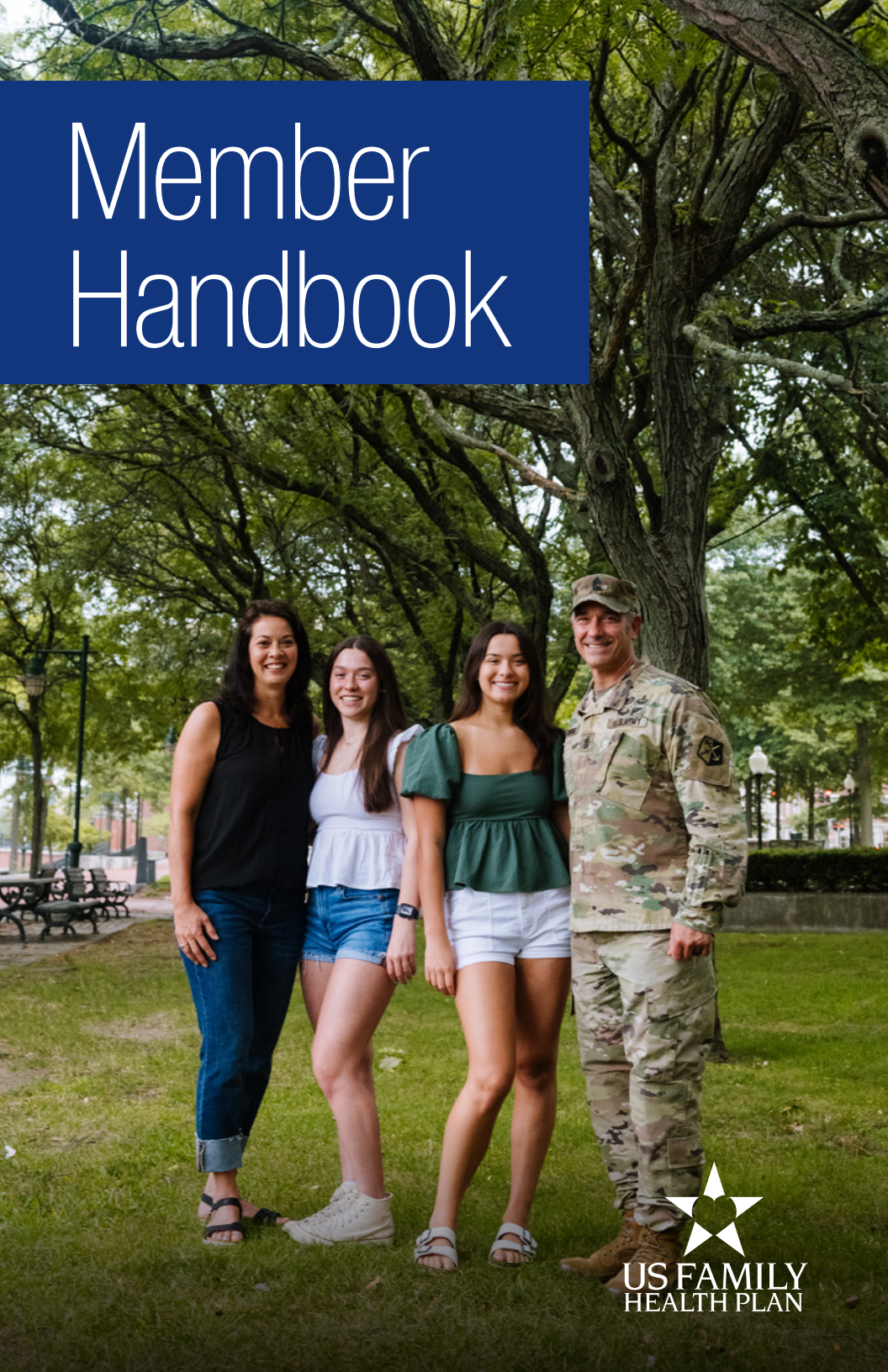
Member Handbook



US FAMILY HEALTH PLAN

Welcome.

We're honored that you've selected US Family Health Plan for your TRICARE benefits. Over the years, we've earned high marks from our members for the quality of care and service we provide. The help starts here — with our Member Handbook.

Important Phone Numbers

Emergency

If you have a medical emergency, call **911** or go to the nearest hospital emergency room immediately. Then call your primary care provider (PCP) within 24 hours. (Your PCP's name and phone number are on the front of your US Family Health Plan member ID card.)

Member Services

1.800.818.8589

For questions about your benefits, authorizations, claims, or billing status.

Appointments, Referrals, Authorizations for Urgent Care

Call your primary care provider (PCP). (Your PCP's name and phone number are on the front of your US Family Health Plan member ID card.)

Pharmacy

Home Delivery pharmacy

1.877.880.7007

Brighton Marine pharmacy

617.562.5304

24-Hour Nurse Advice Line

1.866.767.4546

When you need answers to basic health questions (Does my cut need stitches? Should I worry about this rash?), registered nurses are available by phone every day, all day and night.

Behavioral-Health and Substance-Abuse Self-Referrals

1.800.818.8589

Provides you with a list of professionals affiliated with US Family Health Plan. (Administered by Tufts Health Plan.)

Defense Enrollment Eligibility Reporting System (DEERS)

1.800.538.9552

Website and Secure Member Portal

usfamilyhealth.org

The latest information about US Family Health Plan, including a list of network providers. You also register here for our Secure Member Portal, which lets you review benefit information and view claims, referrals, and authorizations.

Contents

Summary of Benefits

For beneficiaries whose sponsor joined the uniformed services before January 1, 2018

	Active-Duty Family Members and/or those with Medicare Part B	Retirees and Family Members without Medicare Part B
2024 Plan Year Annual Enrollment Fee	$0	$363/individual $726/family
Covered Services – When provided or authorized by a network provider		
	Copayment	
Preventive care visit including: Annual physical (all ages) Annual comprehensive GYN exams Prenatal/postnatal visits Routine eye exams Well-child visits/immunizations (up to 24 mos.)	$0	$0
Primary care outpatient visit (non-preventive)	$0	$25
Specialty care outpatient visit including: Physical/occupational/rehabilitation therapy Radiation therapy/chemotherapy	$0	$37
Lab work and diagnostic radiology	$0	$0
Emergency room visit (network or non-network)	$0	$75
Ambulance service (outpatient ground)	$0	$50
Ambulance service (outpatient air)	$0	$20
Urgent care center	$0	$37
Inpatient hospitalization (including maternity)	$0	$188/admission
Ambulatory surgery	$0	$75
Chiropractic (spinal manipulation) Not covered under other TRICARE options	$0	$37
Skilled nursing facility care	$0	$37/day
Durable medical equipment (supplies, prostheses)	$0	20% of allowable charge

	Active-Duty Family Members and/or those with Medicare Part B	Retirees and Family Members without Medicare Part B
Behavioral Health – When provided or authorized by a network provider		
Outpatient visits	$0	$37
Partial hospitalization behavioral health/substance abuse	$0	$37/visit
Inpatient hospitalization behavioral health/substance abuse	$0	$188/admission
Prescription Coverage **Home Delivery** Maintenance medications (90-day supply)	Copayment (per prescription)	
Generic	$13	$13
Brand-name	$38	$38
Non-formulary	$76	$76
Retail Pharmacy One-time or urgent medications (30-day supply)	Copayment (per prescription)	
Generic	$16	$16
Brand-name	$43	$43
Non-formulary	$76	$76

Catastrophic cap: Your copayment expenses are limited to $1,000 per year for active-duty families and $3,000 per year for retiree families. The enrollment fee (if applicable) and all out-of-pocket copayments (except Point of Service) are included when determining the catastrophic cap.

Deductibles: Covered services provided by or authorized by network providers are not subject to a deductible amount.

Enrollment fee: This fee may increase annually. The benefits and costs described here are accurate as of January 1, 2024.

Important: Beneficiaries whose sponsor joined the uniformed services on or after January 1, 2018 have different costs. Please call Member Services at **1.800.818.8589** for more information.

Your US Family Health Plan Member ID Card

Each person covered by the Plan receives a US Family Health Plan member ID card. When you receive your card, be sure to take the time to read it and verify that the information is correct. If it isn't correct, call Member Services at **1.800.818.8589** right away. We will make the necessary corrections and send you an updated card.

Be sure to present this card any time you receive medical services.
For example,

- At the beginning of all appointments
- When registering at a medical facility or emergency room

It's important to carry your card (and your children's cards) with you in case there is an emergency.

If you lose your card

If you lose your card, call Member Services at **1.800.818.8589** and we'll send you a replacement.

If you change your primary care provider (PCP)

Your primary care provider's name and phone number are on the front of your card. If you change your PCP, it's important to tell us. Call Member Services at **1.800.818.8589** and we will send you a new card with your updated PCP information.

If you update your DEERS information

If there is a discrepancy in your DEERS information, you must first update the information at your local military ID office. (To locate a military ID office near you, go to the site locator at **dmdc.osd.mil/rsl**.) After you update DEERS, please call Member Services at **1.800.818.8589** so that we can send you a corrected US Family Health Plan member ID card.

Enrollment

US Family Health Plan relies on the Defense Enrollment Eligibility Reporting System (DEERS) to verify your eligibility for the Plan.

Enrollment eligibility

To enroll in the Plan, you must be an eligible beneficiary of the Military Health System (MHS) living in the ZIP Code-defined area served by US Family Health Plan from Brighton Marine. This includes Massachusetts, Rhode Island, portions of southern New Hampshire, and portions of Connecticut. You must also be eligible for military health care benefits in DEERS.

Eligible beneficiaries include:

- Spouses, unmarried dependent children (until their 21st birthday, or their 23rd birthday if full-time students), or other qualified dependents of active-duty service members. Unmarried children up to age 26 may be eligible to enroll in TRICARE Young Adult. (See page 38 for more information.)
- Dependents of activated Guard and Reserve Component members (active more than 30 days)
- Retirees, their spouses or survivors, and unmarried dependent children
- Eligible former spouses of active-duty or retired service members
- Military beneficiaries eligible for the Transitional Assistance Management Program (TAMP)
- Unremarried spouses and qualified unmarried children of active-duty or retired service members who have died
- Medal of Honor recipients

While dependent family members of active-duty sponsors are eligible to enroll in US Family Health Plan, active-duty members of the uniformed services are not. Active-duty sponsors receive their health care from military hospitals or clinics.

Dependents must keep their military identification cards (and DEERS information) up to date in order to be eligible to continue to receive US Family Health Plan benefits.

New enrollments

For all new enrollments, you may submit a completed TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form (DD Form 2876) to the Plan. You may also call **1.888.815.5510** to enroll by phone.

If you are not currently enrolled in TRICARE Prime or another US Family Health Plan, you will only be able to enroll during two periods:

- During Open Season, or
- Up to 90 days following a Qualifying Life Event (QLE)

Open Season

Open Season is the yearly period during which you can enroll in or change your health plan. Open Season ordinarily runs for a month starting in early November. Any changes you select will take effect January 1. During Open Season, you will be able to:

- Do nothing and stay in US Family Health Plan
- Change to another TRICARE plan, if eligible
- Disenroll (disenrolling during Open Season will mean that you will only be eligible for space-available care at a military hospital or clinic for that Plan Year)

Qualifying Life Events

Outside of Open Season, you can only enroll in or make changes to your plan if you have a Qualifying Life Event (QLE) such as getting married or divorced, birth or adoption of a child, retiring, moving to a new location, or losing other health coverage.

*For a current list of QLEs, go to **tricare.mil/LifeEvents**.*

If you are transferring your enrollment to US Family Health Plan from TRICARE Prime or another US Family Health Plan program, you may transfer your enrollment immediately. A QLE is not required for an enrollment transfer. We will make your coverage effective as of the date we receive your enrollment application. (See the "Enrollment transfer" section on page 10 for more information.)

If you are an inpatient

You may not change your enrollment while you are an inpatient at a hospital or other inpatient facility.

If you are an inpatient on the date your coverage is scheduled to begin, your coverage will not be effective until the date you are discharged from the hospital or other inpatient treatment facility.

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

Newborns and adoptees

A newborn or adopted child of an already enrolled family is covered by the Plan for a period of 90 days, starting at birth or date of adoption, provided the child is registered/enrolled in DEERS.

If the newborn or adoptee is not registered/enrolled in DEERS by the 90th day, he or she will only be eligible for space-available care at a military treatment facility and may not enroll in the Plan until the next Open Season.

Military hospitals or clinics

Individuals who are enrolled in US Family Health Plan may not use military hospitals or clinics for medical care or prescription drugs except for medical emergencies. Because the government is paying for your care through US Family Health Plan, using military hospitals or clinics for services covered by the Plan is considered "double-dipping" and is prohibited.

Likewise, by enrolling in the Plan, you have agreed to receive your TRICARE health care benefits through US Family Health Plan of Southern New England. The government requires as a condition of membership that you agree not to use other TRICARE programs while a member of US Family Health Plan.

Maintaining enrollment / Lifetime members

Members who enrolled before October 1, 2012 are eligible for lifetime enrollment with US Family Health Plan. (Members who enrolled on or after October 1, 2012 must leave the Plan on turning age 65.)

If you enrolled before October 1, 2012, it is very important that you maintain your enrollment. If, for any reason, you disenroll or have a break in your coverage, you will lose your lifetime eligibility for US Family Health Plan. This means that:

- If you are age 65 or older and disenroll for any reason, you will not be eligible to re-enroll in the Plan.
- If you are under 65 and disenroll for any reason, you may re-enroll, but you will have to leave the Plan on turning age 65.

If you are a member in this category, it is important to call us at **1.800.818.8589** before making any enrollment changes so that you do not unintentionally lose your lifetime eligibility.

Enrollment transfer

Enrollment transfer allows TRICARE Prime members to transfer their enrollment to US Family Health Plan and vice versa. No change in residence is necessary for the transfer to take place. A QLE is not required for an enrollment transfer.

To transfer from or to US Family Health Plan or TRICARE Prime, simply complete the TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form (DD Form 2876) and submit it to the program you wish to transfer into. When transferring your enrollment to another US Family Health Plan or to TRICARE Prime, do not submit a disenrollment form, as this will cause you to lose TRICARE coverage for the remainder of the Plan Year.

If you want to transfer to US Family Health Plan from TRICARE Prime, we recommend that you call us at **1.888.815.5510** to transfer your enrollment by phone.

Enrollment fee

As part of the DoD Uniform Benefit, US Family Health Plan must collect an annual enrollment fee from retirees and retiree family members.

There is no enrollment fee for active-duty families. There is no enrollment fee for any individual who is paying for Medicare Part B coverage. Members will be asked to provide proof of coverage in Medicare Part B in lieu of enrollment-fee payment.

You may pay the fee on a quarterly basis or you may pay the full amount all at once. For your convenience, you may pay the enrollment fee monthly by credit card, electronic funds transfer, or military payroll allotment.

Members will be disenrolled for nonpayment of an enrollment fee by the required date. Members who are disenrolled for nonpayment will not be able to re-enroll or enroll in another TRICARE plan until the next Open Season, and will be eligible only for space-available care at an MTF. Enrollment fees are nonrefundable.

Split-family enrollment

If members of the same family are enrolled in different TRICARE Prime or US Family Health Plan programs, the total family enrollment fee is paid to the program in which the sponsor is enrolled. If the sponsor is not enrolled in any program, then the enrollment fee is paid to the program in which the spouse is enrolled. If neither the sponsor nor the spouse is enrolled in any program, then the enrollment fee is paid to the program in which the oldest dependent is enrolled.

For example, if the sponsor is enrolled in US Family Health Plan, and the spouse is enrolled in TRICARE Prime, the enrollment fee would be paid to US Family Health Plan, and no amount would be paid to TRICARE Prime. Likewise, if the sponsor is not enrolled in a TRICARE program, and the spouse is enrolled in TRICARE Prime, and the family's children are enrolled in US Family Health Plan, then the enrollment fee is paid to TRICARE Prime, where the spouse is enrolled, and no payment would be made to US Family Health Plan. In no case will a family's total annual enrollment fee exceed the family enrollment-fee amount in any given Plan Year.

Keeping your enrollment information up to date

If there are certain changes in your life, it is important to update both DEERS and US Family Health Plan. If you don't, you may have difficulty obtaining care.

These changes include:

- Moving
- Marriage or divorce
- Welcoming a new baby (birth or adoption)
- Change in the sponsor's military status (including retirement)

Updating DEERS

You can update your information in DEERS by:

- Bringing your information or papers to the ID card-issuing facility or military/unit personnel office, or
- Going online to **tricare.mil/deers** (for address changes only)

For a full list of the changes that require you to make an update in DEERS, go to **tricare.mil/deers**. You can ask questions about DEERS by calling the Defense Manpower Data Center (DMDC) at **1.800.538.9552**.

If you move within our service area

If you change your residence within our area, please notify the Plan as soon as possible by calling Member Services at **1.800.818.8589**.

If you move outside our service area

If you move out of the US Family Health Plan ZIP Code-defined service area, you will no longer be eligible for coverage under the Plan.

- If you will be using TRICARE Select at your new location, after you move you must disenroll from US Family Health Plan and enroll in TRICARE Select within 90 days of your move.
- If you will be using TRICARE for Life at your new location, after you move you must disenroll from US Family Health Plan within 90 days of your move. Your coverage will automatically default to Medicare and TRICARE for Life upon disenrollment from US Family Health Plan.
- If you will be using US Family Health Plan through another designated provider, or you will be using TRICARE Prime at your new location, complete a TRICARE Prime enrollment application and submit it to the program in which you wish to enroll. That program will coordinate your disenrollment from us.
- If you will be using TRICARE Prime or a different US Family Health Plan at your new location, do not disenroll from US Family Health Plan. Instead, submit an enrollment form to the program that you plan to use, and they will transfer your enrollment effective the day that they receive the form.

It is very important to inform the Plan of any of the changes described above. As an enrollee, you will automatically stay enrolled in the Plan unless you lose eligibility or decide to disenroll during Open Season.

Disenrollment

All members have the option to disenroll once each year during Open Season unless they become ineligible in the DEERS system or move out of the US Family Health Plan service area. Disenrollment requests outside of Open Season are considered on a case-by-case basis. Members who disenroll outside of Open Season will be ineligible to re-enroll until the next Open Season.

To request disenrollment from the Plan, you must complete the TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form (DD Form 2876) and have it signed by each adult (over 18) involved in the request. You can obtain this form by calling Member Services at **1.800.818.8589**. Submit the completed form to:

US Family Health Plan
Attn: US Family Health Plan Enrollment
P.O. Box 495
Canton, MA 02021-0495

When coverage ends

If you disenroll from the Plan or become ineligible for Plan benefits, your coverage ends on the earliest occurrence of any of the following:

- If you move out of the Plan service area. (Please note that if you and/or your dependent move out of the area and fail to inform the Plan of your move, only emergency services when medically necessary will be covered at the full level of benefits under the Plan. All other services will pay at the Point of Service level of benefits.)
- If you do not provide payment of the enrollment fee by the required date.
- At midnight on the date you stop being an eligible beneficiary, including when you move permanently out of the Plan area.
- At midnight on the date all coverage or certain benefits are terminated by modifications of the Plan, should this occur.
- At midnight on the date the Plan is terminated or amended to terminate coverage for you, should this occur.
- If you are an inpatient on the date your coverage is scheduled to end, coverage will continue until the date of your discharge.
- If you request disenrollment on your 12-month enrollment anniversary, your Plan coverage will terminate at midnight on that date.
- If it is determined that you provided false information to the Plan or committed fraud with respect to the Plan, or permitted someone else to do so, to the extent that the termination of your coverage is permitted by law, your coverage will be terminated at midnight on the date that determination is made.

Note: If you move out of a US Family Health Plan service area, you will be disenrolled from US Family Health Plan and your enrollment fee cannot be refunded.

Your Benefits and How to Use Them

Understanding how to make the most of your coverage and get the care you need will help you avoid unnecessary costs or paperwork.

The Summary of Benefits on pages 4–5 summarizes your covered services, copayments, and the extras that US Family Health Plan provides. A list of limitations and exclusions appears on pages 31–37. A glossary of terms used in this handbook appears on pages 45–49. If you have a question about your benefits, be sure to call Member Services at **1.800.818.8589**.

Copayments

A copayment is your share of the cost for care, services, or medication that you receive. Please keep in mind that:

- You pay copayments to the provider, not to the Plan. The Plan pays the cost for your care, minus your copayment.
- Most copayments are due at the time you receive care or prescriptions.
- Your member ID card lists the most common copayments you might have, if any.
- Active-duty family members and members who have Medicare Part B have no copayments for most services except for prescriptions.

Emergency care

A medical emergency is a situation that requires immediate intervention to prevent the loss of life, limb, sight, or body tissue, or to prevent undue suffering. In a medical emergency, care cannot be safely postponed while you contact your PCP or the doctor on call. (For a more detailed definition of medical emergency, please see the glossary on page 47.)

What to do

In an emergency, call 911 or go to the closest medical facility for treatment. Emergency-room treatment:

- does not require a PCP referral,
- does not require Plan authorization before you obtain services, and
- does not have to be provided at a network facility.

Once you are at the medical facility,

- **You or someone you designate must inform your PCP (or the doctor on call at your PCP's office)** about your emergency treatment within 24 hours or the next business day after you receive the emergency care. Your PCP's name and phone number are on the front of your member ID card.

Inpatient hospitalization at an out-of-network facility

If you require inpatient hospitalization at an out-of-network facility as a result of an emergency-room visit, you, a family member, or a hospital staff member should inform Member Services at **1.800.818.8589** as soon as possible.

Once your provider determines that your medical condition is stable, you may be transferred to a US Family Health Plan network facility.

To find out if a doctor or hospital is part of the US Family Health Plan network, go to **usfamilyhealth.org** and click on "Our Network," then "Find a Doctor."

Follow-up care

Many emergency-room treatments require follow-up care. For example, you may need to have stitches removed or see a specialist about an underlying condition. Please discuss any necessary follow-up care with your PCP. Your PCP will arrange these services within the US Family Health Plan network.

Follow-up care for an emergency-room visit must be provided by or authorized by your PCP and, in some cases, (if you are out of the area or in a non-network hospital) also requires Plan authorization in order for the visit to be fully covered by US Family Health Plan. In most cases, follow-up care must be received from an in-network provider.

Payment for emergency care

If you have copayments for medical services (see the chart on pages 4–5), you will be charged a copayment for each visit to an emergency room, whether you decide to go on your own or are directed there by your PCP. If you are then admitted to the hospital, the emergency-room copayment is waived and the inpatient copayment applies.

Urgent care / after-hours care

You may find yourself in a situation that requires urgent (but not emergency) medical attention. For example:

- A sprained ankle
- Eye irritation
- Urinary tract infections

If you need urgent care over a weekend or holiday, or after your PCP's office is closed, it's appropriate to seek care at an urgent care clinic.

What to do

Treament at urgent care clinics is covered by US Family Health Plan, and you do not need a referral from your PCP before receiving urgent care.

Care at any urgent-care clinic is allowed, but we prefer that you receive urgent care at Carewell® Urgent Care, American Family Care® (AFC), or CVS MinuteClinics®.

Follow-up care

- Your follow-up care must be provided by your PCP, not by the urgent-care clinic.
- Always call your PCP after you have received the urgent care and talk with them about any follow-up care you might need.

Telehealth from Teladoc®

For an urgent, non-emergency health concern outside of your doctor's usual business hours, you may use Teladoc virtual health care to supplement your usual in-network care. You may also use Teladoc during ordinary business hours if your doctor doesn't provide telehealth services. With Teladoc, you can talk with a licensed medical doctor by web, through an app, or by phone.

Telehealth requires a copayment but not a referral. The service is also available for behavioral concerns — for example, anxiety — but only for ages 18 and up. Go to **member.teladoc.com/USFHP** or call **1.800.835.2362** to learn more.

Routine care

Routine care outside of the Plan network without Plan authorization is covered only under our Point of Service option. Routine care includes physical therapy, an office visit for a blood-pressure check, and well visits.

You and your primary care provider

When you joined US Family Health Plan, you chose a doctor or other licensed health care professional to be your primary care provider (PCP).

The relationship between you and your PCP is at the center of our system of patient-focused health care. Your PCP sees you for annual physicals, provides care when you're sick or injured, and keeps your medical records up to date.

Your PCP also refers you to specialists, arranges hospitalizations, and authorizes urgent care, X-rays, lab work, and other medical services when medically necessary and appropriate.

Having a PCP provide or manage most of your care means that you have someone to call when you need care, and that there is coordination of care from your PCP to your specialists, hospitals, and other facilities. Your medical records, including your prescriptions, are in one place. You have someone to help you navigate the complex world of health care. In addition, your PCP takes care of the paperwork, so you don't have to file claims.

In-area coverage

In-network care

All members must use the US Family Health Plan network of inpatient facilities. If a procedure or service is unavailable at a US Family Health Plan network hospital, both your PCP and the Plan must first provide authorization for you to receive care at an out-of-network hospital.

To find out if a doctor or hospital is part of the US Family Health Plan network, go to **usfamilyhealth.org** and click on "Our Network," then "Find a Doctor."

Out-of-network care

Referrals for care received out of network, whether inpatient or outpatient, must be approved by the member's PCP and authorized by the Plan before the member receives services, unless an emergency dictates otherwise. The Plan needs at least one week to review these referrals. If they are submitted on the same day as the appointment, they may be billed to you at Point of Service rates. (See page 20.)

Referrals to specialists

Full Plan benefits apply only for covered services that are provided by in-network specialists with a referral from your PCP. Services provided by out-of-network specialists require both a PCP's referral and Plan authorization.

Most PCPs will send referrals electronically to specialists. Some PCPs, however, may give you a paper referral (except for referrals for physical therapy).

Referrals are valid for only those services or diagnoses indicated. Most referrals are valid for one year, or for the number of visits indicated, whichever comes first.

It is very important that you keep track of the number of visits authorized and how many times you have seen the specialist to whom you have been referred. You can keep track of your visits and view your referrals on the Plan's secure member portal at **usfamilyhealth.org.** (Click on "For Members," then "Member Portal.")

Additional visits

If visits with the specialist beyond those authorized by your referral are necessary, it is your responsibility to obtain another referral from your PCP for the additional visits. (One exception is for additional Physical Therapy or Occupational Therapy visits. See the information on page 19.)

Referrals from a specialist to another specialist

Also, if the specialist wishes to refer you to another specialist or for other services, you must first receive a referral from your PCP. For example, if an oncologist refers you to a surgeon, or if a cardiologist refers you to a thoracic surgeon, you must first obtain a referral from your PCP. If the provider is out of network, Plan authorization is needed in addition to the PCP's referral.

Services requiring both a referral from your PCP and Plan authorization

Certain services require both a referral from your PCP and Plan authorization. Medical services for which there is a limited benefit, such as oral surgery, for example, need to be reviewed by the Plan first to make sure that the services being requested are covered by the Plan. Examples of other situations where Plan authorization would be required include specialized genetic testing or the purchase of Durable Medical Equipment.

Referrals to out-of-network providers or facilities also require Plan review to determine whether that particular service could be provided within the network.

Transferring care from an out-of-network provider

If you have been seeing a physician (this includes both PCPs and specialists such as cardiologists) or receiving services (such as physical therapy or home health care) from a provider not affiliated with the Plan, and you have a condition that needs ongoing management, please call your US Family Health Plan PCP to discuss the appropriate transfer of your care to a Plan provider.

Managing your referrals

Keep in mind that you are responsible for:

- Obtaining a referral for any specialty services before the services are rendered.
- Keeping track of the number of visits.
- Seeking additional authorization from your PCP before a new referral is needed.

If you have any questions about the referral process or the status of a referral, please call Member Services at **1.800.818.8589**. You can also keep track of your visits and view your referrals on the Plan's secure member portal, which you can access at **usfamilyhealth.org** (Click on "For Members," then "Member Portal.")

Behavioral-health and substance-abuse self-referrals

You may self-refer to an authorized US Family Health Plan network behavioral-health or substance-abuse provider for the first eight outpatient visits in a Plan Year (January 1 through December 31).

Although a referral from your PCP is not required, you must call **1.800.818.8589** to obtain a current list of authorized network providers before accessing services. This is to make sure that claims will be paid. When you call, please identify yourself as a US Family Health Plan member.

Massachusetts Community Behavioral Health Centers

The Plan covers behavioral health crisis services provided by Massachusetts Community Behavioral Health Centers (CBHCs). CBHCs are one-stop shops for a wide range of behavioral health and substance use services and treatment. The statewide network includes 25 centers across Massachusetts offering immediate, confidential care around the clock. No referral is required, but a copayment may be required. For more information, call/text **833.773.2445** or use the web chat at **masshelpline.com**.

Physical-therapy and occupational-therapy referrals

- Like all referrals, referrals to physical therapy and occupational therapy need to be written by your PCP and not by the specialists you have seen.
- Your PCP can provide referrals for only the initial evaluation and the first eight occupational-therapy and physical-therapy visits in the Plan Year (January 1 through December 31). The PCP must contact the Tufts Health Plan pre-certification department for authorization of additional visits.
- You will need to obtain a new physical-therapy or occupational-therapy referral from your PCP at the beginning of every Plan Year.
- Members are covered for up to 30 visits per calendar year for rehabilitative physical therapy and occupational therapy. The number of visits is reset each Plan Year.
- Habilitative physical- and occupational-therapy is covered only for members enrolled in the ECHO program. The duration of therapy is based on consideration of the medical necessity of treatment and requires prior authorization. The maximum allowable coverage for the combined ECHO benefit is $36,000 per year. There is co-insurance for ECHO benefits.
- You must receive treatment at an in-network facility or be subject to the costs of the Point of Service option.

Speech-therapy referrals

The Plan covers speech therapy for certain diagnoses. If the therapy is covered, your PCP can provide referrals for only the first 30 visits. Please follow physical-therapy referral guidelines above for speech-therapy referrals.

If Plan authorization is denied

If a referral request is denied (for example, if a referral has been made to an out-of-network provider), you will receive a copy of the denial letter in the mail, typically within 7 to 10 business days.

If you make an appointment and receive services, then receive a denial letter, you will be charged for the services at our Point of Service rate. Please do not obtain services until you have received the referral determination letter. You can call Member Services at **1.800.818.8589** to find out the status of a referral request.

Inpatient skilled nursing care

The Plan provides inpatient skilled nursing care in an accredited, contracted, skilled nursing facility when it is medically necessary.

This 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 a Plan provider
- Other medically necessary treatments and services deemed appropriate

The Plan does not cover custodial care (residential nursing home care), whether short-term or long-term.

Point of Service option

As a TRICARE Prime option, US Family Health Plan includes a Point of Service benefit option that provides limited coverage for unauthorized, non-emergency, out-of-network services.

In order for Point of Service coverage to apply, the care provided must be a TRICARE-covered benefit. While this option provides some coverage for unauthorized out-of-network care, you should be aware of the high out-of-pocket costs:

- Deductible (outpatient): $300 for individual, $600 for family per Plan Year (January 1 through December 31)
- Cost share (outpatient): 50 percent of the TRICARE allowable charge, after annual deductible is met
- Cost share (inpatient): 50 percent of the TRICARE allowable charge
- Additional charges by out-of-network providers: Beneficiary is fully responsible. Up to 15 percent above the TRICARE allowable charge is permitted by law.

Out-of-pocket costs under the Point of Service option are not applied to the catastrophic cap. This means there is no cap on your out-of-pocket costs for unauthorized non-network care. (See page 5 for information about the catastrophic cap.)

You may, of course, seek care on your own. However, unauthorized non-emergency out-of-network care will be processed under the Point of Service option, potentially resulting in substantial out-of-pocket costs for which you will be responsible.

You may not ask your PCP to complete a referral after the services have been rendered in order to avoid the Point of Service deductible and coinsurance costs.

There is no appeal for Point of Service charges if the service in question could have been delivered within our network.

24-Hour Nurse Advice Line

Questions about your health can come up at any time. When you need answers, you can call our 24-Hour Nurse Advice Line at **1.866.767.4546** and speak with a registered nurse. For example, nurses at the 24-Hour Nurse Advice Line can help you:

- Decide whether you should go to the emergency room
- Learn more about medications, medical tests, or procedures
- Learn more about a new or chronic condition
- Learn about new ways to stay healthy

*Note: Our 24-Hour Nurse Advice Line is not a substitute for medical attention. Registered nurses cannot provide diagnoses or treatment. If you have an emergency medical condition, please call **911** or your local emergency medical services number.*

Vision care

US Family Health Plan covers one eye examination per Plan Year (January 1 through December 31) by a participating provider. Here are some important things to know before you seek eye-care services:

The difference between an optometrist and an ophthalmologist

An optometrist is a medical professional who is trained and licensed to examine eyes for visual defects, diagnose problems or impairments, and prescribe corrective lenses or provide other types of treatment. Ordinarily, members see an optometrist for routine eye care.

An ophthalmologist is a medical doctor who specializes in diseases of the eye and provides treatment of non-routine medical conditions. As is the case with all specialists, you need a referral from your PCP for any and all ophthalmology services.

Routine eye exams (vision check for corrective lenses)

Covered routine eye care with an optometrist must be provided by an EyeMed network provider.

Medical/non-routine eye care with an optometrist

Covered services by an optometrist must occur within the EyeMed network. No referral is required. US Family Health Plan contracts with EyeMed as a specialized eye-care network.

Medical/non-routine eye care with an ophthalmologist

Covered services (for example, an eye exam if you have glaucoma or diabetes) by an ophthalmologist must occur within the Tufts Health Plan network and require a referral from your PCP.

To find network providers

EyeMed:
Visit **eyemedvisioncare.com** or call **1.866.504.5908**.

US Family Health Plan:
Visit **usfamilyhealth.org** or call **1.800.818.8589**.

If you have any questions, call Member Services at:
1.800.818.8589.

Hearing-aid coverage for active-duty family members

Active-duty family members who meet specific hearing-loss requirements are eligible to receive hearing aids and all medically necessary and appropriate services and supplies, including hearing examinations, for the qualified family member. Exams must be administered by a Plan-contracting provider.

Hearing-aid coverage for active-duty family members is available only to those who have been diagnosed with "profound" hearing loss. TRICARE has two separate criteria of hearing-level thresholds for adults and children of active-duty family members. Please refer to TRICARE Policy Manual 6010.57-M, February 1, 2008 edition at **manuals.health.mil** for additional information.

Hearing aids are otherwise excluded from coverage under TRICARE. However, discounts are available to US Family Health Plan members as an extra. (See page 30 for more information.)

Durable medical equipment

Before you buy or rent Durable Medical Equipment (DME), call Member Services at **1.800.818.8589** to find out if the equipment is covered and whether you need authorization to buy or rent it. Please don't buy DME based on an advertisement. Call Member Services first to see if the DME is covered by the Plan.

To obtain DME, you need a prescription from your PCP. You also need to call Member Services at **1.800.818.8589** to obtain a list of contracted suppliers. Once a supplier has been selected, contact the DME supplier to provide the prescription and order the item. Once the supplier receives the prescription, the supplier will ship the item. Keep in mind that you will receive coverage for only the TRICARE-authorized amount. You will be responsible for the rest of the cost.

Members who are required to make copayments for medical services are responsible for 20 percent of the cost of the item at the standard level. For members who are not required to make copayments, DME is free, again at the standard level. However, if the member selects a model that is above the standard level, the member may receive the upgraded model, but the difference in payment is the member's responsibility.

US Family Health Plan pays for authorized DME (for example, walkers, wheelchairs, and oxygen tanks) that is:

- Approved by the U.S. Food and Drug Administration (FDA)
- Used as indicated by the FDA
- Primarily for your use in the home

Durable medical equipment is authorized when it:

- Can improve, restore, or maintain the function of an abnormal, diseased, or injured body part, or can minimize or prevent the worsening of your function or condition
- Can maximize your function consistent with your physiological or medical needs
- Provides the medically appropriate level of performance and quality for the medical condition present
- Is not otherwise excluded by the regulation and policy

Hospice care

Hospice care is an integrated set of services and supplies for the care of terminally ill members. Hospice care emphasizes palliative care and symptom management through supportive services, such as some limited multidisciplinary home care; inpatient symptom management; and periodic, brief, inpatient respite-care stays. Primary care providers, in coordination with the Plan, use established medical criteria to make eligibility determinations and referrals to approved hospice care providers

Prescriptions

US Family Health Plan follows the TRICARE uniform formulary and covers most prescription medications prescribed by an authorized US Family Health Plan provider. We send maintenance medications to your home through our Home Delivery service. You may fill urgent and one-time prescriptions at a retail pharmacy. (See the Summary of Benefits on pages 4-5 for copayments.).

If you have insurance coverage in addition to US Family Health Plan

If you have elected to keep private/primary (other) insurance in addition to US Family Health Plan, and that insurance includes a pharmacy benefit, you cannot use the Home Delivery service. *Your other insurance must be used as your primary insurance* and US Family Health Plan will be your secondary insurance.

You must use the primary (other) insurance at your local retail pharmacy to fill your prescriptions. In this case, your medications will ultimately be free to you. Use your primary (other) insurance at your retail pharmacy for your medications and pay that insurance's copay. Using that receipt, fill out the manual claim form at **usfamilyhealth.org** (click on "For Members," then on "Pharmacies & Medications") and mail it to the indicated address. You will then receive a reimbursement check for the full amount of the copay that you paid using your primary (other) insurance.

Home Delivery for maintenance medications

Maintenance medications are medications that you take on a regular basis for chronic conditions, such as medications to control blood pressure or diabetes. We mail these medications to you through our Home Delivery service. Please do not use retail pharmacies for fulfillment of maintenance medication prescriptions.

You may receive up to a 90-day supply of all maintenance medications. (Please ask your doctor to prescribe a 90-day supply.) In most circumstances, you will receive your medication within 10 business days after we receive your prescription.

Home Delivery saves you money. You may receive a 90-day supply of your maintenance medication for significantly less than three 30-day supplies would have cost at a retail pharmacy, and you pay no shipping or handling charges.

Prescription copayments

Home Delivery and the US Family Health Plan Pharmacy in Brighton Maintenance medications (up to a 90-day supply)	
Generic	$12
Brand-name	$34
Non-formulary	$68
Retail Pharmacy One-time or urgent medications (up to a 30-day supply)	
Generic	$14
Brand-name	$38
Non-formulary	$68

There is a fourth tier of non-covered drugs. These medications provide little or no clinical effectiveness compared to other medications in the same class. Preference has been given to medications with enhanced clinical effectiveness. If you choose to purchase a non-covered medication, you will pay for 100 percent of the medication's cost.

How to use Home Delivery

New prescriptions

You can choose from these options:

- **Phone.** Your doctor calls our pharmacy at **1.877.880.7007** with your prescription.
- **Fax.** Your doctor faxes your prescription to our pharmacy at **1.617.562.5296**.
- **Electronically.** Your doctor submits your prescription electronically to the Brighton Marine Pharmacy at 77 Warren Street, Boston, MA 02135.
- **Mail.** When your doctor gives you a prescription, you mail it to us in a special pre-paid, pre-addressed Home Delivery envelope. You should have received a supply of these, plus a special Medication Tracker, in the mail. If you need more envelopes, call **1.877.880.7007**. Please be sure that your name, date of birth, and address are clearly printed on the prescription.

Refills

You can obtain refills of your maintenance medications the following ways:

- **Online.** Order the refill online at **usfamilyhealth.org** (click on "For Members," then on "Pharmacies & Medications").

- **Phone.** Call **1.877.880.7007** and use our automated system or speak with a pharmacist.

Refills are not automatic. If you run out of refills, let us know and we will ask your provider to create a new prescription for you. Please call our pharmacy at **1.877.880.7007**.

You can request a refill after you have used 75 percent of your current supply (or about two weeks before you run out). Please request refills a minimum of 10 business days in advance. This will give us plenty of time to get your medication to you before you run out.

Getting started

You should have received a packet in the mail containing materials related to our Home Delivery service. If you haven't received this packet, call **1.877.880.7007** and ask to have one sent to you. When you receive the packet:

- Fill out the Home Delivery Sign-Up Sheet. We will need an email address for each adult in your family who uses Home Delivery in order for them to use our online refill request tool.
- Mail your completed Home Delivery Sign-Up Sheet and your new prescriptions (written for a 90-day supply) to us at 77 Warren Street, Boston, MA 02135 in one of the pre-paid, pre-addressed Home Delivery envelopes included in the packet. Or fax them to **617.562.5296**.
- Make sure that your provider knows that we will be the first choice of pharmacies for your maintenance medications so they can document this in your chart. This way, they won't send your prescriptions to other pharmacies.

Circumstances where Home Delivery is not available

Home Delivery is not available for maintenance medications if:

- You are in an extended-care facility that requires special unit-dose packaging.
- You have Schedule II narcotic maintenance medication prescriptions written by a provider in a state other than Massachusetts and its contiguous states (Maine, Rhode Island, Connecticut, New York, Vermont, and New Hampshire).

  We can fill Schedule II maintenance medication prescriptions if they have been written by a provider in Massachusetts or a contiguous state. Please mail us the prescription or ask your provider to submit the prescription to us electronically. (Your provider must be certified in order to do this.)

  We send Schedule II medications by overnight delivery at no extra charge to you.

  In order to be covered by the Plan, prescriptions for Schedule II CNS stimulant medications related to Attention Deficit Hyperactivity Disorder (ADHD) must now be filled through our Home Delivery mail-order pharmacy. You may fill up to a 60-day supply at your applicable mail-order copayment if your provider's state allows. Please make sure that your provider includes the diagnosis on the prescription.

Home Delivery questions? Please call **1.877.880.7007**.

Shipping

We ship most medications by First Class or Priority Mail. If your medications require refrigeration, we will ship them by overnight delivery in cooler packaging.

When you're on vacation out of the area

If you have your mail forwarded while you are away, the U.S. Postal Service will forward your medications to the forwarding address. If you are not having your mail forwarded, then give us your temporary address, and let us know how long you will be there. We will send your medications to that temporary address.

Urgent and one-time prescriptions

For medications that you will be taking for only a short time, such as antibiotics and/or pain medications for an acute illness, go to your local retail pharmacy.

Brighton Marine pharmacy

You can pick up both your maintenance and short-term (urgent or one-time) medications at the US Family Health Plan pharmacy at Brighton Marine.

Family-planning prescriptions

Because of certain restrictions, our Home Delivery and Brighton Marine pharmacies may not fill family-planning prescriptions (for example, prescriptions for birth-control medications). We have made provisions for members to obtain these medications at retail pharmacies for up to a 90-day supply at the Home Delivery service copayment rate. Please present your member ID card at the pharmacy.

Prescription medication limitations and exclusions

The Plan does not cover:

- Prescriptions written by physicians not affiliated with US Family Health Plan, except when required for emergency care as determined by the Plan
- Food supplements
- Homeopathic and herbal preparations
- Multivitamins (except for prenatal vitamins for pregnant women)
- Medications prescribed for cosmetic purposes (including but not limited to medications used for hair growth or for wrinkle reduction)
- Fluoride preparations
- Over-the-counter products (except insulin, diabetic supplies, and certain specified non-prescription medications, including smoking-cessation products)
- Medical supplies such as dressings and antiseptics

Manufacturer copay cards and vouchers cannot be combined with your coverage. When enrolled in government health care programs (such as US Family Health Plan, Medicare Part D, Medicaid, TRICARE, or the VA), you aren't eligible for copay assistance for retail pharmacies or Home Delivery. To ask about financial assistance, call Member Services at **1.800.818.8589**.

Vaccines and immunizations

All vaccines recommended by the CDC Advisory Committee for Immunization Practices are covered under TRICARE and US Family Health Plan. You can find a current list of these vaccines at the Centers for Disease Control and Prevention website at **cdc.gov/vaccines/vpd-vac/vaccines-list.htm**.

Vaccines and immunizations for elective travel will not be covered.

Extras

Our members receive extras that go beyond the full TRICARE Prime benefit.

Health-promotion and disease-management programs

As our doctors and nurses get to know you, they may encourage you to participate in programs that will help you lead a healthier lifestyle.

Help with chronic conditions

Through our affiliation with Tufts Health Plan, you have the opportunity to participate in high-quality programs that help people manage chronic conditions, including:

- Chronic heart failure
- Asthma
- Diabetes

For more information about these and other programs, contact Member Services at **1.800.818.8589**.

Tufts Health Plan Alzheimer's Association Referrals

Eligible US Family Health Plan members have the benefit of the education and resource needs assessment provided by the Alzheimer's Association through its relationship with Tufts Health Plan. Members and caregivers are eligible for a referral to the program when a member has been identified with a cognitive concern and/or a change in an existing cognitive-related condition.

Learn more by contacting the US Family Health Plan Manager of Care Coordination at **617.562.5522**.

Health-promotion programs at hospitals and fitness centers

Our members also receive substantial discounts on programs at many local hospitals and fitness centers. You can choose from a number of current topics, including aging, men's health, women's health, nutrition and weight control, safety and prevention, smoking cessation, sports nutrition, stress management, and yoga and meditation.

For a list of participating hospitals and fitness centers, call Member Services at **1.800.818.8589**. To obtain your wellness discounts, present your US Family Health Plan member ID card when you register for one of the programs. If you sign up by phone, be sure to tell the person who takes your call that you are a member of US Family Health Plan.

Fitness centers

Discounts

Through our relationship with Tufts Health Plan, US Family Health Plan members receive discounts on annual memberships at participating fitness centers, with no initiation or joining fees. To learn more or to find a participating fitness center, go to **preventure.com/ifcn-tufts/**. If you are prompted for a password, use "**Fit4You**".

Finding out more

To use your fitness discounts, call Member Services at **1.800.818.8589** and ask for a list of participating fitness centers. You will receive an updated US Family Health Plan member ID card with your fitness site selection listed.

Weight control

US Family Health Plan members have access to certain weight-management programs to make it easier to lose weight and lead a healthy lifestyle. For more information, call Member Services at **1.800.818.8589**.

Health information online from MedLinePlus

MedLinePlus.gov, a National Institute of Health website, provides free, comprehensive, easy-to-read information on diseases, conditions, and wellness, 24 hours a day.

Chiropractic care

US Family Health Plan covers spinal manipulation only — up to 12 visits per Plan year — by a participating Tufts Health Plan chiropractor. Referrals are not needed for chiropractic care.

*Note: Chiropractic care is excluded for children ages 12 and under. For more information, call Member Services at **1.800.818.8589**.*

Hearing-aid discount

Although hearing aids (except for certain active-duty family members) and hearing services are not covered by TRICARE, US Family Health Plan members may receive a 20 percent discount on hearing aids and some hearing services with participating providers. To locate a participating provider, call Member Services at **1.800.818.8589**. Be sure to present your US Family Health Plan member ID card along with your prescription at the time of service.

Eyewear discount

Our members receive significant savings on eyewear purchased through participating optometrists and opticians. In addition to lenses, a large selection of frames is available through participating providers. To find a participating provider, call EyeMed at **1.866.504.5908** or visit **eyemedvisioncare.com**.

How to use this benefit

1. Have your eyes examined by a participating optometry provider and get an appropriate eyewear prescription.
2. Call EyeMed at **1.866.504.5908** or visit **eyemedvisioncare.com** to find a participating provider.
3. Take the prescription to the participating provider for your discount on lenses or frames. Contact lenses are also available at reduced prices. Other eyewear services — such as tinting, scratch-proofing, and anti-reflective coating — are also available to our members at a discount. Make sure you present your US Family Health Plan member ID card to the provider.

The extras described here are not part of the TRICARE Prime benefit. They cannot be appealed if denied, and extensions of these extras cannot be considered. They are provided exclusively to members of US Family Health Plan of Southern New England.

Limitations and Exclusions

Waiver forms

A waiver form is a notice that a doctor or supplier should give you when furnishing an item or service for which the Plan is expected to deny payment, such as a service the Plan doesn't cover. If you do not get a waiver form before you receive the service or item from your doctor or supplier, and the Plan does not pay for it, then you are not financially responsible for the service.

If you don't know whether a service or item is covered, don't sign the form. Call Member Services at **1.800.818.8589**.

If the doctor or supplier does give you a waiver form and you sign it before receiving the service or item, and the Plan does not pay for it, then you are financially responsible for the service.

Services not covered under the Plan

Please refer to TRICARE Policy Manual 6010.60-M, April 1, 2015 edition, at **manuals.health.mil** for additional information.

General exclusions

The Plan does not provide coverage for:

- Services provided or charges incurred prior to the effective date of coverage under the Plan
- Services not specifically included as covered services in this handbook
- Care or treatment as a result of being engaged in an illegal occupation or commission of, or attempted commission of, a felony or assault
- Charges or services for which you or your covered dependent are not legally required to pay, or that would not have been made if coverage had not existed
- Services and drugs not prescribed or authorized by your primary care provider (PCP) or a specialist to whom you were referred
- Services provided or received after the date your coverage terminated under the Plan
- Services and supplies that are not medically or psychologically necessary for your diagnosis and treatment, or services that are experimental or of a research nature
- Any mental-health or substance-abuse services denied or not preauthorized by the Plan's Care Coordination Department (with the exception of the eight authorized self-referral outpatient mental-health visits)
- Any services provided for employment, licensing, immigration, elective travel, or other administrative reasons
- Complications due to a treatment or a service not covered by the Plan
- Services and supplies provided by an unauthorized provider

Some specific exclusions (This list is not all-inclusive.)

- Routine abortions, specifically, when the mother's well-being/life is not in jeopardy. (US Family Health Plan does cover abortions in the cases of pregnancies resulting from incest or rape.)
- Acupuncture and acupressure. (However, the Plan does offer discounts for self-pay with participating providers.)
- Alterations to living space. (However, you may qualify for benefits from the Department of Veterans Affairs (VA).) The VA provides up to $4,100 lifetime benefit for veterans with service-connected injuries and up to $1,200 for veterans with non-service-connected injuries to make home improvements necessary for:
  - Continuation of treatment
  - Disability access to the home, and
  - Essential lavatory and sanitary facilities

  To learn more, contact the VA at **1.800.827.1000**.
- Alternative treatments
- Ambulance transportation for non-emergencies. However, chair cars to provide transport between facilities may be allowed (and require prior authorization).
- Artificial insemination or any form of artificial conception. This non-coverage includes in vitro fertilization and gamete intrafallopian transfer, as well as all other non-coital reproductive methods and all services, supplies, and drugs related to them.
- Assisted living facility care. The Plan does not cover assisted living facility care or routine personal care associated with assisted living. Assisted living is a housing arrangement where people can live independently but can find help with tasks and have some services provided for them. These services may include meals, medication administration, personal care, housekeeping, medical services, recreational activities, and more.
- Augmentation mammoplasty. US Family Health Plan does not cover augmentation mammoplasty or breast-enhancement procedures. However, the Plan does cover post-mastectomy reconstructive breast surgery.
- Autopsy services and postmortem examinations
- Aversion therapy in connection with alcoholism
- Birth control (over the counter). Other types of birth control, such as IUDs and birth control pills, are covered, but not through the Brighton Marine Pharmacy.
- Blood-pressure monitoring devices
- Bone-marrow transplants for treatment of ovarian cancer
- Camps — for example, camps for diabetics or obese people
- Charges for missed appointments
- Computerized Dynamic Posturography (CDP)
- Cosmetic drugs

- Cosmetic, plastic, or reconstructive surgery not connected to medical treatment, such as skin tag removal
- Counseling services — for example, stress management, life-style modifications, or marriage counseling
- Custodial or convalescent care (nursing homes or at home). US Family Health Plan does not cover custodial care in an institution or at home. Custodial care is defined as taking care of someone's daily needs, such as eating, dressing, or providing a place to sleep. However, some aspects of the care may be covered if approved through the pre-authorization process, such as
  - Limited specific skilled-nursing services
  - Prescription medicines and up to 12 physician visits per calendar year
  - Medically necessary care for inpatient care in an acute-care hospital or medically necessary care for short-term home care. Long-term care at home is not covered.
- Dental X-rays and services, including tooth extraction
- Diagnostic admissions
- Domiciliary care (care provided in an institution or home-like environment)
- Dynamic posturography
- Dyslexia treatment
- Elective psychotherapy and mind expansion psychotherapy such as Ehrhard seminar training, transcendental meditation, and Z-therapy.
- Elective services or supplies that are not medically and/or psychologically necessary
- Electrolysis
- Elevators and/or chair lifts
- Employment-requested physical examinations
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, or other such charges or items
- Exercise programs
- Experimental or unproven procedures
- Fluoride preparations
- Foot care, except in connection with medical treatment (routine foot care is covered only for enrollees with specific medical conditions, such as diabetes) and foot orthotics
- Gym membership (See fitness centers on page 29)
- Habilitative benefits. However, habilitative benefits are covered for children who qualify for the Extended Health Care Option (ECHO) program for conditions that require them.
- Hair removal (including laser hair removal)

- Homeopathic and herbal drugs
- Hospitalization for medical or surgical error. US Family Health Plan does not cover services or hospitalization as a result of medical or surgical error.
- Immunizations for elective travel
- Inpatient stays directed or agreed to by a court or other governmental agency unless medically necessary
- Inpatient stays for the following: 1) to control or detain a runaway child, whether or not admission is to an authorized institution, 2) to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis, 3) in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care, 4) for rest or rest cures
- Investigational drugs
- LASIK surgery
- Learning disorders. US Family Health Plan does not cover diagnostic, evaluation, treatment, services or supplies (including special education services) for learning disorders, such as dyslexia.
- Long-term care. Long-term care is often used as an umbrella phrase to refer to all kinds of assistance to the aging, the elderly, or the disabled, whether that care is given in a patient's home or in a nursing home. It includes a wide range of support services for patients with a degenerative condition, prolonged illness or cognitive disorder. Also known as "custodial care," long-term care primarily involves assistance with daily living (walking, personal hygiene, dressing, etc.) or supervision of someone who is cognitively impaired.

  You may qualify to purchase long-term care insurance through commercial insurance programs or through the Federal Long Term Care Insurance Program (FLTCIP).

  - Eligible beneficiaries include active duty and National Guard members activated for more than 30 days, retired uniformed service members, and members of the Selected Reserve.
  - Eligibility and enrollment requirements are complex. Not everyone who applies for this insurance will be approved for it.
  - For complete details, please visit the FLTCIP website at **opm.gov**
- Magnetic resonance neurography
- Massage therapy
- Medical care from a family member. The Plan does not cover care or supplies that an immediate family member provides or prescribes.
- Medical marijuana
- Medications: drugs prescribed for cosmetic purposes, fluoride preparations, food supplements, homeopathic and herbal preparations, multivitamins
- Megavitamins

- Naturopathic service
- Neurofeedback
- Non-surgical treatment of obesity or morbid obesity
- Nursing homes for custodial long-term care
- Nutritional counseling. Nutritional counseling is not covered except for certain diagnosed conditions.
- Orthodontia (Coverage exists only if related to surgical correction of a cleft palate.)
- Orthomolecular psychiatric therapy
- Orthoptics. US Family Health Plan does not cover orthoptics, which includes:
  - Vision therapy
  - Eye exercises
  - Visual training
- Over-the-counter drugs, vitamins, or food supplements. The Plan will cover alcohol swabs, needles, and syringes for home use; injectable drugs; glucose test strips; insulin and insulin syringes; and spacers for inhalers.
- Paternity tests
- Personal, comfort, luxury, or convenience items, such as beauty and barber services, radio, television, and telephone
- Postpartum inpatient stay for a mother to stay with a newborn infant (usually primarily for the purpose of breastfeeding the infant) when the infant (but not the mother) requires the extended stay, or continued inpatient stay of a newborn infant primarily for the purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.
- Private hospital rooms
- Psychiatric treatment for sexual dysfunction
- Psychogenic surgery. The Plan does not cover surgery performed for psychological reasons.
- Respite care (except as part of the hospice benefit)
- Rest cure
- Retirement homes
- Safety medical supplies. US Family Health Plan does not cover safety medical supplies, such as bath or toilet rails, sleep safe beds, helmets, and childproof locks.
- Sensory integration therapy

- Services and supplies that are 1) provided under a scientific or medical study, grant, or research program, or 2) furnished or prescribed by an immediate family member for which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE eligible.
- Sex-change or gender-change reassignment surgery. The Plan does cover other non-surgical, medically necessary treatment of gender dysphoria.
- Sexual dysfunction or inadequacy treatment services. The Plan may cover some erectile dysfunction medications if such have been determined by a patient's provider to be medically necessary for treatment of a Plan-covered medical problem.
- Speech therapy. The Plan will cover speech therapy when prescribed and provided or supervised by a physician to treat speech, language, and voice dysfunctions resulting from birth defects, disease, injury, hearing loss, and pervasive developmental disorders. The Plan does not cover services for:
  - Disorders resulting from occupational or educational deficits
  - Myofunctional or tongue-thrust therapy
  - Videofluoroscopy evaluation
  - Maintenance therapy that does not require a skilled level after a therapy program has been designed
  - Special educational services from a public educational agency to beneficiaries age 3–21
- Surgical sterilization reversals
- Temporalmandibular joint syndrome treatment (TMJ)
- Therapeutic absences from inpatient facility. The Plan does not cover therapeutic absences from an inpatient facility. The exception is when the Plan approves these absences specifically in a treatment plan.
- Transportation for convenience
- Treatment for learning disorders
- Uncovered services and supplies. The Plan does not cover services and supplies:
  - From a scientific or medical study, grant or research program,
  - Provided for free,
  - That would be free if you or your sponsor were not eligible for the Plan,
  - Like inpatient stays directed or agreed to by a court or other government agency, unless medically necessary,
  - Needed for an occupational disease or injury when worker's compensation or a similar law can pay for them. The exception is if you have exhausted those benefits.
  - That any other health insurance can pay for. The Plan will be the secondary payer for any remaining charges.

- Unnecessary Diagnostic Tests. The Plan does not cover tests that are unnecessary. They must be related to a specific illness, injury, or defined set of symptoms.
- Vestibular rehabilitation
- Vision therapy
- Vitamins — except for formulations of folic acid, niacin, and vitamins D, K, and B12 (injection)
- Weight-control or weight-reduction services and supplies.
- Workers' Compensation

If You Are 65 or Over

Legislative changes took effect on October 1, 2012 that affect the eligibility of TRICARE beneficiaries age 65 and over to enroll in US Family Health Plan in the following ways:

- As of October 1, 2012, US Family Health Plan may not accept new enrollees age 65 and over.
- Any member who enrolled October 1, 2012 or later will lose eligibility for US Family Health Plan at age 65 and will have to use Medicare and TRICARE For Life.

US Family Health Plan members who enrolled before October 1, 2012 are considered "grandfathered" and may remain enrolled in the Plan for life, regardless of age, as long as they maintain continuous enrollment. However, if a grandfathered member disenrolls for any reason, he or she will lose the grandfathered status and may not re-enroll if age 65 or over.

US Family Health Plan and Medicare Part B

For each individual member who has Medicare Part B coverage, there is no annual enrollment fee for US Family Health Plan, and no copayments for any covered services except for prescriptions.

Grandfathered members who are age 65 or older and remain enrolled in the Plan do not lose their entitlement to Medicare. Members can be enrolled in US Family Health Plan and still have Medicare coverage. However, to avoid duplication of coverage under government-sponsored programs, members may not use their Medicare benefit for services covered by US Family Health Plan.

Members may not use Medicare for a service that has been denied or for unauthorized care obtained from an out-of-network provider. This is because even if a service is covered by the Plan, it may not always be medically necessary or appropriate in every case. (See pages 40 and 47 for more about medically necessary care.)

Members are not allowed to enroll in Medicare-sponsored managed care plans (HMOs) while enrolled in US Family Health Plan. The use of Medicare benefits by a US Family Health Plan member for covered services is grounds for disenrollment from the Plan.

However, the use of Medicare for services not covered by US Family Health Plan, such as end-stage renal disease, is allowed.

For grandfathered members age 65 and over, having Medicare Part B is not required for continued enrollment in the Plan. However, if you have Medicare Part B, we urge you to retain this coverage. If you do not enroll when you are initially eligible, or you drop Medicare Part B and choose to enroll at a later time, you will pay a higher Part B premium and there will be a waiting period before your coverage is effective. It is important to understand that if you ever disenroll from US Family Health Plan or move out of our service area, you must have Part B to continue to receive TRICARE benefits.

TRICARE Young Adult

TRICARE Young Adult is a premium-based health care plan that qualified dependents may purchase. TRICARE Young Adult provides medical and pharmacy benefits, but the program does not provide dental coverage.

TRICARE Young Adult allows dependent adult children to purchase TRICARE coverage after their eligibility for "regular" TRICARE coverage ends at age 21 (or age 23 if enrolled in a full course of study at an approved institution of higher learning). The option you select when you enroll (Prime or Select) determines how you get care.

US Family Health Plan offers only the Prime benefit through the TRICARE Young Adult program. For information on enrolling in the Select option or other Prime options through the TRICARE Young Adult program, please visit **tricare.mil/tya**.

Eligibility

You may qualify to purchase TRICARE Young Adult if you are:

- An adult child of an eligible sponsor. Eligible sponsors include:
  - Active-duty service members
  - Retired service members
  - Activated Guard/Reserve members
  - Non-activated Guard/Reserve members using TRICARE Reserve Select
  - Retired Guard/Reserve members using TRICARE Retired Reserve
- Unmarried
- At least age 21 but not yet 26 years old (Note: If you are enrolled in a full course of study at an approved institution of higher learning and your sponsor provides 50 percent of your financial support, your eligibility may

not begin until age 23 or upon graduation, whichever comes first.)

- Not eligible to enroll in an employer-sponsored health plan based on your own employment
- Not otherwise eligible for TRICARE program coverage

Premiums and costs

To participate, you must pay monthly premiums. TRICARE Young Adult premium rates are established annually on a calendar year basis. You can find out the current premium at **usfamilyhealth.org.**

You may buy coverage by submitting a completed application with a premium payment for two months of coverage. After the initial two-month payment, you must pay the premiums on a monthly basis. These recurring monthly premiums can only be paid by an automatic debit/credit card charge or electronic funds transfer from a checking or savings account.

Note: Under the law, you must pay for the full cost of coverage. As an adult, you and not your sponsor are legally responsible for premium payments.

Purchasing TRICARE Young Adult

TRICARE Young Adult coverage may be purchased at any time. Complete the TRICARE Young Adult application available at **usfamilyhealth.org** and mail the completed form and initial two-month premium payment to US Family Health Plan at:

US Family Health Plan
Attn: TYA Enrollment
P.O. Box 495
Canton, MA 02021-0495

You may also fax the form to **617.562.5234** or enroll online at **milconnect.dmdc.osd.mil**.

Please make checks or money orders for the initial premium payable to US Family Health Plan.

After we process your application, you will receive a welcome letter along with an enrollment card. Be sure to keep a copy of your application until you have received your enrollment card. If you must seek care before you receive your card, call Member Services at **1.800.818.8589** to verify your TRICARE Young Adult start date.

Care Coordination

Providing quality medical care in the setting that is (1) most appropriate for your symptoms or condition, and (2) is also an efficient use of medical resources, is an important aspect of our approach to managing care. For example, care will be provided on an outpatient basis unless inpatient treatment is necessary.

Authorization for non-emergency hospital admissions (pre-registration)

The Plan will review non-emergency hospital admissions in advance to make sure that inpatient care is appropriate. This procedure is called pre-registration. Certain other procedures such as outpatient surgery and certain diagnostic services may also require Plan authorization.

Authorizations are handled through the Plan's Care Coordination department, which uses nationally accepted guidelines for health-services utilization in managing the treatment-review process.

If you have any questions regarding whether the pre-registration process has been completed for an upcoming scheduled admission or outpatient surgery, call Member Services at **1.800.818.8589**.

Medically necessary care

One purpose of the care-coordination process is to make sure that you receive all the benefits to which you are entitled. It is also intended to make sure that the Plan pays only for care that is medically necessary.

Medically necessary care means services or supplies provided by a hospital, physician, or other provider for the prevention, diagnosis, and treatment of an illness, when those services or supplies are determined to be:

- Consistent with the condition, illness, or injury of the patient
- Provided in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where and when the service or supply is ordered
- Delivered in the most appropriate health care setting

(See page 47 for more information.)

Inpatient hospitalization as the result of emergency

If you are admitted into a US Family Health Plan network hospital as a result of an emergency-room visit, the emergency copayment is waived and the inpatient copayment applies.

If you require inpatient hospitalization at an out-of-network facility as a result of an emergency room visit, you, a family member, or a designee (for example, an emergency-room nurse or staff member) must call your PCP for authorization before you are admitted. Once your PCP determines that your medical condition is stable, you may be transferred to a US Family Health Plan network facility.

Grievances and Appeals

The Plan maintains grievance procedures for the resolution of complaints between members and physicians or other health care providers of the Plan or Plan operations.

A grievance is a formal complaint, presented to the Plan in writing, which initiates the formal grievance process.

A complaint, by contrast, is usually orally reported and orally resolved. However, an informally presented complaint may evolve into a formal grievance if a satisfactory resolution is not achieved.

Confidentiality

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

Under no circumstances will such information become part of the member's medical record. However, compliance with a member's request to remain anonymous is not always possible in resolving a grievance. This will be explained to the member before proceeding.

Grievance and complaint procedures

The grievance and complaint procedures to be used by members in any way dissatisfied with the Plan or a participating provider are as follows:

Informal complaint process

Any Plan member who has a complaint concerning personnel, service, quality of care, or contractual benefits, should first attempt to resolve the concern by contacting and discussing the matter with Member Services at **1.800.818.8589**. Every effort will be made to resolve the problem to the satisfaction of the member during this initial contact.

Grievance process

Any requests for consideration must be sent in writing to the Plan at:

US Family Health Plan, c/o Tufts Health Plan
Appeals and Grievances Department
P.O. Box 474
Canton, MA 02021-0495

Once a grievance is received, a letter confirming receipt of the grievance is sent within 10 days. The issues raised are then reviewed in accordance with our Quality Improvement Program. This requires that the grievance be forwarded to the director responsible for the department involved and that a thorough investigation be conducted. All members will receive a written response within 30 calendar days from the date the grievance was submitted.

Member appeals

Level-One appeals

Members who are not satisfied with the Plan's determination regarding coverage for health care services provided or scheduled to be provided may appeal this initial determination. Written appeals must be submitted to the Plan at:

US Family Health Plan, c/o Tufts Health Plan
Appeals and Grievances Department
P.O. Box 474
Canton, MA 02021-0495

Level-One appeals may also be submitted orally by calling Member Services at **1.800.818.8589**.

The appeal should include all pertinent information regarding the issue. Once the appeal is received, it is logged and a receipt letter is sent to the member within five days. The appeal is then reviewed by the US Family Health Plan Appeals Committee.

A final determination is made within 20 business days of the receipt of the appeal. A written determination that includes the basis for the decision is sent to the member at this time.

Expedited appeals

In some cases, the member has the right to an expedited appeal. An expedited appeal may be appropriate if:

(1) the member's health or ability to function could be seriously harmed by waiting for the standard appeals process, and/or

(2) continuing coverage for inpatient or skilled nursing level of care has been denied.

If the member feels that his or her request meets the criteria cited above, the member or the member's Attending Physician should call Member Services at **1.800.818.8589**. If the Plan determines that the member's request meets the criteria for an expedited appeal, the member will be notified by telephone of the decision within one business day of the Plan's receipt of all necessary information, but no later than 72 hours or 3 business days after receipt of the request. The member will be notified in writing within one business day after the appeal determination.

Level-Two appeals

If the member is not satisfied with the initial denial determination of the Level-One Appeals Committee, the member may submit an additional letter to request that the issue be further reviewed and reconsidered. Appeal cases, along with a copy of the denial letter, should be forwarded to:

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

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

Note: Members cannot appeal the rules and regulations of the Plan, such as copayments. In addition, members cannot appeal cost shares under the POS option, unless the member believes and can demonstrate the services were related to an emergency. Emergency services are exempted from rules that require referrals and plan authorization.

Coordination of Benefits

If you have other medical coverage

If you or your US Family Health Plan-covered family members have other medical coverage, or you receive care or services that would also be covered by workers' compensation or automobile medical benefits, US Family Health Plan has a legal right to recover some of the costs of your care. In fact, US Family Health Plan is the secondary payer to any other health insurance you might have, except Medicare and Medicaid.

This Coordination of Benefits provision doesn't deny you any benefits you're entitled to or reduce your benefits. It's intended to make sure that duplicate payments aren't made. All the health care expenses covered by the Plan are subject to this provision.

It's your responsibility to provide us with the information that will allow us to coordinate payment for your health care services with any other health insurance you may have. If you have other health insurance (OHI) that is primary to US Family Health Plan, you must use your OHI to fill prescriptions. (Exception: If your OHI doesn't cover a particular prescription drug, in most cases you may use your US Family Health Plan coverage.)

After your OHI pays for a prescription, US Family Health Plan will reimburse you for your OHI's copayment*. Download the reimbursement form from the Pharmacies and Medication section of **usfamilyhealth.org** or call Member Services at **1.800.818.8589**. You have 90 days from the date that you fill the prescription to send the form to US Family Health Plan.

**If your OHI requires prior authorization for other approvals before they will cover your prescription, you must go through their approval process first before submitting to US Family Health Plan for reimbursement.*

What you must disclose

If (1) before you enrolled in the Plan, you had other health care coverage that's still effective while you're a member of the Plan, or (2) you qualify for other coverage while you're a member of the Plan, you are required to disclose this information.

You may call Member Services at **1.800.818.8589** with this information. Please be sure to provide information for all insurance coverage you have when you register for an appointment.

Third-Party Recovery/Subrogation

If you receive care due to injuries sustained in an accident for which another party is responsible for payment, call us at **1.800.818.8589**. These accidents might include motor vehicle accidents, slip and falls, or product liability.

The government is entitled to reimbursement from the liable party as well as from any other party legally responsible for indemnifying you (including but not limited to underinsured and uninsured coverage on automobile policies). The covered person, or the covered person's representative or beneficiary, will execute documents and do whatever is necessary for US Family Health Plan to exercise its subrogation and assignment rights and will do nothing to prejudice this process.

Note: US Family Health Plan has contracted with The Rawlings Company to assist us in determining if treatment received by a member is a result of an accident or injury for which another party may be responsible. The criteria used are based on government guidelines. If you receive a questionnaire from The Rawlings Company, please return it promptly.

Glossary

The terms listed below have the following meanings when they appear in this handbook:

Accident

A sudden, unforeseen, and unexpected event causing external/internal trauma to the body.

Alcoholism or drug-addiction treatment facility

An institution that is engaged mainly in providing inpatient services for the treatment of alcoholism or drug addiction.

Authorized services

Those covered services defined herein that are, except in an emergency, provided by or referred by a Plan provider and authorized by US Family Health Plan.

Copayment

The fee you are required to pay to a provider for some services.

Covered services

Those health care services specified in DoD Regulation 6010.8-R "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)" and its accompanying manual, DoD Regulation 6010.47-M, plus preventive services specified in *A Guide to Clinical Preventive Services: Report of the U. S. Preventive Services Task Force* (Williams & Wilkins, 1996).

Custodial care

Custodial care is defined as taking care of someone's daily needs, such as eating, dressing, or providing a place to sleep — as opposed to taking care of someone's medical needs. Some aspects of the care may be covered, such as limited specific skilled-nursing services (one hour per day), prescription medicines, and up to 12 physician visits per calendar year. Medically necessary care for an inpatient in an acute-care hospital is covered, even if that person's medical care is considered "custodial." Custodial care in an institution or home is not covered.

Defense Enrollment Eligibility Reporting System (DEERS)

The nationwide computerized data bank that lists all active and retired uniformed services members and their dependents. Active and retired service members are listed automatically, but they must list their dependents and report any changes to family members' status (divorce, adoption, etc.).

Dependent

The spouse, child, or dependent parent of an active-duty or retired uniformed sponsor.

Designated Provider of TRICARE Prime
A public or nonprofit entity that was a transferee of a Public Health Service hospital and designated by public law to provide the TRICARE Prime Uniform Benefit. Brighton Marine is a Designated Provider of TRICARE Prime, offering US Family Health Plan in southern New England.

Eligible person
A Military Health System (MHS) beneficiary who meets the requirements set forth in the eligibility section of this handbook.

Enrollee or member
A uniformed services beneficiary who voluntarily and affirmatively seeks and is accepted for enrollment in US Family Health Plan as his or her chosen way of obtaining the health care services specified in the selected enrollment option from the Military Health System (MHS). Eligibility for enrollment is based on (a) eligibility to receive care in the MHS, and (b) residency within a US Family Health Plan service area.

Enrollment period
The period of time during which enrollees agree to receive covered services solely under US Family Health Plan. The enrollment period is for a consecutive 12-month period.

Hospital
An institution that (1) provides medical care and treatment of sick and injured persons on an inpatient basis; (2) is properly licensed or permitted legally to operate as such; (3) has a physician on call at all times; (4) has licensed graduate registered nurses on duty 24 hours a day; (5) maintains facilities for the diagnosis and treatment of illness and major surgery; and (6) meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations. The definition of hospital may also include (1) alcoholism or drug-addiction treatment facility; (2) psychiatric hospital; (3) ambulatory surgical facility; and (4) freestanding birth center — provided the facility is licensed in the state in which the facility operates and is operating within the scope of its license. In no event will the definition of hospital include an institution or any part of one that is a convalescent/extended care facility, or any institution that is used primarily as (1) a rest facility; (2) a nursing facility; (3) a facility for the aged; or (4) a place for custodial care.

Illness
Any physical or mental sickness or disease that manifests symptoms and that requires treatment by a licensed provider. This definition also includes pregnancy (for the purpose of defining coverage).

Injury
Any accidental bodily damage or hurt sustained while the covered person is covered under the Plan and requiring treatment by a physician.

Inpatient
A person treated in a hospital as a registered bed patient incurring a charge for room and board, upon the recommendation of a physician.

Medical emergency
A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and other acute medical conditions.

Medically necessary (and considered proven)
Appropriate and necessary treatment of a member's illness or injury according to accepted standards of medical practice and TRICARE policy. Medical necessity must be documented in clinical notes.

By law, Title 10 U.S.C. Section 1079(a)(13), TRICARE may only pay for medically necessary care. This statute has been implemented by the Code of Federal regulations (32 CFR 199.4), which states that TRICARE will pay for "medically necessary services and supplies required in the diagnosis and treatment of illness or injury." Therefore, TRICARE can cost share only medically necessary supplies and services. Benefits are restricted to those drugs, devices, treatments, or procedures for which the safety and efficacy have been proven to be comparable or superior to conventional therapies. The definition of reliable evidence in 32 CFR 199.2(b) (which is also included in Chapter 1, Section 2.1 of the TRICARE Policy Manual [February 2008 edition]) provides the TRICARE hierarchy of reliable evidence used to determine whether a drug, device, medical treatment, or procedure has moved from the status of unproven to the position of nationally accepted medical practice is as follows:

1. Well controlled studies of clinically meaningful endpoints, published in referenced medical literature
2. Published formal technology assessments
3. Published reports of national professional medical associations
4. Published national medical policy organization positions
5. Published reports of national expert opinion organizations

Military Health System (MHS)
The system through which eligible members of the uniformed services, retirees, and their dependents receive military health care benefits.

Military hospital or clinic
(Also Medical Treatment Facility) A military hospital, clinic, or other facility usually located on or near a military base established for the purpose of furnishing medical care to eligible individuals.

Outpatient
A covered person will be considered to be an outpatient if treated on a basis other than as an inpatient in a hospital or other covered facility. Outpatient care includes services, supplies, and medicines provided and used at a hospital or other covered facility under the direction of a physician to a person not admitted as an inpatient.

Physician
A legally qualified person acting within the scope of his or her license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Plan
The Uniformed Services Family Health Plan as presented in the formal Plan document.

Plan Year
The Plan Year is from January 1 through December 31.

Plan provider
A Plan provider is the facility and all institutional or professional providers associated with the facility, including those employed by, or under contract to, the facility, or a provider who subcontracts with a Plan provider. The Plan provider's purpose is to render covered and authorized care to enrollees in the Plan, or to manage the Plan on behalf of the facility.

Point of Service (POS)
A benefit option that provides limited coverage for unauthorized, non-emergent, out-of-network services. Under this option, members may seek care from a medical provider outside of the Plan's provider network without Plan authorization, but pay higher out-of-pocket costs for doing so.

Primary care provider (PCP)
The internist, family practitioner, pediatrician, or nurse practitioner you choose to be your personal provider or your dependent's personal provider.

Qualifying Life Event (QLE)
An event, including but not limited to birth or adoption of a child; or marriage, divorce, retirement, or loss of other health care coverage, which allows enrollment in the Plan outside of the Open Season period.

Room and board
Charges made by a hospital or other covered institution for the cost of the room, general duty nursing care, and other services routinely provided to all inpatients, not including special care units.

Semi-private charge
The charge made by a hospital for a room containing two or more beds, but does not include the charge made by the hospital for special care units.

Service area
The ZIP Code-defined service area is the geographic area in which US Family Health Plan of Southern New England makes covered services available to enrollees. This area is determined by the Department of Defense.

Special care units
A specific hospital unit that provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant, and continuous care. This term will include charges for intensive care, coronary care, and acute care units of a hospital, but does not include care in a surgical recovery or postoperative room.

The unit must meet the required standards of the Joint Commission on Accreditation of Healthcare Organizations for special care units.

Sponsor
A sponsor is any person who, as a direct affiliate or member of an organization within the DoD, is entitled to benefits from the Department of Defense (DoD), and who, through that affiliation or membership, entitles his or her family members to benefits. Members of non-DoD organizations whose employees are authorized DoD benefits are also sponsors, and often accord eligibility to their family members.

TRICARE Young Adult (TYA)
A premium-based health care plan that qualified dependents may purchase for medical and pharmacy benefits. TYA allows dependent adult children up to age 26 to purchase TRICARE coverage after eligibility for "regular" TRICARE coverage ends at age 21 (or 23 if enrolled in a full course of study at an approved institution of higher learning). US Family Health Plan offers the Prime benefit through the TRICARE Young Adult program.

Urgent care
Health care services that are required within several hours and, in all cases, after the onset of illness or accidental injury that is not life threatening. Examples of urgent-care situations include a sprained ankle or a cut that needs stitches.

US Family Health Plan Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Uniformed Services Family Health Plan (US Family Health Plan) strongly believes in safeguarding the privacy of our members' protected health information (PHI).

PHI is information that:

- identifies you (or can reasonably be used to identify you), and
- relates to your physical or mental health or condition, the provision of health care to you, or the payment for that care

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use, and disclose your PHI, and your rights concerning your PHI. This Notice applies to all members of US Family Health Plan.

How we obtain PHI

As a managed care plan, we engage in routine activities that result in our being given PHI from sources other than you. For example, health care providers — such as physicians and hospitals — submit claim forms containing PHI to allow us to pay them for the covered health care services they have provided to you.

How we use and disclose your PHI

We use and disclose PHI in a number of ways to carry out our responsibilities as a managed care plan. Here are the types of uses and disclosures of PHI that federal law permits us to make without your specific authorization:

Treatment

We may use and disclose your PHI to health care providers to help them treat you. For example, our care managers may disclose PHI to a home health care agency to make sure you get the services you need after discharge from a hospital.

Payment purposes

We use and disclose your PHI for payment purposes, such as paying doctors and hospitals for covered services. Payment purposes also include activities such as determining eligibility for benefits, reviewing services for medical necessity, performing utilization review, obtaining premiums, coordinating benefits, subrogation, and collection activities.

Health care operations

We use and disclose your PHI for health care operations. This includes coordinating/managing care, assessing and improving the quality of health care

services, reviewing the qualifications and performance of providers, reviewing health plan performance, conducting medical reviews, and resolving grievances. It also includes business activities such as underwriting, rating, placing or replacing coverage; determining coverage policies; business planning; obtaining reinsurance; arranging for legal and auditing services (including fraud- and abuse-detection programs); and obtaining accreditations and licenses. We do not use or disclose PHI that is genetic information for underwriting purposes.

Health and wellness information

We may use your PHI to contact you with information about appointment reminders; treatment alternatives; therapies; health care providers; settings of care; or other health-related benefits, services, and products that may be of interest to you. For example, we might send you information about smoking-cessation programs.

Organizations that assist us

In connection with treatment, payment, and health care operations, we may share your PHI with our affiliates and third-party "business associates" that perform activities for us or on our behalf—for example, our pharmacy benefit manager. We will obtain assurances from our business associates that they will appropriately safeguard your information.

Plan sponsors

As a TRICARE Designated Provider, US Family Health Plan is sponsored by the Department of Defense (DoD). We may disclose PHI to DoD for Plan administration purposes. DoD certifies that it will protect the PHI in accordance with law.

Public health and safety, health oversight

We may disclose your PHI to a public-health authority for public-health activities, such as responding to public-health investigations; when authorized by law to appropriate authorities if we reasonably believe you are a victim of abuse, neglect, or domestic violence; when we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to your or others' health or safety; or to health-oversight agencies for certain activities such as audits, disciplinary actions, and licensure activity.

Legal process, law enforcement, specialized government activities

We may disclose your PHI in the course of legal proceedings; in certain cases, in response to a subpoena, discovery request, or other lawful process; to law-enforcement officials for such purposes as responding to a warrant or subpoena; or for specialized governmental activities such as national security.

Research, death, organ donation

We may disclose your PHI to researchers, provided that certain established measures are taken to protect your privacy. We may disclose PHI, in certain instances, to coroners and medical examiners, and in connection with organ donation.

Workers' compensation
We may disclose your PHI when authorized by workers' compensation laws.

Family and friends
We may disclose PHI to a family member, relative, or friend — or anyone else you identify — as follows: (i) when you are present prior to the use or disclosure and you agree; or (ii) when you are not present (or you are incapacitated or in an emergency situation) if, in the exercise of our professional judgment and in our experience with common practice, we determine that the disclosure is in your best interests. In these cases we will only disclose the PHI that is directly relevant to the person's involvement in your health care or payment related to your health care.

Personal representatives
Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative has legal authority to act on your behalf in making decisions related to your health care or health care benefits. For example, an individual named in a durable power of attorney or a parent or guardian of an unemancipated minor are personal representatives.

Mailings
We will mail information containing PHI to the address we have on record for the subscriber of your health benefits plan. Also, we may mail information containing your PHI to the subscriber. For example, communication regarding member requests for reimbursement may be addressed to the subscriber. We will not make separate mailings for enrolled dependents at different addresses unless we are requested to do so and agree to the request. See "Right to Receive Confidential Communications" on page 54 for more information on how to make such a request.

Required by law
We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S. Department of Health and Human Services upon request if they wish to determine whether we are in compliance with federal privacy laws.

If one of the above reasons does not apply, we will not use or disclose your PHI without your written permission (authorization). You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may later change your mind and revoke your authorization in writing. However, your written revocation will not affect actions we have already taken in reliance on your authorization.

Where state or other federal laws offer you greater privacy protections, we will follow those more stringent requirements. For example, under certain circumstances, records that contain information about alcohol-abuse treatment, drug-abuse prevention or treatment, AIDS-related testing or treatment, or certain privileged communications may not be disclosed without your written

authorization. In addition, when applicable, we must have your written authorization before using or disclosing medical or treatment information for a member appeal. See "Who to Contact with Questions or Complaints" on page 55 if you would like more information.

How we protect PHI within our organization

US Family Health Plan protects oral, written, and electronic PHI throughout our organization. We do not sell PHI to anyone. We have many internal policies and procedures designed to control and protect the internal security of your PHI. These policies and procedures address, for example, use of PHI by our employees. In addition, we train all employees about these policies and procedures. Our policies and procedures are evaluated and updated for compliance with applicable laws.

Your individual rights

Here is a summary of your rights with respect to your PHI:

Right of access to PHI

You have the right to obtain and inspect a copy of most PHI that US Family Health Plan has about you, or a summary explanation of PHI if agreed to in advance by you. Requests must be made in writing and reasonably describe the information you would like to inspect or copy. If your PHI is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable cost-based fee for paper or electronic copies as established by state or federal law. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice of denial describing the basis of our denial. You may request that we send a copy of your PHI directly to another person that you designate. Your request must be in writing, signed by you, and clearly identify the person and the address where the PHI should be sent.

Right to request restrictions

You have the right to ask that we restrict uses or disclosures of your PHI to carry out treatment, payment, and health care operations; and disclosures to family members or friends. We will consider the request. However, we are not required to agree to it and, in certain cases, federal law does not permit a restriction. Requests may be made orally or in writing to US Family Health Plan.

Right to receive confidential communications

You have the right to ask us to send communications of your PHI to you at an address of your choice or that we communicate with you in a certain way. For example, you may ask us to mail your information to an address other than the subscriber's address. We will accommodate your request if (1) you state that disclosure of your PHI through our usual means could endanger you, (2) your request is reasonable, (3) it specifies the alternative means or location, and (4) it contains information as to how payment, if any, will be handled. Requests may be made orally or in writing to US Family Health Plan.

Right to amend PHI

You have the right to have us amend most PHI we have about you. We may deny your request under certain circumstances.

If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial. Requests must be in writing to US Family Health Plan and must include a reason to support the requested amendment.

Right to receive an accounting of disclosures

You have the right to a written accounting of the disclosures of your PHI that we made in the last six years prior to the date you request the accounting. However, except as otherwise provided by law, this right does not apply to (1) disclosures we made for treatment, payment, or health care operations; (2) disclosures made to you or people you have designated, (3) disclosures you or your personal representative have authorized, (4) disclosures made before April 14, 2003, and (5) certain other disclosures, such as disclosures for national security purposes. If you request an accounting more than once in a 12-month period, we may charge you a reasonable fee. All requests for an accounting of disclosures must be made in writing to US Family Health Plan.

Right to authorize other use and disclosure

You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

Right to receive a privacy breach notice

You have the right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.

Right to this Notice

You have a right to receive a paper copy of this Notice from us upon request.

How to exercise your rights

To exercise any of the individual rights described above or for more information, call Member Services at **1.800.818.8589** (TDD: **1.800.815.8580**) or write to:

US Family Health Plan, c/o Tufts Health Plan
Attn: Privacy Officer
P.O. Box 495
Canton, MA 02021-0495

Effective date of Notice

This Notice took effect July 1, 2013. We must follow the privacy practices described in this Notice while it is in effect. This Notice will remain in effect until we change it. This Notice replaces any other information you have previously received from us with respect to privacy of your medical information.

Changes to this Notice of Privacy Practices

We may change the terms of this Notice at any time in the future and make the new Notice effective for all PHI that we maintain — whether created or received before or after the effective date of the new Notice. Whenever we make an important change, we will send subscribers an updated Notice of Privacy Practices. In addition, we will publish the updated Notice on our website at **usfamilyhealth.org**.

Who to contact with questions or complaints

If you would like more information or an additional paper copy of this Notice, please contact Member Services at **1.800.818.8589**. You can also download a copy from our website at **usfamilyhealth.org**.

If you believe your privacy rights may have been violated, you have a right to complain to US Family Health Plan by calling the Privacy Officer at **1.800.818.8589** or writing to:

US Family Health Plan, c/o Tufts Health Plan
Attn: Privacy Officer
P.O. Box 495
Canton, MA 02021-0495

You also have a right to complain to the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Notes

77 Warren Street
Boston, MA 02135

1.800.818.8589
usfamilyhealth.org

April 22, 2024 online