

US FAMILY HEALTH PLAN AT MARTIN'S POINT

Member Handbook



US FAMILY
HEALTH PLAN



**US FAMILY HEALTH PLAN
MEMBER HANDBOOK**

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

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

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

Martin's Point Health Care, a former Uniformed Services Treatment Facility (USTF) within the Military Health System (MHS), has been providing health care to military beneficiaries for over 24 years. Martin's Point Health Care is a locally owned, not-for-profit, ambulatory health care center with three clinical practice sites. We also have a contract with the Department of Defense to administer the TRICARE Prime benefit, which we call the US Family Health Plan.

The US Family Health Plan at Martin's Point provides medical benefits for retirees from the uniformed services, their family members, and active-duty family members of the seven uniformed services: the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service (PHS), and the National Oceanic and Atmospheric Administration (NOAA). Medical care and service are provided by the three Martin's Point practices and a network of primary care providers (PCPs), specialists, hospitals, and pharmacies within our designated service area of Maine, New Hampshire, and portions of northern Massachusetts. In 2005, the US Family Health Plan at Martin's Point will be expanding our service area and provider network to Vermont and northeastern New York.

How the Plan Works

The US Family Health Plan is a managed care plan, designed to provide comprehensive medical benefits to enrolled beneficiaries at a low out-of-pocket cost. The provider-patient relationship is the heart of the US Family Health Plan. As an enrolled member you are required to select a PCP, who will coordinate your medical care, including routine care, urgent care, and preventive health care needs, and refer you for specialty care and hospitalization, if needed. There are no claims forms when Plan-approved providers are used.

Let's Get Started

As your health plan administrator, the staff at the US Family Health Plan wants to help ensure that you understand your military health care entitlement and that you always receive the health care services you need. We hope this Member Handbook will help you understand the following:

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

We hope you will take the time to read and understand this handbook and to call us if you



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have any questions. Our Member Services Representatives and Health Benefits Advisor are available Monday—Friday, 8 am—6 pm, to help you find the answers you need in the sometimes confusing world of health care. Member Services can be reached by calling, toll-free, 1-888-674-8734.

Quick Reference Telephone Numbers

Medical Emergencies

- Call 911.
- Notify your PCP within 48 hours of your emergency room visit so all follow-up care can be arranged and approved by your PCP.

Urgent Care (to include evenings, weekends, holidays, etc.)

- Call your PCP first to get instructions for the urgent care. The telephone number is printed on the front of your Member Identification (ID) Card.

Specialty Care

- Call your PCP first. The telephone number is printed on the front of your Member ID Card.

Mental Health

- Behavioral HealthCare Program (BHCP): call 1-888-812-7335
- NOTE: For more information regarding mental health services, see page 20.

US Family Health Plan

- Member Services 1-888-674-8734
- Pharmacy:
 - Mail-Order Pharmacy 1-800-707-9853
 - Pharmacy at Portland 1-800-707-9853

- Pharmacy at Portsmouth 1-603-436-0562
or 1-800-222-5154 ext. 5555
- Refills at Portsmouth 1-603-436-0610
or 1-800-603-0562

Defense Enrollment Eligibility Reporting System (DEERS)

- Manpower Data Center Support Office 1-800-538-9552
- Fax 1-831-655-8317

Members' Rights and Responsibilities

We are dedicated to protecting the rights and responsibilities of our members. This listing is designed to inform you of your rights and responsibilities as a member of the US Family Health Plan at Martin's Point.

MEMBERS' RIGHTS

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

- Receive information about covered benefits and cost sharing.
- Receive information about the US Family Health Plan at Martin's Point, our services, licensure, certification, and accreditation status.
- Receive information about our practitioners, providers, and health care facilities, including information about the composition of our network.
- Have a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.
- Receive information on member satisfaction.



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- ▶ Be informed of the processes for accessing specialists and emergency services.
 - ▶ Receive considerate and respectful care, with recognition of your personal dignity at all times.
 - ▶ Have access to all of the health care and treatment services we provide, including care management information, consistent with available resources and generally acceptable standards.
 - ▶ Have access to emergency health care services when and where the need arises.
 - ▶ Refuse treatments to the extent permitted by law and government regulations and the right to be informed of the consequences of such refusal of treatment.
 - ▶ Question the adequacy of care being provided.
 - ▶ Have privacy and confidentiality concerning your medical care and records to the extent permitted by law. You have the right, and will be afforded the opportunity, to approve or refuse the release of such information, except when release is required by law or the Department of Defense.
 - ▶ Know the identity and professional status of the health care provider primarily responsible for providing and managing your care, as well as other health care personnel involved in your treatment.
 - ▶ Participate in decisions involving your health care. Members who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
 - ▶ Understand an explanation of the diagnosis, treatment, and prognosis of your illness.
- ▶ Be informed of possible complications, risks, benefits, and alternative treatments associated with consent or refusal for treatment in order to make knowledgeable decisions about your course of care.
 - ▶ Be advised if the US Family Health Plan proposes to engage in or perform experimental research in order to make knowledgeable decisions about your care. You have the right to refuse to participate in experimental research.
 - ▶ Receive care and treatment in a safe environment and to be informed of the facility's rules and regulations that relate to patient and visitor conduct.
 - ▶ Be informed of the US Family Health Plan member grievance and appeals process, designated for the initiation, review, and resolution of patient complaints and appeals. You have the right to file complaints and appeals with Martin's Point, as outlined in the Grievances (Complaints) and Appeals Processes section of this Member Handbook.

MEMBERS' RESPONSIBILITIES

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

- ▶ Becoming knowledgeable about your health plan coverage and health plan options, including all covered benefits, limitations and exclusions; rules regarding use of network providers, coverage, and authorization rules; appropriate processes to secure additional information; and the process to appeal coverage decisions.
- ▶ Providing your PCP complete information, to the best of your knowledge, regarding your past



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medical history and other matters relating to your health.

- ▶ Becoming involved in specific health care decisions.
- ▶ Complying with the medical and nursing treatment plan, including the follow-up care, agreed upon by you and your health care provider(s). This includes keeping appointments and notifying providers, in a timely manner, when an appointment cannot be kept. You also have the responsibility of letting your provider know whether or not you understand the treatment plan and what is expected of you.
- ▶ Making a good-faith effort to meet financial obligations, to include paying applicable co-payments at the time the services are received and enrollment fees, as required.
- ▶ Being considerate of the rights of other patients, and of Martin's Point Health Care personnel and network providers.
- ▶ Being respectful of the property of other persons and facilities.
- ▶ Reporting recommendations or questions you have to a Member Services Representative or Health Center Manager.
- ▶ Using our internal complaint and appeals processes to address concerns that may arise.
- ▶ Following provider facility rules and regulations affecting patient conduct, including no-smoking rules, parking regulations, etc.
- ▶ Reporting wrongdoing and fraud to appropriate resources or legal authorities.

US Family Health Plan Member Identification Card

All members of the US Family Health Plan receive a Member ID Card soon after joining the Plan. These cards do not have an expiration date, so Member ID Cards are not issued each year. If you recently enrolled in the US Family Health Plan and have not received your US Family Health Plan Member ID Card, please call Member Services, toll-free, at 1-888-674-8734 and let us know that you are still waiting for your card.

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

This information includes:

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

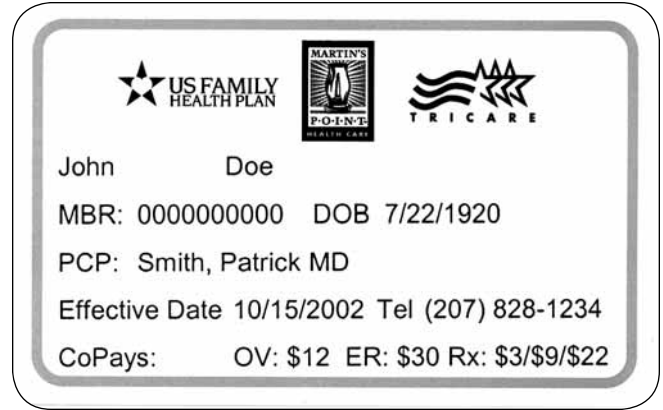


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Please review your Member ID Card for accuracy. If any information is incorrect, simply call Member Services and a corrected card will be sent to you within a few days.

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

If you lose or seriously damage your card, please call Member Services, toll-free, at 1-888-674-8734 and we will send you a replacement Member ID Card.



Except in emergencies, contact your Primary Care Provider (PCP) before obtaining medical services. Non-emergency care not coordinated by your PCP will not be covered.
Emergencies: Seek care immediately. All follow up care must be coordinated by your PCP.
Abuse Services: Call the Behavioral HealthCare Program, toll-free at 1-888-812-7335.
Member Services: Call toll-free at 1-888-674-8734, for assistance regarding benefits, eligibility, and/or claims.
Prescriptions: Present this card to a participating pharmacy when you have an emergency or one-time prescription.
Health Coach Service: For health information and health care decision support call the Health Coach Service, toll-free at 1-800-574-8494.
Providers: Send claims to US Family Health Plan at Martin's Point P.O. Box 9746 Portland, ME 04104-5040 Attn: Claims Department Provider Inquiry: 1-888-732-7364
Pharmacies: For claims submission questions, please contact PharmaCare at 1-800-777-1023.
PharmaCare: BIN 610468, Processor Control #: PC2 Group: USFHP Member ID: See MBR on front of card.



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MEMBER HANDBOOK**Primary Care Provider (PCP)*****Choosing Your Primary Care Provider***

The provider-patient relationship is the heart of the US Family Health Plan. Your primary care provider (PCP) is responsible for coordinating your medical care. Your PCP sees you when you are sick or injured, and for your preventive health care needs, and keeps your medical record up-to-date. He or she refers you to specialists (and other medical services) when medically necessary.

When you applied for membership in the US Family Health Plan, you were asked to select a PCP. Our goal is that each enrolled family member selects a PCP with whom he or she is comfortable. If you or a family member ever wishes to choose a different PCP, simply call Member Services, toll-free, at 1-888-674-8734. They will make the change in our membership database and send you a new Member ID Card listing your new PCP. You are free to change your PCP at any time during your membership.

Role of Your Primary Care Provider

Your PCP is key to accessing services that will meet your health care needs. He or she sees you for all of your routine health needs, monitors the medications you receive, orders tests or special services such as physical therapy when needed, and maintains your medical records. If you have a complex problem, your PCP may refer you to one of our many qualified contracted specialists. Your PCP and

the specialist will work together as a team to meet your health care needs.

There are advantages to having your own PCP. These advantages include the following:

- ▶ You have only one office to call whenever you need care.
- ▶ Your medical records are kept in one secure place.
- ▶ Your PCP has good working relationships with the specialists and hospitals that he or she refers you to.
- ▶ Your prescriptions can be monitored for interactions.
- ▶ Your PCP and his or her staff can help you navigate the complex world of health care.

Although we would like to promise that you will always see your personal PCP when you need a routine or urgent appointment, your PCP may not always be available. However, when that happens, you will be given an appointment with another physician, physician assistant, or nurse practitioner who works with your PCP and who has access to your medical records.

Changing Your Primary Care Provider

If you or a family member change PCPs, it is important to establish a relationship with the new PCP as soon as possible. Here are some helpful hints for establishing the relationship:

- ▶ Call your former PCP's office and request a transfer of your medical records to the office of your new PCP.



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- ▶ Call your new PCP's office to inquire about its process for establishing a patient-provider relationship.
- ▶ If you are currently taking medications on a daily basis, obtain a 90-day supply from your former provider (before you change your PCP) to ensure you don't run out prior to your first visit with your new PCP.

If You Need Specialty Care

Except for instances when you may self-refer (see page 8), you must receive a referral from your PCP before seeing any other provider or specialist. Your PCP will identify the appropriate specialty for care and assist you in selecting a specialty provider.

Provider Directory

The names, addresses, and telephone numbers of all our participating internists, family practitioners, and pediatricians are listed in your Provider Directory. Directories are subject to change and are updated on a regular basis. You may check the current status of any provider (PCP or specialist) by calling Member Services. The Provider Directory is also updated daily on our web site, at www.martinspoint.org. Once at the site, click on the US Family Health Plan icon and follow the directions to the Provider Directory.

Continuity of Care

If you are following a treatment plan prescribed by a specialty physician prior to joining the US Family Health Plan at Martin's

Point and you require ongoing management of this condition, you must notify your US Family Health Plan PCP as soon as possible. A referral from your PCP is required in all circumstances. Authorization of the care is required by the US Family Health Plan if the specialist is not a network provider with Martin's Point. Every effort will be made to ensure that there is continuity of your care. If you do not obtain prior authorization from the US Family Health Plan for continued treatment with a non-network provider, you will be held financially responsible for payment of those services. **Each time you choose to see a non-network provider in a non-emergency situation without receiving proper authorization from the US Family Health Plan, you will be fully responsible for payment of all charges related to that visit.** New episodes of care will not be authorized to non-network providers you may have seen in the past prior to enrolling in the US Family Health Plan.

If You Are Admitted to a Hospital

If you require a planned hospitalization, your PCP or specialist will make the necessary arrangements for you at a network facility. Your hospital care will be coordinated by your PCP or another network provider. If you are admitted to a hospital on an emergency basis, notify your PCP within 24 hours, or the next business day. You should also notify the US Family Health Plan by calling Member Services, toll-free, at 1-888-674-8734.



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MEMBER HANDBOOK**Self-Referrals**

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

- ▶ Emergency care for treatment of a potentially life-threatening condition.
- ▶ Eight (8) visits to a network provider for mental health or substance abuse treatment (To ensure that you make your appointments with a network provider, please contact Behavioral HealthCare Program (BHCP) by calling, toll-free, 1-888-812-7335 prior to your first appointment. For more information about your mental health and substance abuse benefit, please turn to page 20.
- ▶ One (1) annual routine eye examination with a network optometrist or ophthalmologist.
- ▶ Annual preventive health care services such as an annual Pap smear or routine mammogram at a network provider office, network hospital, or network diagnostic facility.

Referral and Authorization Process

Your PCP is responsible for coordinating all your health care needs except life-threatening emergencies, annual eye examination, annual physicals, and select mental health services. Should your medical condition require the services of a specialist, your PCP will start the referral process for you and explain to you why you need to see a specialist. This process is known as the “referral process.”

It is very important to note that a referral from your PCP is not the same as an authorization letter for coverage from the

US Family Health Plan. A referral from your PCP is your PCP’s verification that the services being recommended for you are medically appropriate or medically necessary—PCP referrals do not imply or guarantee payment by the US Family Health Plan.

There are some covered services that the US Family Health Plan is required to pre-certify (authorize) prior to your receiving the services. In these circumstances, your PCP will forward the referral to the US Family Health Plan for review and prior authorization. The US Family Health Plan will determine coverage and generate an authorization letter. This process is known as the “authorization process.”

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

ANSWER: No.

- ▶ Some services, such as diagnostic testing (e.g., X-rays), do not require your PCP to request an authorization from the US Family Health Plan. Authorization letters for these services are not mailed from the US Family Health Plan.
- ▶ Some services, such as office consultations and office visits, do not require your PCP to request an authorization from the US Family Health Plan if the services are provided by a network provider. However, if the services are provided by a non-network provider, your PCP will need to request an authorization from the US Family Health Plan. All PCP referrals for non-network services are



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reviewed by the Medical Services Department to determine if they can be provided within our network. Only those medically necessary services that cannot be provided within our network will be authorized by the Plan.

- ▶ Some services, such as inpatient care, will always require your PCP to request an authorization from the US Family Health Plan, whether the services are provided by a network or non-network provider/hospital. The US Family Health Plan will continue to generate authorization letters for these services.

You may utilize a variety of methods to determine if an authorization letter is required from the US Family Health Plan for a service:

1. View the latest Authorization Grid on-line at www.martinspoint.org. Once at the site, click on the US Family Health Plan icon and follow the directions to the Authorization Grid.
2. Contact the Member Services Department at Martin's Point by calling, toll-free, 1-888-674-8734.
3. Contact your PCP. He or she will have a copy of the Authorization Grid.

The Authorization Grid provides you with an alphabetical list of benefits and informs you if an authorization letter from the US Family Health Plan is required or not.

The US Family Health Plan continues to expand your options for PCP care into new areas of Maine, New Hampshire, Vermont and upstate New York in order to offer more convenient access to quality health care. **It is a shared responsibility between you and your**

PCP to ensure that the specialist to whom you are referred is a network specialist.

Therefore, always check the Provider Directory to make certain that the specialty provider, hospital, agency, or company to which you have been referred is part of the US Family Health Plan network. Any questions you may have about the US Family Health Plan network in your area should be directed to Member Services, toll-free, at 1-888-674-8734.

In order to determine if a provider is a network provider or a non-network provider, please refer to your Provider Directory, or contact our US Family Health Plan Member Services Department, toll-free, at 1-888-674-8734. The Provider Directory is updated daily on our web site, located at www.martinspoint.org. Once at the site, click on the US Family Health Plan icon and follow the directions to the Provider Directory.

For authorization of mental health and substance abuse benefits, please call the Behavioral HealthCare Program, toll-free, at 1-888-812-7335.



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MEMBER HANDBOOK**Utilization Management and the
US Family Health Plan Medical
Services Department*****Medically Necessary Care***

One purpose of the utilization review process is to ensure that you receive all of the benefits to which you are entitled. It also ensures that the US Family Health Plan at Martin's Point only pays for care that is medically necessary and is a service covered under the Plan. Care is considered medically necessary when:

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

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

Nonemergency Elective Hospital Admissions

The US Family Health Plan at Martin's Point will review your nonemergency or elective hospital admission in advance to ensure that the treatment or surgery you are to receive is covered under your Plan and is being provided at a network facility and at the most

appropriate level of care. Most procedures, such as outpatient surgery, require prior authorization by the US Family Health Plan. It is important to note that without receiving proper authorization from the US Family Health Plan, you will be fully responsible for payment of all charges related to that procedure.

Emergency Hospital Admissions

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

If you require inpatient hospitalization as a result of an emergency visit, either you, a family member, or a designee must notify your PCP within 48 hours of admission.

Case Management Services

Members of the US Family Health Plan who have complex care coordination needs may be eligible for the services of a Case Manager. Members of the US Family Health Plan Case Management Team are nationally certified, highly trained, and have extensive experience in the areas of chronic disease management, management of catastrophic events, and oncology care coordination. Members may self-refer for Case Management or be referred by any member of their health care delivery team. Case Managers work collaboratively with the Martin's Point Health Coaches to ensure that members receive the most



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beneficial services delivered via the most appropriate means. For more information on how Case Management or the Health Coach Service may be of benefit to you, please contact the Medical Services Department at the US Family Health Plan at 1-800-322-0280.

US Family Health Plan Special Programs

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

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

PLEASE NOTE: Before agreeing to participate in ANY clinical trial, study, or experimental or investigational treatment, call Medical Services, toll-free, at 1-800-322-0280 to determine coverage.

Extended Care Health Option (ECHO) Program

The ECHO Program supersedes the Program for Persons with Disabilities (PFPWD) in the fall of 2005.

The US Family Health Plan authorizes and coordinates services for active-duty family members who qualify for the ECHO Program. The ECHO Program provides financial assistance to reduce the effects of mental retardation or a serious physical disability. Members must enroll in the Exceptional Family Member Program for their family member to retain extended health care benefits. For more information, please contact Medical Services, toll-free, at 1-800-322-0280.

Health Coach Service

Members can take a step toward a healthier life by taking advantage of the Health Coach Service offered by the US Family Health Plan at Martin's Point. This service is available to all members at no charge. The US Family Health Plan at Martin's Point has partnered with Health Dialog to provide this additional service to our members. To contact a Health Coach, call, toll-free, 1-800-574-8494.

A personal Health Coach. When you call the Health Coach Service, you will be connected to a Health Coach—a specially trained health professional (such as a nurse, respiratory therapist, or dietitian, depending on your personal needs). The Health Coach Service is available day or night, 365 days a year.



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Decision support. Health Coaches are trained to present members with evidence-based, unbiased views of health care options and to encourage patients to work with their providers to choose the health care options that are right for them.

Educational materials mailed to your home, at no charge. Health Coaches can send you current information—written by nationally recognized sources—on a wide variety of topics, such as lowering your cholesterol or a low-salt diet. Videotapes are available on specific topics such as breast cancer, prostate cancer, hormone replacement, and low back pain. All materials are yours to keep.

Online resources to help you learn about and manage your health. You can go online to complete a survey and use the results to help you understand health risks you may be facing. The survey can be found at www.thedialogcenter.com/usfhp.

Information on health education classes . Your Health Coach can tell you about health classes and other health-related services in your community. Get help with smoking cessation, weight loss, diabetes management, stress reduction, and more.

The US Family Health Plan at Martin's Point encourages you to communicate with your provider about your health care needs. **The Health Coach Service is not meant to be a substitute for the patient-provider relationship but rather an additional resource for maintaining a healthy lifestyle.**

Emergency Care

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

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

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

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

At the time of the ER visit, retirees and family members of retirees will be asked to pay a \$30 co-payment. If you are admitted as an inpatient, only the inpatient co-payment applies. Active-duty family members and retirees with Medicare Part B pay no co-payment for emergency room visits.

Your PCP will provide or coordinate your follow-up care, such as removal of stitches,



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X-rays, or checking a cast. Do *not* return to the emergency room or see the attending physician unless your PCP refers you. Non-authorized follow-up visits will be the financial responsibility of the member.

US Family Health Plan Member ID Card. All PCP offices have instructions for receiving calls when the office is not open. Your PCP or on-call physician will provide you with instructions on how to care for your urgent health issue.

Urgent Care

For urgent medical situations, always call your PCP prior to seeking care, even if you are out of the service area.

Urgent care is defined as “care that can safely be postponed until you speak to your PCP or the doctor on call for instructions.”

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

- Sprained ankle
- Cuts needing stitches
- Urinary tract infections
- Flu symptoms
- Bronchitis
- Ear infections
- Migraine headaches
- Muscle strains
- Gradual worsening of a chronic condition

AFTER-HOURS URGENT CARE

The need for urgent care will not necessarily coincide with your PCP’s office hours. Should an urgent medical situation arise at night or on a weekend or holiday, you must call your PCP at the telephone number listed on your

Out-of-Area Care

When you travel outside the US Family Health Plan at Martin’s Point service area, whether to go on vacation, attend college, or winter in a warmer climate, only qualified emergency care is covered. In some cases, a one-time urgent care visit that has been pre-approved by your PCP and pre-authorized by the US Family Health Plan will be covered. All non-emergency care that is obtained by a US Family Health Plan member outside the US Family Health Plan at Martin’s Point service area that has not been pre-approved by your PCP and pre-authorized by the US Family Health Plan will not be covered.

Examples of care that will *not* be covered by the US Family Health Plan at Martin’s Point while out of the area include:

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

Additionally, routine obstetrical care and inpatient labor and delivery services are not



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covered when a member chooses to travel outside the US Family Health Plan at Martin's Point service area within 30 days of her expected due date.

If you are out of the area, including travel outside the United States, and have a qualifying medical emergency, go immediately to the nearest emergency room. You must notify your PCP within 48 hours so that coordination of any necessary follow-up care can occur.

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

Prior to leaving the service area, please call Member Services, toll-free, at 1-888-674-8734 and we will mail you a brochure titled "Wherever You Go...Bring Your Health Care with You." This brochure provides information on receiving health care while traveling outside the service area.

Health Care Benefits

The following chart provides a summary of your covered benefits and co-payments. A list of limitations and exclusions to the TRICARE benefit is listed on page 23.

If applicable, co-payments are due at the time you receive care or pick up prescriptions. If you use the mail-order prescription service, your co-payment is due when you order your prescription.



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Summary of Your Health Care Benefits

	Active-Duty Family Members or Retirees and Family Members Who Also Carry Medicare Part B	Retirees and Family Members Who Do Not Carry Medicare Part B
Annual Enrollment Fee	\$0	\$230/individual \$460/family
Out-of-Pocket Maximums (per family) (Catastrophic Cap)	\$1,000 (active-duty) \$3,000 (retiree with Medicare Part B)	\$3,000 (retiree)
COVERED SERVICES	YOUR COST	YOUR COST
Allergy Shots	\$0	\$12 per visit
Annual Physical Examinations and Other Preventive Services, (e.g., Pap smears, mammograms, and prostate screening)	\$0	\$0
Diagnostic Tests (e.g., lab work, X-rays, MRIs, CAT scans, PET scans, cardiac tests)	\$0	\$0
Durable Medical Equipment (e.g., wheelchair, walkers, canes, elastic stockings)	\$0	20% of the fee negotiated by the US Family Health Plan at Martin's Point
Emergency Ambulance Services, Including Ground and Air (Note: Benefit limitations apply)	\$0	\$20 per occurrence
Emergency Room Visits	\$0	\$30 per visit (waived if admitted to the hospital)
Eye Examinations	\$0	\$0 – Routine annual \$12 – Medical diagnosis
Home Health Care: Skilled nursing, occupational/physical therapy, speech therapy	\$0	\$12 per visit
Hospice	\$0	\$0
In-patient (hospitalization): Semi-private room, physician services, general nursing services, meals, drugs, labs, operating room & anesthesia services, diagnostic therapy, blood, etc.	\$0	\$11 per day/ \$25 minimum charge per admission
Maternity: Hospital	\$0	\$11 per day/\$25 minimum charge per admission
Maternity: (Prenatal and postnatal)	\$0	\$0
Medical Supplies (e.g., wound care supplies) (Note: Over-the-counter supplies such as band-aids, saline solution, etc. are not covered.)	\$0	20% cost share
Mental Health: Inpatient	\$0	\$40 per day
Mental Health: Outpatient	\$0	\$25 per visit (individual) \$17 per visit (group)
Mental Health: Partial hospitalization (up to 60 days per enrollment year)	\$0	\$40 per day
Oncology Treatments (e.g., chemotherapy, radiation treatments, office visits)	\$0	\$12 per visit
Outpatient/Day Surgery (including anesthesia)	\$0	\$25 per procedure
Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation	\$0	\$12 per visit
Prescription Drugs: Retail (up to a 30-day supply)	\$3 for generic prescription \$9 for brand-name prescription \$22 for non-formulary prescription	\$3 for generic prescription \$9 for brand-name prescription \$22 for non-formulary prescription
Mail-Order (up to a 90-day supply)	\$3 for generic prescription \$9 for brand-name prescription \$22 for non-formulary prescription	\$3 for generic prescription \$9 for brand-name prescription \$22 for non-formulary prescription
Primary Care Provider Office Visits	\$0	\$12 per visit

continued on next page



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Summary of Your Health Care Benefits (continued)

	Active-Duty Family Members <i>or</i> Retirees and Family Members Who Also Carry Medicare Part B	Retirees and Family Members Who Do Not Carry Medicare Part B
Skilled Nursing Facility (rehabilitative facility): Semi-private room, nursing services, meals/special diets, rehabilitative therapies, drugs, supplies, and appliances furnished by the facility (Note: Long-term care and custodial care are NOT covered)	\$0	\$11 per day/\$25 minimum charge per admission
Specialist Office Visits	\$0	\$12 per visit
Substance Abuse Treatment: Inpatient rehabilitation (up to 21 days per year)	\$0	\$40 per day
Substance Abuse Treatment: Inpatient services (up to 7 days for detoxification per year)	\$0	\$40 per day
Substance Abuse Treatment: Outpatient	\$0	\$25 per visit (individual) \$40 per visit (group)
Urgent Care	\$0	\$12 – office / urgent care clinic \$30 – Hospital
Vaccinations & Immunizations (Note: these are NOT covered for elective travel.)	\$0	\$0
Well-Baby / Well-Child Care (including child immunizations)	\$0	\$0

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Prescription Drug Benefit

Prescription Drugs Received at a Network Retail Pharmacy

Your pharmacy benefit covers prescription drugs filled at network pharmacies when prescribed by an authorized US Family Health Plan provider. The co-payment fee is per prescription, for up to a 30-day supply or up to the quantity prescribed by the physician, whichever is smaller. The co-payment for generic medications is \$3 per prescription; “formulary” (brand-name) medications, \$9 per prescription; “non-formulary” medications, \$22 per prescription. Please refer to your Provider Directory for a listing of the network pharmacies in your area. You may also search for a participating pharmacy via the Internet at our web site: www.martinspoint.org.

Urgent, One-Time, and Acute-Need Prescriptions

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

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

NOTE: Prescriptions written by dental providers (e.g., DDS, DMD) are not covered unless the associated procedure has been pre-authorized and

approved by the US Family Health Plan.

Please remember the following about your network retail pharmacy benefit:

1. The prescription drug benefit is only honored at participating retail pharmacies.
2. There is a one-time fill limit for maintenance medications. Maintenance medications are those medications taken regularly to treat a chronic condition, such as high blood pressure, ulcers, or diabetes.
3. Maintenance medication refills must be obtained through the US Family Health Plan Mail-Order Pharmacy.

Martin’s Point has full-service pharmacies at the Martin’s Point Health Care Centers in Portland, ME, and Portsmouth, NH. You can receive up to a 90-day supply at these locations (some restrictions apply) for one co-payment per prescription. You should use these pharmacies or the Mail-Order pharmacy for all long-term medications and refills.

Our Mail-Order Pharmacy Service Saves You Time and Money

Benefits of this program include:

- Convenient delivery to your home or other temporary address
- Savings of up to 66% on your prescription co-payments over the retail pharmacy co-payments
- Ability to order up to a 90-day supply, as prescribed (Please note: Some restrictions apply)
- Free shipping
- A 24-hour toll-free refill telephone line



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It couldn't be easier. Either send your prescriptions or refill information to the Martin's Point Mail-Order Pharmacy using the prepaid pharmacy mail-order form, or call the pharmacy, toll-free, at 1-800-707-9853 with your prescription refill requests. Within 14 days, you'll receive your medications at your door. Your only cost is the co-payment.

If you are taking prescription medications on an ongoing basis (such as for those for high blood pressure, high cholesterol, diabetes, depression, hormone replacement, or birth control), we require that you use the mail-order program. This program is not intended to be used for acute medications, such as antibiotics. Please allow up to 14 days to receive your order. If you are taking a medication for the first time, you are limited to a 30-day supply. This enables you and your physician to determine that this medication will have the desired effect and is appropriate for long-term use.

Quantity Limits

The US Family Health Plan does place quantity limits on some medications. A quantity limit represents the maximum allowable quantity of a drug that may be dispensed in a given time period. Please contact Member Services, toll-free, at 1-888-674-8734 or go to this DoD web site—www.pec.ha.osd.mil/qtylimit.htm—for further information.

Generic Drug Policy

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

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

Preferred Drug Program

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

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



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Payment for Your Medication

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

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

Coordination of Benefits for Prescriptions

When you or your covered family members have other health insurance that covers prescriptions and if the US Family Health Plan at Martin's Point recovers any payment from another health insurance plan, we may be able to apply this payment toward all or part of your US Family Health Plan co-payment. (Note: For more information, please refer to the Coordination of Benefits section on page 30 in this Member Handbook.)

POINTS TO REMEMBER

- ▶ Your co-payment will be refunded if payment received from your other health insurance plan exceeds your US Family Health Plan prescription co-payment.

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



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MEMBER HANDBOOK***Prescription Drug Limitations/Exclusions***

The US Family Health Plan at Martin's Point does not cover:

- ▶ Drugs not requiring a prescription or over-the-counter items (except insulin)
- ▶ Drugs used for cosmetic reasons (e.g., Propecia, Renova, Rogaine, Vaniqa)
- ▶ Medical supplies (e.g., dressing and antiseptics)
- ▶ Smoking cessation products (e.g., nicotine patches, Nicotrol, Zyban)
- ▶ Weight loss drugs (e.g., Meridia, phentermine, Xenical)
- ▶ Experimental drugs (i.e., drugs that cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of their use or proposed use)
- ▶ Prescription drugs prescribed for an off-label use that is not generally accepted by the medical community
- ▶ Any prescriptions refilled before the previous refill is 80% used
- ▶ Prescriptions filled at non-participating pharmacies, except when part of an emergency treatment
- ▶ Prescriptions written by physicians not in the US Family Health Plan network, except when required for emergency care
- ▶ Prescriptions written by dentists or oral surgeons are not covered, except if used in conjunction with a treatment plan for a pre-approved dental or oral surgery service
- ▶ Prescriptions associated with non-covered TRICARE benefits or non-approved services

**Covered Services Needing
Additional Explanation**

The following services are covered by the US Family Health Plan at Martin's Point but warrant some additional explanation. All services must be referred by your PCP, and many services require medical review and an authorization letter from the US Family Health Plan prior to receiving the service. If you have any questions regarding these benefits, please call Member Services, toll-free, at 1-888-674-8734.

Dental Care in Support of a Medical Condition

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

Durable Medical Equipment and Medical Supplies

- ▶ Rental or purchase of medically necessary durable medical equipment is usually covered when ordered by your PCP.
- ▶ Members are responsible for the co-payments listed in this handbook.



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- ▶ Durable medical equipment includes, but is not limited to, hospital beds, wheelchairs, and walkers.
- ▶ Some durable medical equipment requires pre-authorization of the US Family Health Plan, and not all durable medical equipment is covered under the Plan.
- ▶ Non-covered durable medical equipment, such as orthopedic shoes and shoe inserts, are the financial responsibility of the US Family Health Plan member.
- ▶ Durable medical equipment products that require pre-authorization of the US Family Health Plan that are obtained without pre-authorization will also be the financial responsibility of the member.
- ▶ Medical supplies are covered when related directly to a covered medical condition but must be supplied by a network provider.

Family Planning/Infertility Services

The US Family Health Plan at Martin's Point covers the following:

- ▶ Intrauterine devices (IUDs)
- ▶ Norplant devices
- ▶ Diaphragms (as well as the measurement for them)
- ▶ Birth control pills prescribed by a physician
- ▶ Pregnancy tests performed in a provider's office / facility
- ▶ Sterilization procedures (including tubal ligation and vasectomy)
- ▶ Infertility diagnoses and covered surgical treatments

The US Family Health Plan at Martin's Point does not cover the following:

- ▶ Over-the-counter contraceptives
- ▶ Surgery to reverse sterilization
- ▶ Abortions (except when the mother's life is put in danger by carrying the pregnancy to term)
- ▶ Artificial insemination
- ▶ In vitro fertilization
- ▶ Unproven procedures, services, supplies, and medications

For more specific information, please contact Member Services, toll-free, at 1-888-674-8734.

Home Care

The US Family Health Plan at Martin's Point provides medically necessary home care including:

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

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



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Hospice care is a program that provides an integrated set of services and supplies designated to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients. (Note: Eligibility determination and referrals to approved hospice care providers are made by PCPs or specialists using established medical criteria.)

Mental Health and Substance Abuse Services

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

You may have up to eight (8) mental health and substance abuse visits without a referral from your PCP. However, you must arrange for this care through the Behavioral HealthCare Program. A Customer Service Representative can be reached by calling, toll-free, 1-888-812-7335. After completion of these eight self-referred mental health visits, the Behavioral HealthCare Program is responsible for authorizing additional visits as deemed medically necessary. For mental health or substance abuse emergencies or hospital

admissions after hours, weekends, or holidays, please call, toll-free, 1-888-812-7335.

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

Obesity Treatment

Three types of surgical treatment for obesity are covered: gastric bypass, gastric stapling, and gastroplasty. Gastric banding procedures are not covered. All treatments require medical review and must be pre-authorized by the US Family Health Plan. Consultation visits to network specialists for consideration of covered obesity treatments do not require pre-authorization of the US Family Health Plan but do require a referral from your PCP. Please note that prescriptions and nonprescription medications are not covered for weight loss or the treatment of obesity. Nutritional counseling for obesity and participation in weight loss programs or clinics are also excluded from coverage.

Skilled Nursing Care

The US Family Health Plan at Martin's Point covers inpatient skilled nursing care in an accredited, contracted skilled nursing facility (SNF) when it is medically necessary.



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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

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

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

Limitations and Exclusions

IMPORTANT INFORMATION REGARDING LIMITATIONS AND EXCLUSIONS

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

As with most health insurance plans, not all care, treatment, diagnostic testing, equipment, supplies, medications, and programs are covered, even if they are determined to be medically necessary by your PCP or an approved specialist. Examples include vitamins, orthodontics, and chiropractic care.

To determine if the care that your PCP refers you for is a covered benefit under the US Family Health Plan, please call Member Services, toll-free, at 1-888-674-8734.

Services Not Covered Under the US Family Health Plan

General Exclusions

- The US Family Health Plan does not provide coverage for:
- ▶ Services provided and charges incurred prior to the effective date of coverage as a member of the US Family Health Plan
 - ▶ Services provided and charges incurred after the termination date of coverage as a member of the US Family Health Plan
 - ▶ Care or treatment for conditions that are results of any illegal activity (examples include injuries incurred by a perpetrator who commits any crime, including assault, driving under the influence, and arson)
 - ▶ Charges or services for which you are not legally required to pay



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- Services provided by relatives (by blood, marriage, or legal adoption) or by people ordinarily residing in your household
- Services not referred by and drugs not prescribed by your PCP or the specialist to whom you were referred and authorized to see
- Services not considered medically necessary for your diagnosis and treatment
- Unproven treatments, except Department of Defense (DoD)/National Cancer Institute (NCI) Cancer Prevention and Treatment Clinical Trials Demonstration
- Any mental health or substance abuse services denied or not authorized by the Behavioral HealthCare Program beyond the initial eight visits
- Any services provided for employment, licensing, paternity determination, immigration, elective travel, or other administrative reasons
- Complications due to a treatment or service not covered by the US Family Health Plan (examples include complications resulting from a non-covered plastic surgery procedure, and from a radial keratotomy)

Some Specific Exclusions

- Abortions (elective)
- Arch supports
- Acupuncture and acupressure
- Artificial insemination
- Autopsy and postmortem services
- Aversion therapy in connection with alcoholism
- Contraceptives (over-the-counter)
- Chiropractic services

- Clinical trials for any diagnosis or medical condition (Note: Members with cancer may be eligible for Phase II and Phase III clinical trials sponsored by the National Cancer Institute. For more information, please contact Medical Services, toll-free, at 1-800-322-0280.)
- Cosmetic, plastic, and reconstructive surgery not related to a covered medical condition
- Custodial and long-term care
- Electrolysis
- Exercise equipment, spas, hot tubs, and swimming pools
- Eyeglasses and contact lenses (except for treatment of infantile glaucoma, keratoconus and other limited medical conditions)
- Food, food substitutes, and supplements outside a hospital
- Foot care (routine), except in connection with systemic diseases affecting the lower extremities
- Foot orthotics (Note: Other orthotics may be covered with a qualifying medical condition but require medical review by the US Family Health Plan, as some restrictions apply.)
- Hair transplants
- Hearing aids and batteries (except for eligible active-duty beneficiaries through the Extended Care Health Options (ECHO) Program)
- Hearing examinations (except when required for the diagnosis and treatment of an auditory condition) (Note: Hearing aids are not covered when prescribed for treatment of an auditory condition except for those active-duty beneficiaries enrolled in the ECHO Program.)



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- ▶ Homeopathic treatment
- ▶ Immunizations and prescribed medications for elective travel
- ▶ In vitro fertilization
- ▶ Massage therapy
- ▶ Megavitamins or orthomolecular psychiatric therapy
- ▶ Naturopathic services
- ▶ Orthodontics
- ▶ Orthopedic shoes (covered for diabetics only)
- ▶ Over-the-counter drugs or vitamins (except insulin)
- ▶ Private hospital rooms (except when medically necessary)
- ▶ Radial keratotomy
- ▶ Respite care
- ▶ Retirement homes
- ▶ Sex therapy, sexual counseling, sexual behavioral modification, or sex change procedures
- ▶ Smoking cessation programs
- ▶ Sterilization reversals
- ▶ Telephonic consults with a provider
- ▶ Therapeutic shoes (Note: Therapeutic shoes for diabetics may be covered but require medical review by the US Family Health Plan, as some restrictions apply.)
- ▶ Transportation for convenience (e.g., including, but not limited to, ambulance transportation home from a facility)
- ▶ Treatments for learning disabilities
- ▶ Weight control (e.g., weight programs and medications for weight control)

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

Enrollment Information

All family members are not required to enroll in the US Family Health Plan. Some family members may choose to enroll, whereas other family members may decide not to enroll.

Enrollment Eligibility

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

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

- ▶ Active-duty family members, including spouses and unmarried dependent children (until their 21st birthday, or, if they are full-time students, until their 23rd birthday)
- ▶ Retirees, their spouses, and unmarried dependent children (until their 21st birthday, or, if they are full-time students, until their 23rd birthday)
- ▶ Eligible former spouses of active-duty or retired service members who are not re-married.



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- ▶ Survivors of active-duty or retired service members who are not re-married
- ▶ National Oceanic Services (NOS) members who retired prior to July 19, 1963, or who have had continuous service since before that date, and their family members
- ▶ Retired lighthouse keepers and their family members

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

TAMP provides qualifying active-duty personnel and reservists and their family members with full TRICARE benefits *including the opportunity to enroll in the US Family Health Plan* for a defined length of time as determined by DOES. While eligible for TAMP, the sponsor and his/her family members receive the same TRICARE benefits as active-duty beneficiaries. For more information about TAMP and the US Family Health Plan, call Member Services, toll-free, at 1-888-674-8734.

Effective Date of Coverage

The effective date of coverage is listed on your US Family Health Plan Member ID Card.

Newborns

The effective date of coverage for newborns of mothers enrolled in the US Family Health Plan is retroactive to the date of birth. New mothers are advised to notify Member Services as soon as possible after the birth of the child in order to expedite payment of all delivery charges. In addition, the newborn needs to be enrolled in DOES within 60 days from the newborn's date of birth.

Failure to register your child into DOES within 60 days will result in termination of your child's membership in the US Family Health Plan at Martin's Point on the 61st day after his/her birth. The effective date of coverage for a newborn whose mother is not a member of the US Family Health Plan is the date we receive the application for enrollment of the infant. Also, the newborn must be enrolled in DOES at the time we receive the application.

If an enrolled mother does not want her newborn enrolled in the US Family Health Plan, the mother should notify the US Family Health Plan as soon as possible following the birth so that the US Family Health Plan can make the appropriate changes in DOES.

Costs for the delivery of the infant(s) whose birth mother is not a member of the US Family Health Plan are not the responsibility



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of the US Family Health Plan. Additionally, the US Family Health Plan does not cover dependents of dependents (e.g., a grandchild).

Enrollment Fees

There are no enrollment fees for active-duty family members or for beneficiaries who carry Medicare Part B. However, the TRICARE Prime benefit program requires annual enrollment fees for retirees, survivors, and family members of military retirees who do not participate in Medicare Part B.

Enrollment fees are:

- Individual enrollment: \$230 annually OR \$57.50 quarterly
- Family enrollment: \$460 annually OR \$115 quarterly

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

Subsequent quarterly installments are due by the first day of each new quarter. Failure to pay the quarterly installment within 30 days of the due date results in immediate disenrollment from the US Family Health Plan. Members who are disenrolled from the US Family Health Plan for nonpayment are restricted from re-enrolling into the US Family Health Plan or any other TRICARE Prime program for a 12-month period beginning on the date

of disenrollment.

If you choose to pay on a quarterly basis, the US Family Health Plan will bill you 30 days prior to the quarterly installment due date. Currently, our due dates are based on an October 1 contract year. Payments are due on the first of October, January, April, and July.

Methods of enrollment fee payments are:

- Personal check
- Money orders
- Credit card
- Simple payment options (automatic charge to your credit card or bank account—please contact Member Services, toll-free, at 1-888-674-8734 if you are interested in this program)
- Monthly allotment from military retiree pay (as of the date of publication, this option is scheduled to begin October 1, 2005)

Changes of Enrollment

If there are any additions to your family or changes in personal information, please let us know by calling Member Services, toll-free, at 1-888-674-8734. If a new person enters the family, whether by marriage, birth, or adoption, an application must be completed. If someone leaves the family through divorce or death, written notification must be submitted to the US Family Health Plan Enrollment Department as soon as possible.



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MEMBER HANDBOOK***Changes to your Address***

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

Moving Out of the Service Area

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

If TRICARE Prime is available in your new location, visit the military treatment facility or the local TRICARE Service Center and request to transfer into its program. You will be asked to complete an application or official transfer request form, depending on the transfer process established by the local TRICARE Prime contractor. The new contractor is responsible for contacting the US Family Health Plan at Martin's Point to get your membership transferred. You actually become a member of the TRICARE Prime program in your new location on the day that the servicing contractor receives your

application or transfer request form. The US Family Health Plan at Martin's Point is obligated to retroactively disenroll you effective midnight the day prior to the effective date of membership in your new TRICARE Prime program. You will have no break in coverage.

Portable Transfer of TRICARE Prime Enrollment to the US Family Health Plan at Martin's Point

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

The effective date of coverage by the US Family Health Plan is the actual date that we receive a completed application. The losing contractor is obligated to retroactively disenroll you effective midnight the day prior to the effective date of membership in the US Family Health Plan at Martin's Point. You will have no break in coverage.

Disenrollment

As a member of the US Family Health Plan, you will automatically stay enrolled unless you elect to disenroll during your annual re-enrollment period. A letter will be sent to you on September 1 that will offer you the option to disenroll approximately 30 days prior to September 30.



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

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

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

PLEASE BE AWARE THAT THE US FAMILY HEALTH PLAN WILL NOT BE RESPONSIBLE FOR CHARGES ASSOCIATED WITH ANY SERVICE THAT YOU RECEIVE, TO INCLUDE PRESCRIPTIONS, EFFECTIVE MIDNIGHT OF THE DATE OF YOUR DISENROLLMENT. THIS IS ALSO TRUE FOR RETROACTIVE DISENROLLMENTS.

Annual Disenrollment

Enrollment in the US Family Health Plan is usually for a 12-month period. About 30 days prior to the end of your enrollment period, Martin's Point will mail you an Option to Disenroll Notice that gives you the opportunity to disenroll at the end of your contract year. If you wish to disenroll, you must inform us by completing and returning the Disenrollment Form. We will automatically re-enroll you for another 12-month period if we do not receive your written request to disenroll.

Early Disenrollment

The Martin's Point Appeal Committee will consider requests for early disenrollment for reasons other than the result of ineligibility or the response to the option to disenroll process. This committee has the authority to approve such requests on a case-by-case basis. Appeals of these decisions can be made to the TRICARE North Region Lead Agent.

Though a member may request early disenrollment, it is important to understand that there is a moratorium for re-enrollment into the US Family Health Plan at Martin's Point or any other TRICARE Prime program. Members who disenroll before the completion of the 12-month enrollment period may not re-enroll in any other TRICARE Prime program for at least 12 months from the date of early disenrollment. For appeals information, call Member Services, toll-free, at 1-888-674-8734.



US FAMILY HEALTH PLAN

MEMBER HANDBOOK***Automatic Disenrollment***

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

- Intentional use of Medicare for benefits covered by the US Family Health Plan at Martin's Point, known as Medicare Leakage (Medicare Leakage is further explained in the next section)
- Nonpayment of enrollment fees, co-payments, or co-insurances, as applicable
- Habitual noncompliance with PCP's recommendations or US Family Health Plan regulations; failure to keep scheduled appointments; grossly dishonest, abusive, or disruptive behavior that interferes with the clinical staff's ability to properly treat the member or the patients upon review by the Martin's Point Grievance Committee and concurrence of the TRICARE Regional Office—North
- Loss of eligibility for military health benefits
- Lapse of Military ID Card and notification from DoD to disenroll (Note: Re-enrollment without break in coverage will occur when the US Family Health Plan at Martin's Point can verify that the Military ID Card has been reissued within 30 days of the effective date of disenrollment. A copy of Military ID Card [both front and back] must be sent to the Enrollment Department or can be verbally verified by calling Member Services, toll-free, at 1-888-674-8734.)
- Members diagnosed with end-stage renal disease (ESRD) who also do not carry Medicare Part B will be disenrolled after the initial 90 days of dialysis treatment

Notification of Disenrollment

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



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What More Should You Know About This Plan?

Exchange of Benefits

Being a member of the US Family Health Plan affects your entitlement to use other government-sponsored health care programs. By enrolling in the US Family Health Plan, you agree to exchange certain entitlements for US Family Health Plan membership entitlements. As such, you agree not to use the following health care benefits:

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

Medicare Parts A and B

Enrollment in the US Family Health Plan will *not* cause you to lose your Medicare entitlements. You should continue to have your monthly Medicare Part B premium deducted from your Social Security check; however, you may *not* use Medicare except in a couple of very specific situations:

1. For services that are not covered by the US Family Health Plan, such as chiropractic care.
2. For services related to end-stage renal disease (ESRD).

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

As a member of the US Family Health Plan, you are not required to enroll in Medicare Part B when you become eligible. However, we **strongly** recommend you enroll in Medicare Part B for the following reasons:

1. Delay in Accessing Medicare Part B &

TRICARE Benefits: If you ever disenroll from the US Family Health Plan you will not be able to access TRICARE benefits until you are enrolled in Medicare Part B. If you decline Medicare Part B when eligible, and then decide to enroll in the future, you will not be able to enroll until the General Enrollment Period. The General Enrollment Period for Medicare Part B is January through March each year, with medical insurance coverage (Medicare Part B) starting on July 1 of



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the year you sign up. You could be left without medical insurance coverage for an extended period of time, should you decide to disenroll from the US Family Health Plan.

Example: You decline automatic enrollment into Medicare Part B when you become eligible. You move to Florida in May and are disenrolled from the US Family Health Plan. You no longer have access to TRICARE benefits and determine that you should enroll in Medicare Part B. You will not be able to enroll until the next General Enrollment Period, which begins in January and ends in March. Your effective date of Medicare B coverage would not begin until July. Your only coverage during that 15 month period is Medicare Part A.

2. Penalty in Medicare Part B Premiums:

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

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

3. Limited Coverage for Long-Term-Care Facility:

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

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

Medicare Leakage

Medicare Leakage is the name given to the money that Medicare pays out when a member of the US Family Health Plan intentionally uses Medicare to pay for services that are routinely covered by the US Family Health Plan. **When Medicare-eligible military beneficiaries enroll in the US Family Health Plan, they acknowledge that they may not use Medicare to pay for any health care service that, under normal circumstances, is covered and managed by their US Family Health Plan PCPs and our network of specialists.** However, they may use Medicare to pay for services not covered by the US Family Health Plan, such as chiropractic services. Our contract with the Department of Defense requires us to automatically disenroll members who intentionally use their Medicare for convenience or to obtain services denied as



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“covered but not medically necessary” by the US Family Health Plan. Members who are disenrolled because they elect to use Medicare rather than the US Family Health Plan cannot re-enroll in the US Family Health Plan for at least a 12-month period starting from the disenrollment date. Disenrollment will not be retroactively applied so as to make the beneficiary eligible for Medicare benefits on the date of the Medicare Leakage.

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

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

Third Party Liability and Subrogation

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

Members of the US Family Health Plan who suffer an injury or accident that could possibly be covered by a third party (automobile, workman’s compensation or home and business insurance) are required to complete a Statement of Personal Injury—Possible Third-Party Liability Form. This form will be mailed to you as soon as we are notified of an accident

or injury. Note: A portion of the form will need to be filled out even if there is no third-party liability involved.

All providers will be informed of the possible third-party involvement and instructed to bill the other insurance carrier for any claims related to the accident or injury until the medical allowance on the policy has been exhausted or until a denial has been received by the US Family Health Plan at Martin’s Point Claims Department. During this time we will either coordinate benefits with payments being made by the other payers or if denied we will pay according to the member’s benefits with the US Family Health Plan. (The provider has 90 days to submit claims to us after a claim has been denied by the other payer. All authorizations should be secured for services which require them in the event of a denial from the other payer.)

All confirmed Third Party Liability cases will be processed according to the procedures outlined by the individual branch of the services’ Judge Advocate Generals (JAG) offices.

It is the member’s responsibility to inform the US Family Health Plan at Martin’s Point—by calling the Member Services Department at 1-888-674-8734—about the accident and also to inform the providers that treated the injury. Failure to report this could result in loss of coverage for care related to this injury.

It is the member’s responsibility to inform the US Family Health Plan at Martin’s Point



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Health Care, by calling the Member Services Department at 1-888-674-8734, *about the accident and also to inform the providers in which treatment for the injury was given.*

Failure to report this could result in a loss of coverage for care related to this injury and possible disenrollment from the US Family Health Plan.

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

Some US Family Health Plan members also have private commercial health insurance plans. These other health insurance policies may be a benefit the sponsor earned while working in a civilian job, or the family may be covered under a spouse's/sponsor's employee benefit plan. Regardless why someone has other health insurance, federal law requires that all health care providers bill commercial insurance first, as the patient's "primary payor," before billing any federally sponsored health care plan such as Medicare, Medicaid, TRICARE, or the US Family Health Plan. So, even though your health care services are managed by the US Family Health Plan at Martin's Point, your PCP and the specialists to whom you are referred must bill your private commercial health insurance policy first. To abide by this federal law, we are obligated to ask you about your other health insurance. We ask about other health insurance on the enrollment application and when you come in to see your doctor. We also provide periodic mailings to each household requesting

verification of other health insurance. By collecting this information, the US Family Health Plan can coordinate the benefits of your private insurance policy with those of the US Family Health Plan. This is known as "coordination of benefits" or COB. Coordinating benefits is not a simple task because each commercial policy has its own rules about coverage, deductibles, and co-payments.

The COB provision does not deny or reduce any benefits to which you are entitled. It is intended to ensure that duplicate payments are not made. All of the health care expenses covered by the US Family Health Plan are subject to this provision.

Collection of Primary Health Insurance Co-Payments

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

Insurance Changes

It is the member's responsibility to inform the US Family Health Plan at Martin's Point Health Care about any insurance changes for any member of the family enrolled with the US Family Health Plan. Notification of any changes can be made by calling the Member Services Department at 1-888-674-8734.



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Processing Claims for Members with Other Primary Health Insurance

If you have other primary insurance, your provider is required to bill your primary insurance carrier first. The actual provider of care coordinates your benefits and bills the US Family Health Plan at Martin's Point as your secondary payor. In processing those claims, a co-payment will not be charged from the US Family Health Plan if your private commercial insurance pays charges for that date of service in an amount that is equal to or more than your applicable co-payment. If your private commercial insurance uses the entire charged amount for that date of service toward meeting your annual deductible, you are required to pay your US Family Health Plan co-payment. The US Family Health Plan needs a copy of the explanation of benefits (EOB) that your private insurance sends to the provider before the US Family Health Plan at Martin's Point pays anything more to that provider. Any claim submitted to us as the secondary payor without this EOB will be denied.

Please note that federal law requires you to provide us with any information that will enable us to coordinate payment for your health care services with any other health insurance you may have.

Remember that if you have commercial health insurance, the commercial health insurance is your primary payor and must be billed first.

Please call Member Services, toll-free, at 1-888-674-8734 if you have any questions

concerning other health insurance and its coordination with your US Family Health Plan benefit.

Catastrophic Loss Protection Benefit (Catastrophic Cap)

As US Family Health Plan members, your family has a catastrophic loss protection limit (or catastrophic cap) for your health care needs. This means there is a limit to your out-of-pocket expenses.

The catastrophic cap for active-duty family members is \$1,000 per fiscal year (Oct.–Sept.), per family and \$3,000 for retirees, retiree family members and survivors, per family. Out-of-pocket expenses that contribute toward your cap include enrollments fees, co-payments and cost shares. Once your catastrophic cap has been met, you and your family members will not have to pay any more out-of-pocket expenses for the remainder of the fiscal year.

Balance Billing

Balance billing occurs when a health care provider (e.g., doctor, therapist, or laboratory) bills you for the balance of the amount not paid to them by the US Family Health Plan for the health care services you received. Since most of the health care services you receive are provided directly by either the US Family Health Plan or an affiliated or contracted network provider, balance billing should not routinely occur. However, when you receive health care services from a non-network provider, such as emergency services out of the



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area, you risk the chance of being billed for the balance (“balance billed”) because we do not readily know whether or not the non-network provider is a TRICARE participating provider.

Congress modified the TRICARE law to protect you from having to pay balance bills to nonparticipating providers for amounts greater than 115% above the TRICARE Maximum Allowable Charge (TMAC). When the US Family Health Plan receives a claim for services received outside the US Family Health Plan network, we pay that provider the TMAC rate (100% TMAC). Since many nonparticipating providers may be unfamiliar with the TRICARE law, they may not realize that they should not balance bill our members. The US Family Health Plan sends out an explanation of the TRICARE law to nonparticipating providers with our referral authorization letters. However, if you receive what appears to be a balance bill for more than your appropriate co-payment, **do not ignore it**. Instead, we recommend you take the following actions:

1. Call the provider’s billing office immediately and request clarification of what the bill represents.
2. If the billing specialist in the provider’s office says it is your co-payment, but their co-payment does not match the appropriate co-payment listed in the Summary of Benefits on pages 15 and 16 of this Member Handbook, advise them of their error.
3. If they indicate that it is the balance of the amount that your insurance (the US Family

Health Plan) did not pay, remind them that you are a member of a TRICARE Prime program and cannot, by law, be balance billed.

4. If they insist that the US Family Health Plan has not paid the appropriate amount, take the name of the person with whom you spoke and call Member Services, toll-free, at 1-888-674-8734, for assistance.

A Member Services Representative will research the claim payment and coordinate any further action that may be needed.

We strongly recommend that you use network providers for all services other than emergency care. However, if you must use a non-network provider for a non-emergency service (e.g., out-of-area urgent care), always ask them up front if they participate in TRICARE. You stand a much greater chance of receiving a balance bill from a non-participating provider than you do from a participating TRICARE provider. If they do not participate, always make sure that they are certified Medicare providers. Medicare providers can lose their certification if they continue to balance bill TRICARE Prime members. Finally, reimbursement to you will be at the TMAC rates and not for the amount of the billed charges. The US Family Health Plan will work with you and the out-of-network provider to ensure that you are reimbursed for all fees that you paid, except for applicable co-payments.



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Grievances (Complaints) and Appeals Process

Informal Grievance (Complaint) Process

Any member who is dissatisfied with personnel, service, or quality of care can lodge an informal complaint by contacting Member Services, toll-free, at 1-888-674-8734. The complaint will be forwarded to the Quality Department for review. The member can expect a letter acknowledging receipt of the complaint.

Formal Grievance (Complaint) Process

If you have a complaint against a care management policy or one of the US Family Health Plan at Martin's Point providers, you may file a grievance. This is a formal complaint, presented in writing, which initiates the grievance review process. Patient confidentiality is guaranteed throughout the investigation and resolution of the grievance. All information resulting from the process will not, under any circumstances, become a part of the patient's medical record. However, it is not always possible for a member to remain anonymous throughout the proceedings. Before the member is revealed, he/she will be told of the situation and given the choice of whether or not to proceed. Confidentiality of the providers is also guaranteed throughout the investigation and resolution. In order to maintain provider confidentiality, the findings and action steps will not be shared with the complainant.

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

The US Family Health Plan at Martin's Point
Attn: Health Benefits Advisor
P.O. Box 9746
Portland, ME 04104-5040

Within 10 days of receiving your formal grievance, Martin's Point will send a letter of confirmation notifying you that we have received your formal grievance. The grievance is then researched and follow-up is based on findings. Once a decision is made, the appropriate Martin's Point representative will inform you, in writing, that the research is complete and appropriate follow-up has occurred.

Appeals Process

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

There are two main categories of appeals, factual and medical necessity. A factual appeal is a request to reconsider a claim or authorization that has been denied for any of the following reasons:

1. The requested service is not a covered benefit under the TRICARE program.
2. The service was not pre-authorized by the US Family Health Plan (e.g., no approved prior



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authorization on file).

3. The use of a non-network provider was not authorized.

A medical necessity appeal or clinical appeal is a request to reconsider an authorization that has been denied for either of the following reasons:

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

Appeals may be submitted by a member, the member’s appointed representative, the parent of a minor, or a provider (if the member has signed an “Appointment of Representative”

statement authorizing the provider to act on his or her behalf). Additionally, a US Family Health Plan network provider can file their own appeal.

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

Appeal Type	Appeal Decision Timeframes
<i>Factual Appeal Level 1</i>	US Family Health Plan must receive the appeal request within 90 calendar days from the date of the initial denial determination.
<i>Medical Necessity Appeal: Concurrent Review (Member is Inpatient in a Facility)</i>	US Family Health Plan must review the appeal by noon of the day after the day of receipt of the initial denial determination. Member must be in the facility when the appeal request is received.
<i>Medical Necessity Appeal: Expedited Pre-Admission or Pre-procedure</i>	US Family Health Plan must receive the appeal within 3 calendar days from the date the Member received the denied authorization.
<i>Medical Necessity Appeal: Non-expedited</i>	US Family Health Plan must receive the appeal request within 90 calendar days of the date of the initial denial determination.



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that extraordinary circumstances do not exist is not appealable.

A medical necessity appeal must be filed within a much shorter time frame. Please refer to the table below. If a member does not file a medical necessity appeal within the appropriate time frames, the member must submit the appeal to the US Family Health Plan within 90 days from the date of the initial denial.

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

Member appeals should be mailed to:

The US Family Health Plan at Martin's Point
Attn: Health Benefits Advisor
P.O. Box 9746
Portland, ME 04104-5040

Once an appeal letter is received, the US Family Health Plan will mail you an acknowledgment letter confirming receipt and stating when a final determination of your appeal request will be made, following TRICARE guidelines.

The US Family Health Plan will issue a written determination letter that will include the Appeal Committee's decision (approval or denial), the citation and quotation of relevant authority, and the reasons for the Appeal Committee's decision. The letter

will additionally provide the member with an explanation and finding relative to the member's financial liability under hold harmless or waiver of liability provisions, as applicable, and will provide the member with further appeal rights and instructions, if applicable.

For further information on the appeals process, call Member Services, toll-free, at 1-888-674-8734.



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MEMBER HANDBOOK**Definition of Terms****Appeal**

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

Authorization

Approval by the US Family Health Plan at Martin's Point of a referral generated by a PCP or specialist.

Balance Billing

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

Catastrophic Cap

A cost "cap" or upper limit on out-of-pocket expenses placed on US Family Health Plan covered medical bills. The contract year limit for an active-duty family is \$1,000. Retiree families have a contract year limit of \$3,000.

Co-payment

The fee you are required to pay at the time of service (e.g., \$12 for an office visit).

Defense Enrollment Eligibility Reporting System (DEERS)

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

Durable Medical Equipment (DME)

Medical equipment such as wheelchairs,

hospital beds, oxygen, and respirators. Covered when medically necessary.

Emergency Care

The onset of an illness or accidental injury of such a nature that, without receiving prompt medical attention, the member is in jeopardy of sustaining serious impairment or dysfunction or that presents a significant threat to the member's continuing health. Examples include heart attacks and/or chest pains, uncontrollable bleeding, and loss of consciousness, etc.

Grievance

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

Maintenance Medication

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

Medically Necessary Care

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

Medicare Leakage

Money that Medicare pays out when a member



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of the US Family Health Plan intentionally uses Medicare to pay for services that are routinely covered by the US Family Health Plan.

Out-of-Area Care

Care received when traveling outside the US Family Health Plan at Martin's Point service area.

Primary Care Provider (PCP)

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

Referral

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

Service Area

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

Transitional Assistance Management Program (TAMP)

Transitional health care benefits available for certain categories of service members released from active duty, such as a member who is involuntarily separated from active duty or a reserve component member who is separated

from active duty and who was called up or ordered in support of a contingency operation for an active-duty period of more than 30 days.

TRICARE Prime

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

TRICARE Standard

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

Urgent Care

Care that can safely be postponed until a member speaks with their PCP or the doctor on call. Examples include a sprained ankle, cuts needing stitches, and flu symptoms.

US Family Health Plan

A TRICARE Prime benefit administered in the Maine, New Hampshire, northern Massachusetts, Vermont, and upstate New York areas by Martin's Point Health Care. The US Family Health Plan is a managed care plan, designed to provide comprehensive medical benefits to enrolled beneficiaries at a low out-of-pocket cost.



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US FAMILY HEALTH PLAN AT MARTIN'S POINT



For nearly a quarter century, the US Family Health Plan has been an integral part of the military health care system. Our plan is available to military beneficiaries in six areas across the country. In each, the Department of Defense has designated a health care provider to manage the plan. In northern New England, the US Family Health Plan has always been administered by Martin's Point, a locally owned and operated not-for-profit health care organization.

