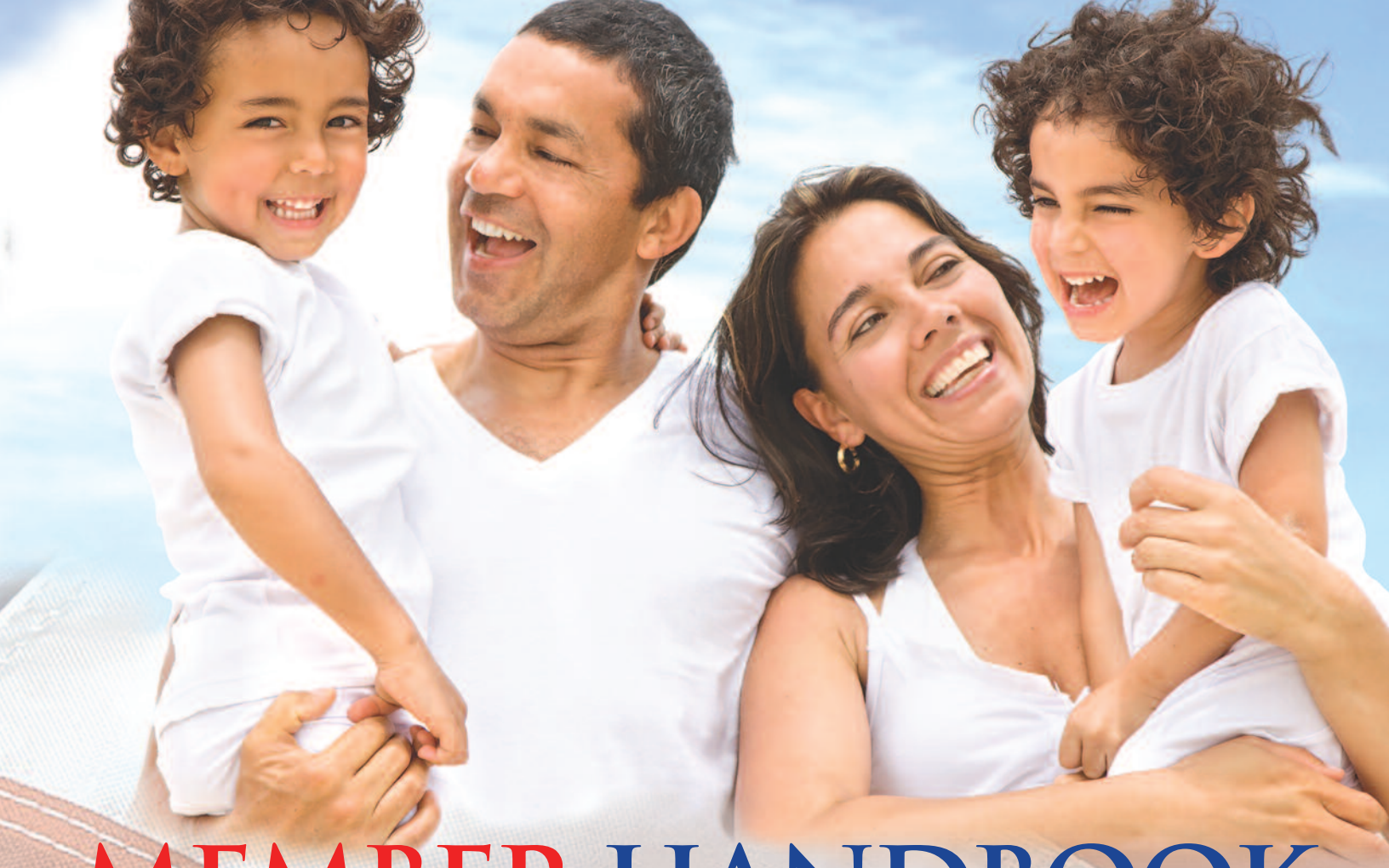

MEMBER HANDBOOK

U.S. ARMY

US FAMILY HEALTH PLAN

TRICARE®

CONTENTS

*Must be completed and mailed back to US Family Health Plan.

Welcome

Welcome to US Family Health Plan! We are glad you are a member.

This handbook is a guide to using your health plan. We hope it will answer most of your questions. If not, additional questions should be directed to the Customer Service department at **usfamily@svcmcny.org** or 1-800-241-4848.

We are your partners in promoting your best quality of health.

The US Family Health Plan

US Family Health Plan (USFHP) is a TRICARE option within the Military Health System. We are a TRICARE Prime managed care program that provides comprehensive health coverage. We have been providing comprehensive health care for military families and retirees for over 30 years.

Our comprehensive health care benefits are the TRICARE Prime benefits plus many enhanced healthcare services. As a member of US Family Health Plan you will be able to participate in state of the art patient care management programs. We offer comprehensive case management, disease management, 24/7-nurse advice line, and preventative health programs, which are designed to keep you as healthy as possible. We offer personalized and comprehensive care in all of New Jersey, as well as many counties in New York, Pennsylvania, and Connecticut. Our extensive network of highly qualified civilian providers in all service areas gives you freedom to choose!

In addition to TRICARE Prime benefits, USFHP offers the following additional enhanced benefits: annual physical exam, annual eye exam, comprehensive care management, care coaching and disease education, nurse advice line, preventative health screenings, glasses (Jan 1, 2014), and fitness and wellness program.

Member Rights and Responsibilities

You have the following rights and responsibilities as a USFHP member:

- The right to choose the health care provider that is best for you from the Plan's extensive network of highly qualified providers.
- The right and responsibility to fully participate in all decisions related to your health care.
- The right to considerate and respectful communications from all USFHP staff and from all network providers.
- The right to communicate in confidence with all USFHP staff and network providers. You can be assured that your private health information is kept confidential and protected at all times. USFHP adheres to all Federal and TRICARE privacy regulations.
- The right to assume responsibility for your own best health, in partnership with your PCP and USFHP, which will increase the likelihood of achieving your best health outcomes.

Member Health Care Management

Managed Care Approach to Quality Health Care

An important feature of our managed care approach to your overall health care is providing quality medical care in the setting that is most appropriate for you. For example, care will be provided on an outpatient basis unless inpatient treatment is medically necessary, thus sparing you from the risk of an unnecessary hospitalization.

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

- Services that are offered as part of the USFHP (TRICARE) benefit;
- Consistent with the condition, illness, or injury;
- Provided in accordance with approved and generally accepted medical or surgical practice;
- Not primarily for the convenience of the patient, the physician, or other providers;
- Delivered in the most appropriate health care setting;
- Not exceeding (duration or intensity) the level of care, which is needed to provide safe, adequate and appropriate diagnosis and treatments.

Primary Care Provider

Another important feature of our Plan is your use of a Primary Care Provider (PCP). Your PCP is responsible for coordinating your care. This includes making recommendations for specialty consultation and/or facility based care. When, and if, your PCP recommends that you need to see a specialist or need admission to a hospital, or any other facility, he or she will refer you to an appropriate provider. We recommend that our members review our provider locator at **www.usfhp.net** or call Customer Service at 1-800-241-4848 in order to verify that the provider is participating with the Plan. USFHP, as your health care partner, stands ready to assist whenever necessary.

State of the Art Member Health Care Management Programs

An important focus of our member care management philosophy is to partner with you and your PCP to maximize the quality and effectiveness of your health care. We offer several state of the art health care management programs. These programs include:

- **Comprehensive Care Management** – Specially trained registered nurses are available to help you and your PCP coordinate your total healthcare needs to make transitions predictable and efficient across all health care settings.
- **Care Coaching and Disease Education** – offered in partnership with our care management program, specially trained registered nurses and other highly qualified healthcare professionals can help you understand and manage your specific health needs in collaboration with your providers
- **Nurse Advice Line** – In non-emergency situations you can contact the US Family Health Plan's 24-hour nurse advice line for assistance from specially trained registered nurses. These nurses, using nationally accepted guidelines, will ask you some questions and recommend a safe plan of action. This service is available 24 hours a day/7 days a week (even on holidays).
- **Preventative Health Screenings** – The USFHP strongly encourages all of its members to get regular preventative health screenings as recommended by your PCP.

Referrals and Authorizations

Referrals

A referral is your provider's recommendation for you to obtain care from another doctor or facility in the USFHP network. Referrals for specialty care can be written on the specially designed USFHP form or on your provider's prescription pad. USFHP will pay for all covered medical services when, and if, your PCP refers you in advance and the service is provided by a network provider.

Referrals help everyone concerned:

- They inform the specialist why you are referred and where to send the consultation report.
- They assure the specialist that your PCP has recommended the care.
- They assure you that your visit with the specialist is financially covered.

Referrals are valid only for the specific services requested. All referrals are valid for six months, or for the number of visits indicated, whichever comes first. First visit must be within sixty (60) days. It is very important that you keep track of the number of visits that you use from your referral. If more visits are needed, you will need to follow-up with your PCP.

There are a few medical services that do not require you to obtain a referral from your PCP. However it is still very important that you select a participating provider for the following services (except emergency room care):

- Behavioral Health (first 8 visits)
- Emergency Room Care
- Yearly Eye Exam
- Yearly OB/GYN Exam

It is important, and ultimately your responsibility, to stay in the USFHP network of participating providers. If you are not sure that a doctor, hospital, or facility that your PCP has referred you to is in the USFHP network, please visit our website at **www.usfhp.net**, contact Customer Service at **usfamily@svcmcny.org**, or call 1-800-241-4848.

Any referral to an out of network provider or facility also requires an authorization. It is your PCP's responsibility to obtain necessary authorizations for recommended out of network care. **Only your PCP or other participating provider can request an authorization for out of network care. Members and out of network providers cannot initiate an authorization request.**

Authorizations

Authorizations are handled through the Plan's Utilization Review Department using nationally accepted guidelines. Any time an authorization is required; your provider must obtain the necessary approval for you. Members may not initiate requests for medical services. If an authorization request is denied a letter will be sent to you (the member), the PCP, requesting provider, and the facility to explain why it was denied and how to appeal that decision.

Authorizations are necessary in order for claims to pay correctly. When they are not obtained, claims may be denied and you may get a bill. This process protects you from getting unnecessary care and from getting paperwork and bills. It is important for you to help us in this process of obtaining referrals and authorizations. This process is necessary to ensure efficient use of health care resources and as a result will help to ensure that you get maximum value.

Additionally, the professional credentials of an out of network provider have not been reviewed by the Plan; nor have they agreed to accept USFHP/TRICARE fees. So, if you see an out of network provider without authorization, under the point of service (POS) option you may be responsible for part of the bill.

Authorizations are not the same as referrals. There are **two types** of **authorizations.**

1. An authorization is **approval from the USFHP to use an out of network provider or facility.** The USFHP requires that you obtain most, if not all of your health care from our extensive list of participating provider and facilities. In very rare situations, the USFHP may allow you to use a provider or facility that is not within the USFHP network. All requests for out of network care must be reviewed and authorized by USFHP in advance of the service (with the exception of emergency care and select urgent care services). Your PCP is responsible to contact USFHP to obtain authorization on your behalf to any out of network doctor or facility.

    a. The Point of Service (POS) option allows you to refer yourself for care and/or go to a non-network provider without an authorization from the USFHP. The POS option applies to office, hospital based clinics, ambulatory surgery facilities, and all behavioral health and drug rehabilitation facilities & providers; however, using this option comes at a price. TRICARE regulations require that if you use this POS option, the USFHP will not deny payment, but will pay the provider 50% of the TRICARE allowable charges, after you have paid an initial deductible. This deductible will only be applied for care received under the POS option and is based on the TRICARE allowable, not billed charges. The deductible is $300 per enrollment year for an individual, and $600 for a family. After paying the deductible you would also be responsible for up to 65% of the TRICARE allowable charge.

2. An authorization is an **approval from USFHP for you to receive certain medical services that your PCP has recommended for you.** These include elective hospital or skilled nursing facility admissions, selected outpatient procedures, and skilled home care services to name a few. This type of authorization is sometimes also referred to as pre-certification or pre- authorization.

Remember, it is your provider's responsibility to initiate all necessary authorization requests, but it is ultimately your responsibility to have the authorization when needed.

Authorizations

All services below require prior authorization (not an all-Inclusive list).

- Adjunctive dental
- Arthroscopy
- Augmentative communication device (ACD)
- Biofeedback
- Cardiac rehabilitation
- Carotid angiography
- Chelation therapy
- Coronary angiogram
- Cosmetic/plastic surgical procedures
- CT angiography
- Dental anesthesia and related institutional services
- Diabetic education
- Dialysis
- Electrophysiologic (EP) Study Ablation
- Endoscopic retrograde cholangiopancreatography (ERCP)
- Gamma knife radiosurgery
- Hearing aid and hearing aid services (benefit limited to active duty dependents)
- Home birth
- Home Care
- Home infusion therapy
- Hospice
- Hyperbaric Oxygen Therapy
- Indium Pentetreotide (Octreoscan) Scintigraphy
- Injectibles, select and covered under medical benefit
- Laminectomy/microdiskectomy
- Laparoscopic procedures, select
- Lithotripsy (except renal lithotripsy)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- Medical transport, non-emergent
- Meniscectomy
- Mental health/behavioral health (except first 8 visits with participating BH provider)
- NCI trial participation (phase I, II and III)
- Neuropsychological testing
- Nutritional therapy infusion
- Pain management services
- Percutaneious transluminal coronary angioplasty (PTCA)
- PET scans
- Pulmonary rehabilitation
- Psychological testing
- Septoplasty/rhinoplasty
- Single Photon emission Computer Tomography (SPECT)
- Speech therapy
- Stereotactic radiosurgery
- Vertebroplasty
- Virtual colonoscopy (CT colonoscopy)

Covered Services

Your membership with USFHP entitles you to many health care benefits. Since referrals and authorizations can be confusing, the following table is designed to summarize what services require an authorization and/or a referral. You will find more detailed information on each of these covered service categories in the pages after the table.

COVERED SERVICE CATEGORY	REFERRAL	AUTHORIZATION
Inpatient	Elective -Yes Elective -Yes	Emergent -Yes Emergency –Yes (after)
Outpatient Procedures	Yes	Participating providers have a list of outpatient services that require authorization
Ambulatory Surgery	Yes	Participating providers have a list of outpatient services that require authorization
Emergency Room Care	No	No
Urgent Care Facility	No	No
Medical Transportation	Yes – except if an emergency or if requested as part of an inpatient hospitalization	Yes – except if an emergency
Out of Service Area	No	Yes – the out of service benefit is limited
Behavioral Health Inpatient	No	Yes
Behavioral Health Outpatient	No	Yes – beginning with the 9th visit (when in network)
Durable Medical Equipment (includes prosthetics and orthotics)	Yes – but requires prescription	Yes – depends on the item prescribed
Medical Supplies	No, but requires prescription	Yes – if out of network
Laboratory	No, but requires prescription	No- for standard Yes- for specialized
Outpatient Physical and Occupational Therapy	Yes, requires prescription	Yes – after the initial evaluation
Radiology, diagnostic	Yes – also requires prescription	Yes – some radiology services require authorization; your provider has a complete list

Inpatient Services

Inpatient services generally include medical services provided in an acute care hospital, skilled nursing facility, or rehabilitation facility. **All elective or scheduled inpatient admissions must be pre-authorized 7 days in advance of the intended service date by your PCP or authorized specialist.** Emergency admissions are reviewed for medical necessity after the admission; in case of a medical emergency you do not need to obtain a referral or pre-authorization. If an elective inpatient service is not available at a USFHP network facility, or you have an emergent admission at an out of network facility, USFHP will work with you, your PCP and the facility to meet your needs. USFHP must provide pre-authorization for you to receive inpatient services at an in or out of network facility for all elective or scheduled care.

Co-payments may be required for inpatient admissions. Refer to the Summary of Benefits.

Outpatient Services

Outpatient services always require a referral and/or a prescription from your PCP and, depending on the procedure, may also require an authorization; we recommend that you specifically ask your PCP. If unsure, please contact USFHP Customer Service by email at **usfamily@svcmcny.org** or call 1-800-241-4848.

Covered outpatient services include:

- Office visits to your PCP.
- Office visits to all specialists to whom your PCP refers you to.
- Preventative health services

  a. Newborn and well child care for babies up to age 24 months (except when the mother is an unmarried dependent)

  b. Well child care and well adult care, such as immunizations and annual physicals
- Diagnostic tests including laboratory procedures, and radiology (i.e. EKG and x-ray, etc.)
- Surgical procedures that do not require hospitalization
- Maternity Care
- Treatment of behavioral disorders (with a medical diagnosis) and outpatient alcohol and chemical detoxification and outpatient rehabilitation treatment.
- Physical, occupational and speech therapies
- Hospice Care
- Skilled Home Care

Co-payments may be required for outpatient services. Refer to the Summary of Benefits

Ambulatory Surgery Services

Members can use any participating hospital or participating ambulatory surgery center. Some ambulatory surgery procedures require that your doctor get pre-authorization from USFHP even though the procedure is being performed at participating hospital. Contact the Customer Service department for assistance at **usfamily@svcmcny.org** or 1-800-241-4848. Ambulatory surgical procedures may be performed at an out of network facility if there is not a participating facility near your home, or if your network doctor generally performs the procedure elsewhere.

However, if performed in an out of network facility ALL ambulatory surgical procedures require pre-authorization from USFHP.

Co-payments may be required for ambulatory surgery. Refer to the Summary of Benefits.

Emergency Care Services

In the event of an emergency, call 911 or go to the nearest hospital and/or medical facility for treatment. A medical emergency is a situation that requires immediate intervention to prevent the loss of life, limb, sight, or body tissue, or to prevent undue suffering. In an emergency, care cannot be safely postponed while you contact your PCP and/or a doctor on call.

Emergency room treatment for a condition that meets this definition does not have to be authorized by your PCP prior to obtaining services and does not have to be provided at a USFHP facility. You are not required to obtain pre-authorization for emergent care. Remember, emergency dental care (with very few exceptions) is not a covered USFHP/TRICARE benefit.

Schedule an appointment with your PCP promptly after discharge and make sure that all follow-up care is obtained within the network, or that your PCP obtains an authorization for additional out of network care. It is always best to call your PCP soon after an emergency room visit or unplanned admission to a hospital.

If you happen to require inpatient hospitalization at an out-of-network facility as a result of an emergency room visit, a hospital staff member will call the USFHP Utilization Review department shortly after your admission. A network provider must provide post-hospital care, or an authorization must be obtained by your PCP for an out of network provider in order for the claim to be paid efficiently. A call to your PCP is always a good idea following an unplanned admission. The USFHP will generally provide an out of network provider with an authorization for you to obtain short-term post-hospital follow-up care with the treating physician. However, you must quickly return to a network provider.

Co-payments may be required for emergency care. Refer to the Summary of Benefits.

Urgent Care Services

It's hard to predict when or where accidents, injuries, or sudden onset of an illness may occur. But you may find yourself in situations that require urgent, but not emergent, medical attention, such as spraining your ankle during an afternoon jog.

Urgent care is defined as health services that are required within 24 hours after the onset of illness or accidental injury which is not life threatening. Unlike an emergency, urgent medical situations can safely wait until you can call your PCP, the USFHP Nurse Advice Line, or speak with a doctor for instructions as to what you should do.

The USFHP Nurse Advice Line is available 24-hours a day 7 days a week at 1-800-241-4848. At any time you can speak to a medical professional who will evaluate the urgency of your medical needs and instruct you how to proceed based on nationally accepted standards of care. If an authorization is required, they can assist.

Co-payments may be applicable for emergency and urgent care services. Refer to the Summary of Benefits.

USFHP will cover care provided at any urgent care facility anywhere In the US.

Medical Transportation

Emergency medical transportation, usually ambulance, is a covered benefit. It does not require authorization from USFHP or referral from your PCP. Non-emergency medical transportation, usually ambulette, is not a covered TRICARE benefit. In limited situations (i.e., transfer from one facility to another facility), USFHP may authorize non-emergency medical transportation. The facility or your PCP is responsible to request authorization for non-emergency medical transportation.

Co-payments may be applicable for medical transportation services. Refer to the Summary of Benefits.

When You Travel - Out Of Area Coverage

When you are outside of the USFHP service area, USFHP will cover emergency and urgent services provided by licensed physicians and hospitals on an outpatient or inpatient basis. Urgent care that is not provided by an emergency room or a free-standing urgent care center must be authorized by USFHP. Please note, the Nurse Advice Line staff cannot help you locate a provider out of area.

Emergency services, including prescriptions, provided outside of the USFHP network of facilities/service area are not generally covered if the need for care could have been foreseen before leaving the service area.

Healthcare services that are part of an established and active medical treatment plan may be covered out of the Plan's service area. Members who are in the process of an established and active treatment plan for an acute or chronic medical problem may also require medical care, as part of the active treatment plan, while temporarily out of the Plan's geographic service area. Examples of healthcare services included in an active treatment plan of care for an acute or chronic medical problem include lab work or diagnostic radiology. Discuss your needs with your PCP to identify resources and to work with the Plan's utilization review department to obtain pre-authorization.

There is no out-of-area coverage for routine or elective healthcare services.

Before traveling out of the area, check your medication supply. See how much you have left before leaving the service area (i.e., last pill, last shot of insulin). Do not wait until your last dose of medication. Obtain a refill, if you can, before you depart.

Summary of Benefits and Co-Payments

COVERED SERVICES	Active Duty Family Members	Retirees with Medicare Part B	Retirees without Medicare Part B
Outpatient Services ***(Fees are subject to change)***			
Office Visits	$0	$0	$12 per visit
Maternity Care (prenatal, postnatal)	$0	$0	$0
Well-baby care (up to age 6)	$0	$0	$0
Annual well-child care (age 6 and older	$0	$0	$0
Annual physical examination	$0	$0	$0
Ambulatory surgery and procedures (including anesthesia)	$0	$0	$25
Physical, occupational, speech therapy	$0	$0	$12 per visit
Inpatient Services ***(Fees are subject to change)***			
Semi-private room and board	$0	$0	$11 per day/$25 minimum charge per admission
Physicians services	$0	$0	$0
General nursing services	$0	$0	$0
Diagnostic tests, including lab and x-ray	$0	$0	$0
Operating room, anesthesia and supplies	$0	$0	$0
Medically necessary supplies and services	$0	$0	$0
Physical therapy	$0	$0	$0
Mental Health Service ***(Fees are subject to change)***			
Outpatient care: individual[1]	$0	$0	$25 per visit
Outpatient care: group[1]	$0	$0	$17 per visit
Partial hospitalization mental health (up to 60 days per enrollment year)[2]	$0	$0	$25 per visit – individual
Inpatient hospital psychiatric care (subject to medical review)[2]	$0	$0	$17 per visit – group $40 per day
Substance Abuse Treatment ***(Fees are subject to change)***			
Outpatient – group therapy	$0	$0	$17 per visit
Inpatient service (up to 7 days for detoxification per year)[3]	$0	$0	$40 per day
Inpatient rehabilitation (up to 21 days per year)[3]	$0	$0	$40 per day
Other Services ***(Fees are subject to change)***			
Medical Transportation service (when medically necessary)	$0	$0	$20 per occurrence
Durable medical equipment (including orthotics and prosthetics) and medical supplies	$0	$0	20%
Emergency room services[4]	$0	$0	$30 per visit
Eye examinations (1 per enrollment period)	$0	$0	$0
Radiation/chemotherapy office visits	$0	$0	$0
Skilled nursing facility care (when medically necessary)	$0	$0	$11 per day/$25 minimum per admission
Home healthcare (part time skilled nursing care)	$0	$0	$0 per visit
Out of area (emergency room)	$0	$0	$30 per visit
Pharmacy (over the counter medications are not covered) ***(Fees are subject to change)***			
Prescriptions drugs (up to 30 day supply)[5] (up to 30 day supply)[5]	$10 generic/ $24 brand/$50 third tier	$10 generic/ $24 brand/ $50 third tier	$10 generic/ $24 brand/ $50 third tier
Mail order pharmacy drugs (up to 90 day supply)[5]	$0 generic/ $20 brand/ $49 third tier	$0 generic/ $20 brand/ $49 third tier	$0 generic/$20 brand/ $49 third tier
Yearly Enrollment Fee	$0	$0	$282.60 per individual $565.20 per family

Note: Out of network services without an authorization may be subject to POS

1. One hour of therapy, no more than two times per week, when medically necessary.
2. With authorization, up to 30 days per enrollment year for adults (age 19+); up to 45 days per enrollment year for children under age 19; up to 150 days residential treatment for children and adolescents.
3. Maximum of one rehabilitation program per year, three per lifetime. Detoxification and rehabilitation days count toward the limit for mental health benefits.
4. Unless you are admitted to the hospital, in which case only the inpatient co-pay applies.
5. Prescription drug availability is limited to those prescribed by a licensed provider and covered as a Plan benefit.

Availability of non-emergency prescriptions when out of area is also limited. Over the counter medications and supplies are not covered.

Co-payments, Co-insurance and Enrollment fees are subject to TRICARE Defense Health Agency (DHA) changes. For the most updated information, please visit our webpage **www.usfhp.net**; or contact Customer Service at (800) 241-4848.

Service Limitations and Exclusions

USFHP, according to TRICARE policy, cannot provide coverage (payment) for the following general services:

• Services provided or charges incurred prior to, or after, the effective date of coverage under the Plan • Services not specifically included as a TRICARE benefit • Care or treatment as a result of being engaged in an illegal occupation or commission of, or attempted commission of, a felony or assault • Charges or services for which you or your covered dependent(s) are not legally required to pay, or that would not have been made if coverage had not existed • Charges for missed appointments, telephone consultations, or the completion of medical reports or certification services • Services and drugs not prescribed or authorized by your primary care provider (PCP) or a specialist to whom you were referred, unless using the POS option.	• Services provided by people who ordinarily reside in your household, or the household of your covered dependent or who are related by blood, marriage, or legal adoption to you or your covered dependent • Services not considered medically necessary for your diagnosis; and, treatment provided at an inappropriate level • Services that are experimental/ investigational, or of a research nature • Any services provided for education, employment, licensing, immigration, elective travel, or other administrative reasons • Any services provided by an unlicensed provider or a provider who is not a TRICARE authorized provider type • Complications due to a non-approved, or non-covered, procedure • Care which is custodial in nature

According to TRICARE policy USFHP cannot provide coverage for the following specific services (this list is not all-inclusive and subject to change):

- Acupuncture and acupressure
- Artificial insemination, in vitro fertilization, and other therapies (including drug therapy) to induce pregnancy
- Autopsy and postmortem exams
- Bed wetting correctional devices
- Breast implants for cosmetic services or removal of breast implants if obtained for augmentation or cosmetic reasons
- Aversion therapy in connection with alcoholism
- Cosmetic, plastic, or reconstructive surgery not connected to medical treatment
- Custodial care
- Dental care
- Dentures
- Education or training
- Electrolysis
- Experimental or investigational treatment and procedures (limited exception)
- Food, food substitutes or supplements, and vitamins consumed outside a hospital, except for home parenteral/ nutrition therapy
- Foot care, except in connection with medical treatment (routine foot care is covered only for enrollees with specific medical conditions, such as diabetes)
- Genetic tests not ordered by your PCP and under certain other conditions
- Hearing aids (limited exceptions)
- Hearing examinations, except in connection with medical or surgical treatment of a covered illness or injury
- Immunizations for elective travel
- Learning disorder treatments, including dyslexia
- Chiropractic services
- Massage therapy
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion
- Naturopathic service
- Orthodontia
- Orthopedic shoes and arch supports, except when a part of a brace - orthotics (limited exceptions)
- Over the counter drugs or vitamins or food supplements
- Private hospital rooms, unless ordered by the attending physician for medical reasons, or if a semiprivate room is not available
- Radial keratotomy
- Respite care (limited exception)
- Retirement home, assisted living facilities, domiciliary homes
- Sex change procedures
- Sterilization reversals
- Telephone services or advice including remote monitoring and consultation, except for trans-telephonic monitoring of pacemakers
- Transportation for convenience
- Visual training
- Weight control or weight Reduction services and supplies

Pharmacy Benefit

The USFHP pharmacy benefit manager is Maxor Plus. MaxorPlus assists US Family Health Plan in the management of the pharmacy benefit.

Prescription drugs are covered by USFHP when ordered by a licensed provider and when obtained from a Maxor pharmacy in our 2 owned practices or from Maxor mail order. Acute medications, like antibiotics, and the initial prescription for non-urgent medications may also be obtained at a participating network pharmacy. The medications must be approved by the Food and Drug Administration (FDA), be medically necessary for the condition being treated, and must abide by all TRICARE Uniform Formulary regulations and policies. The TRICARE Uniform Formulary covers most FDA approved prescription medications at one of 3 levels of co-payment.

Medications that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness are not covered by TRICARE (USFHP). The Department of Defense (DoD) Pharmacy & Therapeutics Committee recommends medications for the Uniform Formulary and the Director, TRICARE Management Activity (DHA), makes the final decision.

TRICARE (USFHP) has a mandatory generic substitution policy. If a brand name medication has a generic equivalent, it is DOD policy to dispense the generic equivalent instead of the brand name medication. The brand name medication may be dispensed only if the USFHP determines that it is clinically required for you to use the brand name instead of the generic. Maxor will initiate a request for clinical justification from your provider when it is necessary. The information will be reviewed. In non-emergent situations it generally takes 2-3 days for your provider to respond and a decision made. Only a physician can determine if a medication cannot be justified. You or your provider can appeal any denial to the USFHP. At times it may be necessary for you to discuss the use of brand versus generic with your provider.

TRICARE (USFHP) has pre-authorization requirements for some medications. Some drugs may require your provider to submit a special pre-authorization form. TRICARE has set the medical necessity criteria that must be met prior to dispensing. In order to minimize inconvenience, Maxor will send this form to any provider who orders such a medication; in non-emergent situations it generally takes 2-3 days for your provider to respond and a decision made. Only a physician can determine if a medication cannot be justified. Any denial can be appealed to the USFHP by you or your provider. A copy of the pharmacy pre-authorization form is available to your provider on the Plan's website (**www.usfhp.net**); only licensed providers may initiate and submit this form for review.

TRICARE (USFHP) also has quantity limitations:

- You may obtain up to a 90-day supply through Maxor Mail Order or at a Maxor pharmacy located at the Fort Wadsworth Family Health Center (Staten Island, NY) or the Mitchel Field Family Health Center (Garden City, NY).
- You may obtain up to a 30-day supply at a Maxor participating local retail pharmacy for urgent, or initial non-urgent medications.
- The amount of medication dispensed is limited to the amount of medication expected to be used in a 90-day or 30-day period based on the directions for use on the prescription.
- Some medications have more stringent quantity limitations.

Quantity limits are applied by the DOD to address overuse of medications that can be unsafe for the patient and costly to the government. The USFHP will make exceptions to quantity limits if the prescribing provider is able to justify medical necessity. A copy of the quantity limit override request form is available for your provider at our website (www.usfhp.net); only licensed providers may initiate and submit this form for review.

MaxorPlus is available to assist with TRICARE Uniform Formulary and other clinical questions. Routine refills of most covered prescription medications can be obtained from Maxor Mail Order Pharmacy. Maxor pharmacies are also conveniently located at two of the Plan's Family Health Centers. In addition, many national and local pharmacies are in the Maxor network for acute medications. Please visit our website at **www.usfhp.net** (pharmacy benefits page) to locate a Maxor network pharmacy in your area.

Maxor Pharmacy at Fort Wadsworth
(Staten Island, NY)

- 718-273-4260 (phone)
- 718-816-5830 (fax)
- Current pharmacy hours:

Monday	9 am – 7 pm
Tuesday	9 am – 5 pm
Wednesday	9 am – 5 pm
Thursday	9 am – 6 pm
Friday	9 am – 2 pm

Please note that pharmacy hours are subject to change based on physician/ office schedule. Always call ahead to make sure the pharmacy is open.

- Members may obtain 90-day supply of covered prescription medications at this location.

Maxor Pharmacy at Mitchel Field
(Garden City, NY)

- 516-222-0401 (phone)
- 516-222-0672 (fax)
- Current pharmacy hours:

Monday	9 am – 4:30 pm
Tuesday	9 am – 4:30 pm
Wednesday	9 am – 4:30 pm
Thursday	9 am – 4:30 pm
Friday	9 am – 4:30 pm
Saturday	9 am – 1:00 pm

Please note that pharmacy hours are subject to change based on physician/ office schedule. Always call ahead to make sure the pharmacy is open.

- Members may obtain 90-day supply of covered prescription medications at this location

Co-payments are required on prescriptions, and the amount will depend on whether the drug is 1st Tier (generic), 2nd Tier (formulary name brand), or 3rd Tier (non-formulary). The co-payment for generic prescriptions are $10, formulary name brand prescriptions are $24, and prescriptions for TRICARE non-formulary medications are $50. This fee will cover up to a 30-day supply when filled by a participating pharmacy. For ongoing

medication filled through **Maxor Mail Order**, the co-payment for generic prescriptions are $0, formulary name brand prescriptions are $20, and prescriptions for TRICARE non-formulary medications are $49. This fee will cover up to a 90-day supply when filled through Maxor Mail Order or at our Mitchell Field or Ft. Wadsworth Health Center Maxor Pharmacies. When non-formulary medication is ordered Maxor will initiate a request from your provider for any information your provider can supply that will justify the non-formulary drug and a $49 copay will apply. When medical necessity can be determined future co-payments will be at the lower rate. Mail order is mandatory for all routine prescriptions refills, and some non-urgent medications. Always remember to call Maxor Plus at the number on your membership card should you feel it is necessary to obtain routine drugs from a local pharmacy.

The TRICARE Pharmacy & Therapeutics Committee meets quarterly and makes changes to the formulary status and co-payments. If you are taking medication that change, the USFHP/Maxor will notify you and your provider before the change takes effect.

How to get prescriptions filled:

New or urgent, short-term acute medications for 30 days or less, and oral antibiotics: Present your prescription and member ID card at a Practice Maxor Pharmacy, a participating Maxor Retail Pharmacy; or use mail order.

Maintenance medications for 31 days or more:

USFHP **requires** members to fill maintenance medications through a Maxor pharmacy (conveniently located at Mitchel Field or Fort Wadsworth) or Maxor Mail Order Pharmacy. When obtaining an initial prescription for a maintenance medication, you may ask that your provider write two prescriptions: one for a 30-day initial supply and one for a 90-day maintenance supply. You may, but are not required, fill the initial 30-day prescription at your local Maxor-participating retail pharmacy. Then you can mail your 90-day prescription or the initial prescription to Maxor Mail Order Pharmacy. Allow 10 days for mailing and make sure that co-payment information is on file. Remember that 75% of your current medication supply must already be used before you can order refills.

Occasionally, members may be told that a medication is not covered. If you are at a Maxor participating retail pharmacy, ask the pharmacist to call Maxor Plus at the telephone number that will appear on their computer screen or that is listed on your member ID card. When a medication, not on the TRICARE Uniform Formulary is requested by a local pharmacy, Maxor Plus always asks the pharmacist to call and explain the situation. If the pharmacist is too busy, call Maxor Plus yourself. Use the telephone number on the back of your USFHP card. Many times the problem can be corrected immediately while you are still in the pharmacy. Almost all prescriptions written in the emergency room or urgent care center may be approved this way. In other non-urgent situations, Maxor Plus may need to contact the prescribing doctor before approval can be given. This service is available 24/7.

Maxor Plus can be reached by phone or fax. The toll free phone number is 1-800-687-0707 and the toll free fax number is 1-866-222-3274.

Maxor Plus Customer Service representatives are available:

- Monday – Friday 9:00 am – 8:00 pm EST
- Saturday 9:00 am – 7:00 pm EST
- Sunday 10:00 am – 6:00 pm EST
- A Maxor Plus pharmacist is always available on-call after routine customer service hours to respond to emergent situations.

Maxor Mail Order pharmacy can be reached by phone, fax, mail or Internet. The toll free phone number is 1-866-408-2459 and the toll free fax number is 1-866-589-7656. Maxor Mail Order pharmacy is only permitted to accept prescriptions that are faxed directly from the prescribing provider's office. Members may fax refill requests. Maxor Mail Order customer service representatives are available Monday – Friday, 8:00 am – 6:00 pm CST (9:00 am – 7:00 pm EST). Members can use the Maxor Mail Order automated system at any time to request refills with the prescription number printed on the label. Refills may also be requested at the Maxor website (**www.maxor.com**). Prescriptions and refill request may also be mailed to the following address:

USFHP/Maxor Mail Order
PO Box 32050
Amarillo, TX79120

Please make sure that your payment information is on file with Maxor Mail Order. Medications cannot be mailed without payment information.

Prescription Drug Limitations and Exclusions

Due to TRICARE restrictions, USFHP will not pay for the following:

- Drugs prescribed for cosmetic purposes including but not limited to drugs used for hair growth or wrinkle reduction
- Food supplements
- Homeopathic and herbal preparations
- Multivitamins (except prenatal vitamins for pregnant women and vitamin with fluoride for children)
- Over the counter (OTC) products or any product purchased without a prescription except insulin and related diabetic supplies
- Weight reduction products
- Compounded medications unless all products are FDA approved, are indicated for your specific reason, no commercial product is available, and you have tried appropriate approved medications
- Any prescription refilled before 75% of a previous filling has been used.

DAVIS VISION
EYECARE REFRAMED℠

US FAMILY HEALTH PLAN

Fashion Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations and eyeglasses!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks

For more details about the plan, just log on to the Member site at **davisvision.com** or call **1.877.923.2847** and enter Client Code **3258.**

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, **Covered in full**
Eyeglasses	
Spectacle Lenses	Every 12 months, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses
Frames	Every 24 months, **Covered in full** Any Fashion frame from Davis Vision's Collection[1] (value up to $125) OR $100 retail allowance toward any frame from provider, plus 20% off balance
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 12 months Non Collection Contacts: Standard Contacts: 15% discount Specialty Contacts[3]: 15% discount
Contact Lenses (in lieu of eyeglasses)	Every 12 months $100 retail allowance toward provider supplied contact lenses, plus 15% off balance

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$40	$0
Polycarbonate Lenses	$64	$0[3]-$35
Standard Anti-Reflective (AR) Coating	$62	$40
Standard Progressives (no-line bifocal)	$154	$65
Plastic Photosensitive (Transitions®[4])	$123	$70

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Lenses		
Bifocals	$80	$0
Scratch-Resistant Coating	$40	$0
Transitions®[4]	$123	$70
Frame	$150	$0
Total	$393	$70

Savings up to:
$323

[1] *The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change.*
[2] *Including, but not limited to toric, multifocal and gas permeable contact lenses.*
[3] *For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.*
[4] *Transitions® is a registered trademark of Transitions Optical Inc.*
Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact Info

For more details about the plan, just log on to the Member site at davisvision.com or call 1.877.923.2847 and enter Client Code 3258.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
FRAMES		
Fashion Frame (from the Davis Vision Collection)	$125	$0
Designer Frame (from the Davis Vision Collection)	$175	$15
Premier Frame (from the Davis Vision Collection)	$225	$40
LENSES		
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$33**	**$0**
Oversized Lenses	**$20**	**$0**
Scratch-Resistant Coating	**$40**	**$0**
Tinting of Plastic Lenses	$20	$15
Polycarbonate Lenses	$64	$0[1/] or $35
Ultraviolet Coating	$28	$15
Standard Anti-Reflective (AR) Coating	$62	$40
Premium AR Coating	$80	$55
Ultra AR Coating	$113	$69
Intermediate-Vision Lenses	$150	$30
Standard Progressive Addition Lenses	$154	$65
Premium Progressives (Varilux®[2/], etc.)	$248	$105
High-Index Lenses	$120	$60
Polarized Lenses	$103	$75
Plastic Photosensitive Lenses	$123	$70
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1/] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

[2/] Varilux® is a registered trademark of Societe Essilor International

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $40 | Frame up to $50 Spectacle Lenses (per pair) up to: Single Vision $40, Bifocal $60, Trifocal $80, Lenticular $100 Elective Contacts up to $80, Medically Necessary Contacts up to $225

Network

USFHP has a comprehensive, highly qualified provider network throughout our service area. Every provider in the USFHP network completes an extensive credentialing process, which helps to ensure that you get the very best quality health care. Our provider network consists of:

- **Primary care providers** – doctors and nurse practitioners with specializations in internal medicine, pediatrics, family practice, geriatrics and general practice.
- **Specialty care providers** – all medical specialists including, but not limited to, cardiology, hematology, neurology, oncology, orthopedics, pulmonology, rheumatology, urology, otolaryngology, surgery.

In addition, our provider network is complemented by an extensive list of acute hospitals, ambulatory surgical centers, rehabilitation facilities, skilled nursing facilities, home care and home infusion agencies, just to name a few.

Behavioral Health Services

Behavioral health issues are common and treatable. Contact your PCP to rule out and/or treat any medical issues. Please contact the USFHP's behavioral health partner, Magellan Health, to get answers to your behavioral health questions. Magellan Health staff can also help you locate a participating behavioral health provider. Authorization is required after the 8th office visit and is arranged by the behavioral health provider. The nurses and other health care professionals at Magellan Health are available 24 hours per day, seven days a week. All calls are confidential. Call 1-800-241-4848.

Covered behavioral health services include:

- Outpatient individual, group, and family counseling
- Inpatient admissions for behavioral health problems
- Inpatient admissions for alcohol and other substance abuse problems
- Partial hospitalization, intensive outpatient programs, and residential treatment centers

You do not need to obtain a referral from your PCP for the first 8 outpatient visits with a participating behavioral health provider. You can easily locate a participating behavioral health provider by calling 1-800-241-4848. All other behavioral health services do require referral and authorization. Remember, you must use a participating behavioral health provider.

Durable Medical Equipment and Medical Supplies

Mount Holly Surgical Supplies is the USFHP's preferred provider for most durable medical equipment (DME) and medical supplies. Your provider must prescribe all DME and medical supplies. Examples of covered DME and medical supplies include:

- Ambulatory assistive devices (i.e., canes, walkers, crutches)
- Home respiratory equipment
- Hospital beds
- Lifts
- Prosthetic devices
- Orthotic devices
- Wheelchairs
- Wound care supplies

In addition to a prescription, your provider may need to obtain authorization from USFHP. **Items purchased directly from a pharmacy or from another store are not eligible for reimbursement.**

Co-payments may be required for DME and medical supplies. Refer to the Benefits Summary.

Laboratory Services

LabCorp is our preferred outpatient laboratory services provider. You can go to any LabCorp service center, or participating hospital outpatient laboratory department for ordered laboratory testing. For your convenience in urgent situations you may also have tests done at any other independent lab facility or hospital-based outpatient lab. A referral and/or prescription from your doctor is always required. A list of LabCorp Service Centers is available on our website at www.usfhp.net, or on LabCorp's website at www.labcorp.com or by calling LabCorp directly at 1-800-788-9091. There are no co-payments for covered laboratory services. LabCorp requires all patients to supply credit card information at time of visit. Please note that USFHP members will not be billed for any covered services. If you receive a bill please contact Customer Service at 1-800-241-4848.

Outpatient Physical and Occupational Therapy

Outpatient physical and occupational therapy is offered in partnership with OrthoNet. A referral from your provider is required. After the initial evaluation from an OrthoNet participating provider, the therapist is responsible to obtain authorizations for any additional medically necessary services directly from OrthoNet. We recommend all members to verify directly with OrthoNet at 1-800-241-4848 to locate or confirm that a provider is an OrthoNet participant. To minimize your financial liability it is extremely important that you only go to a participating OrthoNet provider.

Co-payments may be required for outpatient physical and occupational therapy. Refer to the Summary of Benefits.

Radiology Services

You can go to any participating USFHP radiology facility, participating hospital radiology department, or any other radiology facility. A list of participating radiology facilities and participating hospitals is available on our website at **www.usfhp.net** or by calling Customer Service at 1-800-241-4848. A referral and/or prescription from your doctor are required for all radiology services. For urgent, plain x-rays, sonograms, ultrasounds, Doppler's or routine mammography, you may go to any local facility. Although an authorization is not necessary, it does help to process the claim. If your provider has recommended an MRI, PET scan or MRA, in addition to giving you a referral your provider must also request an authorization. There are no co-payments for radiology services.

USFHP Owned Practices

US Family Health Plan currently owns and operates two family health centers in New York; serving only you - military beneficiaries. Our centers proudly provide primary care services to USFHP members. The offices are staffed by board certified physicians, and knowledgeable and friendly clinical and administrative support staff. They have superb patient satisfactions scores, far beyond the military and other civilian health plans. Not only do they provide superb care but they treat you as part of their family, and will assist you with any medical Issue, including bills and specialty appointments. Fort Wadsworth offers Internal Medicine, Pediatrics, and Podiatry; and Mitchel Field offers Internal Medicine, Pediatrics, OB/GYN and Podiatry. Both perform electrocardiograms, draw blood, provide immunizations, and have a Maxor pharmacy right in the building.

Ft. Wadsworth **Family Health Center** 1-718-442-4158 206 Drum Road 1-718-447-1325 (fax) Staten Island, NY 10305 Office: (718) 442-4158 Fax: (718) 447-1325 Hours of Operations: Mon and Thur. 8AM - 6PM Tues., Wed., and Fri. 8AM - 4:30PM	**Mitchel Field** **Family Health Center** 1-516-222-0228 Building 19, West Road 1-516-745-1519 (fax) Garden City, NY11530 Office: (516) 222-1519 Fax: (516) 745-1519 Hours of Operations: Mon., Wed., Thurs., and Fri 8AM-4:30PM Tues 8AM - 9PM Saturday 9AM - 1PM

Military Treatment Facility

As a member of the US Family Health Plan, you are prohibited from using military treatment facilities (MTFs). The only exception to this limitation is if you have an acute medical emergency and the military treatment facility is the closest facility to you. When out of the USFHP service area or out of the country, it may be possible to obtain an authorization.

Coordination of Benefits (COB)

It is very important to identify yourself as a USFHP member before receiving care from any provider or facility. This is especially important for members who also have Medicare. Please be reminded to present your USFHP card at the beginning of all appointments, when registering at a facility or emergency room, or before beginning any relationship with a health care provider or facility. If you ever lose your USFHP card, please contact Customer Service by email at **usfamily@svcmcny.org** or call 1-800-241-4848 right away to have a new card sent to you. If you are Medicare eligible, please remind your providers that the USFHP is primary to Medicare (with very few exceptions).

US Family Health Plan and federal law requires that you report any other health insurance you carry when enrolling. TRICARE policy and Federal law require that any medical claims be filed with your primary insurance plan first, before using USFHP funds to pay your medical bills. After your primary health insurance pays, USFHP will pay any eligible balance up to the allowable TRICARE amount.

All healthcare expenses, including prescriptions, covered by USFHP are subject to this Coordination of Benefits (COB) process. Under COB, the commercial health insurance is the primary payer (except prescriptions), and only those expenses not covered by the primary payer are the responsibility of the Plan. Also, you have additional USFHP protection regarding co-payments. You are only responsible for the USFHP co pay even when the commercial insurance co pay is higher.

It is your responsibility to provide USFHP with the correct information and/or assistance that will enable us to coordinate payment for your health care services with any other insurance you may have. If, prior to enrolling in USFHP, you had other health care coverage that is still effective, or qualify for other coverage while you are a member of USFHP, you are required to disclose this information. You should contact Customer Services with this information by email at **usfamily@svcmcny.org** or by calling 800-241-4848. Make sure you provide all insurance coverage you have when you register for an appointment with a health care practitioner.

When you or your covered family members have other medical coverage, or receive care or services that would also be covered by workers' compensation or automobile medical benefits (including but not limited to personal injury protection, medical payments, USFHP has a legal right to recover some of the costs of your care. The Coordination of Benefits (COB) provision does not deny you any benefits, to which you are entitled, nor does it reduce your benefits; it is intended to ensure that duplicate payments are not made. All the health care expenses covered by USFHP are subject to this provision.

The COB process for non-pharmacy claims works like this:

- The provider sends a claim to the primary insurance.
- After payment from the primary insurance the provider sends a claim along with the primary insurance explanation of benefits (EOB) to the USFHP.
- USFHP reviews the claim and pays the required amount minus any applicable USFHP co-payment. You are not required to pay any of the primary insurance co-payments or deductibles.

For pharmacy services always use the USFHP pharmacy benefit first. Maxor will then bill the primary insurance if required.

If you change your insurance coverage, or if you obtain commercial insurance coverage after joining the US Family Health Plan, you must report it by contacting the Customer Service Department by email at **usfamily@svcmcny.org** or by phone@ 1-800-241-4848.

If you are 65 or older and are a member of USFHP, you do not lose your entitlement (***USFHP and Medicare not accepting any new members for this program as of October 2012)*** to Medicare; nor do you need to dis-enroll from USFHP to join TRICARE for life You can maintain your enrollment in the USFHP and retain your Medicare entitlement. However, double payment by Federal government - sponsored programs ARE NOT allowed. USFHP members are not allowed to use their Medicare benefit for services covered by the USFHP. Members are not allowed to enroll in Medicare sponsored managed care plans (HMO's) while enrolled in the USFHP Plan. The use of Medicare benefits by a USFHP member for covered services may be a cause for disenrollment from USFHP.

Members may, however, use Medicare for services that are not covered by USFHP, such as chiropractic care.

If you have Medicare Part B and/or other Medicare supplemental insurance (sometimes referred to as "Medigap"), we urge you to retain this coverage due to pre-existing condition clauses, exclusions, and waiting periods often associated with these plans. If you do not enroll when initially eligible, or drop Medicare Part B and you choose to enroll at a later time, you will pay a higher Part B premium and there will be a waiting period before your coverage is effective.

For each individual who has Medicare Part B coverage, there is no annual USFHP enrollment fee and no co-payments for any covered services except for prescriptions.

USFHP and Medicaid

USFHP (TRICARE) is always primary to Medicaid. Members may, however, use Medicaid for services that are not covered by USFHP, such as custodial care services.

End Stage Renal Disease (ESRD) and Medicare

Members, regardless of age, diagnosed with End Stage Renal Disease (ESRD) must apply for Medicare coverage. **Once Medicare coverage is established, it will be considered the primary insurance for the member, and USFHP will be the secondary.** Nurses at USFHP will work with you and your providers to coordinate this transition.

USFHP and Federal Employee Health Benefits Program

Federal employees, active and retired must waive the right to use the FEHBP while a member of the USFHP. This is to protect the government from double payment. Member who violates this regulation may be administratively dis-enrolled.

USFHP and Third Party Liability

Third Party Liability occurs when illness or injury suffered by a patient was caused by negligence or the intentional act of a third-party. Examples are as follows: automobile accidents, on-the-job injuries, etc.

The USFHP (DOD) is entitled to reimbursement from the liable party as well as any other party legally responsible for indemnifying you (including but not limited to underinsured and uninsured coverage on automobile policies). You, your representative, or beneficiary must execute documents, and do whatever is necessary for the USFHP to exercise its subrogation and assignment rights.

Members must disclose the existence of commercial coverage and any third-party payer to the Plan, when requested.

Keeping the Plan Updated

Notifying us right away of such changes will ensure that you and your family will continue to receive the appropriate health care coverage. If there are any changes in your residence, phone number or any additions to your family, it is very important that you notify the USFHP immediately of such a change by emailing the Plan at **usfamily@svcmcny.org**, using the Member Portal at **www.usfhp.net**, or calling Customer Service at 800-241-4848.

Should you move out of our service area without dis-enrolling, you could become responsible for all medical bills.

New additions to the family must be eligible with DEERS (Defense Eligibility Enrollment Reporting System) before they are eligible for coverage with USFHP. To check the status or to establish eligibility with DEERS, please call 1-800-538-9552. Newborns of member mothers must be enrolled in DEERS and USFHP within 60 days in order to retain coverage with USFHP. Failure to do so will result in financial liability for services.

If and when you have questions about USFHP and the benefits it provides, please feel free to visit our website at **www.usfhp.net**, email us at **usfamily@svcmcny.org** and/or call **800-241-4848** to speak to a Customer Service Consultant.

Appeal Rights

As a TRICARE beneficiary, a USFHP member retains all of the extensive appeal rights granted to any TRICARE beneficiary. These rights are extremely valuable and serve to protect your interests. Appeals to the USFHP are simple and straightforward, but when they go to the Defense Health Agency (DHA) they must meet very strict administrative requirements. When necessary, USFHP staff will assist you, or your agent, in submitting appeals to DHA. In most cases an appeal involves two steps. After the initial request for a service has been denied, your first appeal will generally be reviewed by a USFHP physician who was not involved in the original decision. Your 2nd appeal, in response to an unfavorable first appeal decision, will be sent to the TRICARE National Quality Monitoring Contractor for review by another physician. Even after this step you still have the right to appeal directly to DHA.

Medical care services you can appeal include:

- An authorization denial for a service felt to be unnecessary; for example, an MRI, an admission, or the determination that you no longer require admission to a facility.
- An authorization denial for a service felt to be at the wrong level; for example, at a facility versus at home.
- A service denied as experimental or investigational.
- A service denied as not covered by TRICARE; for example, infant head molding helmets, cosmetic surgery (this type of appeal goes directly to DHA).

Medical care services that are not appealable include:

- A decision by your PCP that you don't require a consultation to a specialist or a diagnostic test.
- TRICARE administrative requirements.
- The requirement to use network providers when access standards can be met.
- Amount of the TRICARE allowable payment rates.

However, even in those cases that are not appealable to TRICARE, the USFHP will always review your issue as a complaint.

All medical necessity appeals will be answered in writing, most within 30 days. Expedited appeals will be answered by the USFHP within 3 days. All decisions will be in writing, and if denied, will include the specific medical reason for the denial. When denied, a contact will be provided for more information, and your next level of appeal rights will be explained. In order to protect your right to appeal to DHA it is important to adhere to all of the administrative requirements noted in the letter.

Although not an appeal, it is very important that you send us any collection agency notices or balance bill notices as soon as you get them. If your provider bills you in error, contact the provider to make sure that they have the correct billing address (as displayed on the back of your USFHP ID card). When sending bills or notices to USFHP, add an explanation of the steps you may have taken to resolve these problems.

Complaints and Grievances

USFHP will address all complaints and grievances in an empathetic, efficient, and timely manner. Most verbal complaints are handled over the telephone at the time they are voiced; the majority of the remainder will be addressed within 2 weeks (10 business days). Grievances, which are written complaints, are all addressed within 60 days, most within 2 weeks (10 business days). Grievances are generally responded to in writing, using the same method in which they were sent (letter, fax, or email). It is important to us that our membership remains highly satisfied with our services, so we want to hear from all members when they are dissatisfied with the USFHP. If the answer to a complaint does not adequately address your issue, do not hesitate to ask for a supervisor, director, or our quality improvement coordinator.

Bills and Bill Payments

As a USFHP member who follows all of the Plan policies and procedures, you will never be responsible for payment of more than your legal co-payment. With a participating provider, this is defined in the USFHP-provider contract. Non-participating providers do not have a contract with the USFHP; the allowable reimbursement is noted in the authorization. Without a proper authorization for a non-network provider, you may be responsible for up to 115% of the CHAMPUS (TRICARE) maximum allowable amount (CMAC).

Most provider offices automatically send bills to their patients, sometimes within days of an appointment. As a knowledgeable USFHP member, you should closely review any bills or correspondence you get from a provider. When it appears that there could be a problem with payment, you should immediately contact USFHP Customer Services at 1-800-241-4848. Additionally, it is not unusual that some physicians want to be paid up-front. As a military beneficiary and member of the US Family Health Plan your in-network providers are prohibited by contract from both up-front charges and balance billing. However, non-network providers are not held to quite the same standard. The most you, as a TRICARE beneficiary, can be held financially liable by any provider is 115% of the TRICARE/CHAMPUS maximum allowable charge (CMAC). One problem with up-front billing is that non-network providers do not know the CMAC rate and want you to pay their customary charges. Paying them the correct TRICARE allowed amount and getting you a full refund becomes nearly impossible. The USFHP will never knowingly send you to a provider who demands an up-front payment. And neither should you ever go to one. Nevertheless, should you ever be in an office that unexpectedly requests full payment, you should call Customer Services immediately at 1-800-241-4848, before payment. Our staff can then explain how your health plan works and attempt to negotiate with the provider. If unsuccessful, it may be necessary to arrange alternative care. Bottom line: never pay up-front. When impossible to avoid, please send proof of payment and an explanation of the events to the USFHP, requesting reimbursement. The USFHP will investigate and reimburse all, or part of your up-front payment.

The USFHP is required to send members Explanation of Benefits (EOB) for all denied claims. If you get a denial EOB that you think is in error, please contact us by phone or in writing. From time to time the USFHP may also send EOB's for all care. These EOB's inform you that the USFHP has paid for care. The USFHP requests that you carefully review these EOB's and inform us of any discrepancy; such as you did not see that provider, or did not receive that service on the listed date. We will then investigate for possible fraud.

We hope this member handbook has been informative and helpful. US Family Health Plan knows that navigating the health care system can be confusing and difficult. Please do not hesitate to email us at **usfamily@svcmcny.org** or call us at 800-241-4848. Also visit our website at **www.usfhp.net** it contains answers to many frequently asked questions.

Again, thank you allowing us to serve you!

Important Addresses & Telephone Numbers

USFHP

Customer Service
5 Penn Plaza 9th Floor
New York, NY10001
1-800-241-4848

Monday-Friday 9am-5pm

Website: **www.usfhp.net**

Email Address: **usfamily@svcmcny.org**

Fax: 212-356-4949

Nurse Advice Line
1-800-241-4848

Behavioral Health
1-800-241-4848

Outpatient Physical Therapy/Occupational Therapy
800-401-0062

Pharmacy Information:

Maxor Mail Order phone
800-408-2459

Maxor Mail Order fax: 866-589-7656

Maxor Plus (TRICARE Uniform Formulary) phone 800-687-0707

Maxor Plus fax: 866-222-3274

Laboratory
Labcorp: 800-788-9091

DEERS 800-538-9552

US FAMILY HEALTH PLAN

HEALTH ASSESSMENT

MUST BE COMPLETED AND RETURNED TO USFHP IN PROVIDED POSTAGE PAID ENVELOPE.

Member Name:

Date:

Address:

Phone #:

ID #:

DOB:

The information on your current healthcare service needs is being collected in order to make your transition to US Family Health Plan as smooth as possible. This information will not be used in any other way or shared with any of your providers without your permission.

1. Do you currently reside in an assisted living facility, nursing home or another type of long-term residential care facility?

◯ Yes ◯ No

2. Do you have any surgery or operation planned in the next 30 days?

◯ Yes ◯ No

3. Are you on the wait list for an organ transplant or have you received an organ transplant in the past 12 months.

◯ Yes ◯ No

4. Have you been diagnosed with End Stage Renal Disease (ESRD)?

◯ Yes ◯ No

5. Are you currently receiving treatment for any medical condition (examples: chemotherapy, physical therapy, behavioral health)?

◯ Yes ◯ No

6. Are you currently taking any medications that will need to be refilled in the next 30 days?

◯ Yes ◯ No

7. In the next 6 months, will you need to follow up with a particular doctor for a procedure or treatment you previously received (example: surgery)

◯ **Yes** ◯ **No**

8. Are you aware that any prescription maintenance medication you take (longer term meds like high blood pressure medication) must be filled by mail order?

◯ **Yes** ◯ **No**

9. When you signed up for the Plan, were you made aware that you cannot use Military Treatment Facilities to fill your prescriptions?

◯ **Yes** ◯ **No**

Submit

US FAMILY
HEALTH PLAN

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