



TRICARE Supplement Insurance



TRICARE Supplement Insurance

Plan Design for Employees | 784

TRICARE eligible employees have the freedom to choose an alternative to employer-sponsored health plans.

This document describes how a TRICARE Supplement works with your existing TRICARE coverage. Please note: Check with TRICARE to confirm your actual prescription copays. TRICARE’s portion of coverage is provided here for your convenience, but is subject to change by DHA.

IMPORTANT INFORMATION

TRICARE Supplement Insurance Policy MZ0925784H0000A has a Plan Deductible: \$100 per person | \$200 per family

Note: After you have met both your TRICARE and TRICARE Supplement Plan deductibles, the Supplement Insurance plan pays 100% of your approved expenses not paid by TRICARE.

Note: Benefits are payable for covered cost share amounts up to the TRICARE Catastrophic Cap. The Catastrophic Cap is the maximum out-of-pocket amount you will pay each calendar year (FY) (January 1 – December 31) for TRICARE-covered services. See your Certificate for maximum pay-out of the TRICARE Supplement for Prime POS.

Exclusions may vary by state and underwriter. See your Certificate for complete details.

This is not Medicare Supplement Insurance. For more information about Medicare and Medicare Supplement Insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

TRICARE SELECT WITH SUPPLEMENT

Care Required	TRICARE Select Insured is Responsible for	TRICARE Select Supplement Covers
Annual Deductible	Non-network: \$150 for individual and \$300 for family	50% of TRICARE Deductible
Primary Care Outpatient Visit	Network: \$28 or \$41 Non-Network: 25% of TRICARE allowed amount	Network: \$28 or \$41 Non-Network: 25% of TRICARE allowed amount

<p>Inpatient Admission</p>	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$901 per day, or 25% hospital charge, whichever is less, plus 25% separately billed services</p>	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$901 per day, or 25% hospital charge, whichever is less, plus 25% separately billed services</p>
<p>Inpatient Skilled Nursing/Rehab Admission</p>	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$250 per day, or up to 25% hospital charge, whichever is less, plus 25% separately billed services</p>	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$250 per day, or up to 25% hospital charge, whichever is less, plus 25% separately billed services</p>
<p>Prescription Drugs Civilian network pharmacy; up to a 30-day supply</p>	<p>Copayments: \$11 generic; \$28 brand name or \$53 formulary</p>	<p>Copayments: \$11 generic; \$28 brand name or \$53 formulary</p>
<p>Prescription Drugs Home Delivery, mail order; up to 90-day supply; co-pays based on each 30-day supply.</p>	<p>Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.</p>	<p>Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.</p>

Prescription Drugs Civilian non-network pharmacy; up to a 30-day supply	Annual Deductible (\$150 or \$300) PLUS: Formulary drugs: \$28 or 20% of total cost, whichever is more Non-Formulary: \$53 or 20% of total cost, whichever is more	50% of TRICARE Deductible PLUS: Formulary drugs: \$28 or 20% of total cost, whichever is more Non-Formulary: \$53 or 20% of total cost, whichever is more
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TRICARE PRIME WITH SUPPLEMENT

Care Required	TRICARE Prime or Point-of-Service (POC) Insured is Responsible for	TRICARE Prime or Point-of-Service (POS) Supplement Covers
TRICARE Prime Annual Enrollment Fee	Single: \$289.08 Family: \$578.16	Supplement does NOT cover TRICARE Prime Enrollment Fee
Annual Deductible	\$300 for individual and \$600 for family (POS deductible/out of network)	25% POS deductible
Primary Care Outpatient Visit	Network: \$20 or \$30 POS: TRICARE deductible (\$300 or \$600) and 50% POS cost share	Network: \$20 or \$30 POS: 25% of TRICARE deductible (\$300 or \$600) and 50% of POS cost share

Inpatient Admission	MTF: \$18.60 per day Network Hospital: \$150 per admission	MTF: \$18.60 per day Network Hospital: \$150 per admission
Inpatient Skilled Nursing/Rehab Admission	Network: \$30 per day POS: TRICARE deductible (\$300 or \$600) and 50% POS cost share	Network: \$30 per day POS: 25% TRICARE deductible (\$300 or \$600) and 50% POS cost share
Prescription Drugs Civilian network pharmacy; up to a 30-day supply	Copayments: \$11 generic; \$28 brand name or \$53 formulary	Copayments: \$11 generic; \$28 brand name or \$53 formulary
Prescription Drugs Home Delivery, mail order; up to 90-day supply; co-pays based on each 30-day supply.	Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.	Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.

Prescription Drugs Civilian non-network pharmacy; up to a 30-day supply	POS deductible (\$300 or \$600) PLUS 50% cost share	25% of POS deductible (\$300 or \$600) PLUS 50% of TRICARE POS cost share
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TRICARE RESERVE SELECT WITH SUPPLEMENT

Care Required	TRICARE Reserve Select Insured is Responsible for+F1:G8	TRICARE Reserve Select Supplement Covers
Monthly TRICARE Reserve Select Enrollment Fee	Member only: \$46.09 per month Member + Family: \$221.38 per month	TRICARE Supplement does NOT cover TRICARE Reserve Select Enrollment Fee
Annual Deductible	Sponsor Rank E4 and below: \$50 per individual, but no more than \$100 per family Sponsor Rank E5 and above: \$150 per individual, but no more than \$300 per family	Sponsor Rank E4 and below: \$50 per individual, but no more than \$100 per family Sponsor Rank E5 and above: \$150 per individual, but no more than \$300 per family
Primary Care Outpatient Visit	Network: \$15 or \$25	Network: \$15 or \$25

	Non-network: 20% of allowable charge	Non-network: 20% of allowable charge
Inpatient Admission	Network: \$60 per admission Non-network: 20% of TRICARE allowed amount	Network: \$60 per admission Non-network: 20% of TRICARE allowed amount
Inpatient Skilled Nursing/Rehab Admission	Network Provider: \$25 per day Non-network: \$50 per day	Network Provider: \$25 per day Non-network: \$50 per day
Prescription Drugs Civilian network pharmacy; up to a 30-day supply	Copayments: \$11 generic; \$28 brand name or \$53 formulary	Copayments: \$11 generic; \$28 brand name or \$53 formulary
Prescription Drugs Home Delivery, mail order; up to 90-day supply; co-pays based on each 30-day supply.	Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.	Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.
Prescription Drugs Civilian non-network pharmacy; up to a 30-day supply	Annual Deductible (\$50/\$100 or \$150/\$300) PLUS: Formulary drugs: \$28 or 20% of total cost, whichever is more Non-Formulary: \$53 or 20% of total cost, whichever is more	25% of Annual Deductible (\$50/\$100 or \$150/\$300) PLUS: Formulary drugs: \$28 or 20% of total cost, whichever is more Non-Formulary: \$53 or 20% of total cost, whichever is more

TRICARE RETIRED RESERVES WITH SUPPLEMENT

Care Required	TRICARE Retired Reserves Insured is Responsible for:	TRICARE Retired Reserves Supplement Covers
Monthly TRICARE Retired Reserves Enrollment Fee	Member only: \$431.35 per month Member + Family: \$1,038.31 per month	Member only: \$431.35 per month Member + Family: \$1,038.31 per month
Annual Deductible	Network Provider: \$150 for individual and \$300 for family Out of Network: \$300 for individual and \$600 for family	50 % of In-network TRICARE Deductible 50% of Out of Network TRICARE Deductible
Primary Care Outpatient Visit	Network: \$25 or \$40 Non-network: 25% of TRICARE allowed amount	Network: \$25 or \$40 Non-network: 25% of TRICARE allowed amount
Inpatient Admission	Network: \$175 per admission Non-network: 25% of TRICARE allowed amount	Network: \$175 per admission Non-network: 25% of TRICARE allowed amount

Inpatient Skilled Nursing/Rehab Admission	Network Provider: \$50 per day Out of network: Lesser of \$300 per day or 20%	Network Provider: \$50 per day Out of network: Lesser of \$300 per day or 20%
Prescription Drugs Civilian network pharmacy; up to a 30-day supply	Copayments: \$11 generic; \$28 brand name or \$53 formulary	Copayments: \$11 generic; \$28 brand name or \$53 formulary
Prescription Drugs Home Delivery, mail order; up to 90-day supply; co-pays based on each 30-day supply.	Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.	Copayments: \$7 for generic, \$24 for brand name, or \$53 non-formulary.

CONTACT

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9:00am - 7:00pm ET, Monday-Friday

Policy Form MLTRC1000GP | Transamerica Premier Life Insurance Company, Cedar Rapids, IA
Policy Form TFTRC1000GP | Transamerica Financial Life Insurance Company, Harrison, NY

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