POINT OF SERVICE
Your TRICARE Prime® Out-of-Network Benefit

Choosing to use out-of-network providers when in-network providers are available

Know before you go!

What is the Point of Service benefit and how does it affect me?

US Family Health Plan members usually get their health care from in-network providers with very low out-of pocket costs. The **Point of Service (POS)** benefit gives members more flexibility in their choice of provider. Under the POS benefit, members may **choose** to get medically necessary, TRICARE-covered care from out-of-network providers/facilities, even when they can get those services from an in-network provider/facility. **Your out-of-pocket costs will be much higher if you make the choice to use your POS benefit.**

What services qualify to be covered under the POS benefit?

There are several conditions that must be met before a member can use their POS benefit to cover services obtained from an out-of-network provider:

1. The service must be covered under TRICARE; *AND*
2. The service must be determined to be "medically necessary" by the Martin's Point US Family Health Plan *(If the service is not determined to be medically necessary, it will not be covered under ANY US Family Health Plan benefit); AND*
3. There must be in-network providers who are available to perform this service (*If there are no in-network providers available, the service falls under the in-network US Family Health Plan benefit*); AND
4. The service will be (or was) obtained from an out-of-network provider

What are my costs under the Point of Service benefit?

When you use the Point of Service benefit to get care from an out-of-network provider/facility, your costs will be much higher than they will be if you get that same service from an in-network provider:

DEDUCTIBLE

OUTPATIENT SERVICES ONLY: You will pay a $300 (individual) or $600 (family) DEDUCTIBLE for outpatient services per fiscal year (October 1-September 30).

COST SHARE

INPATIENT AND OUTPATIENT SERVICES: You will pay a cost share of 50% of the TRICARE Maximum Allowable Charge for services rendered.

ADDITIONAL CHARGES
INPATIENT AND OUTPATIENT SERVICES: An out-of-network provider may also "balance bill" you for an additional 15% of the TRICARE Maximum Allowable Charge. ***If your provider does not accept Medicare or TRICARE, you may be responsible for the total cost of services.***

So, if I see Dr. Smith for an office visit; how do my costs change if he is out of network?

IN NETWORK: If Dr. Smith is in network and you see him for a procedure for which he bills $2,000, your cost share is $0 if you are an active-duty member or member with Medicare Parts A and B. Your cost share is $12 if you are a retiree without Medicare.

OUT OF NETWORK: If Dr. Smith is out of network, here is an example to show how your costs could add up. This example is for an outpatient service:

Provider charge (how much the doctor bills):	$2,000
TRICARE Maximum Allowable Charge (the amount TRICARE allows us to pay):	$1,000
YOU PAY: Outpatient Service Individual DEDUCTIBLE (amount you pay out of your pocket each fiscal year before the Plan starts to share costs):	**$300**
Balance (the TRICARE Maximum Allowable Charge minus your deductible):	$700 ($1000 – $300)
YOU PAY: Point of Service cost share:	**$350** (50% of $700 balance)
PLAN PAYS: Point of Service cost share:	$350 (50% of $700 balance)
YOU PAY: The provider may "balance bill" you for an additional 15% of the TRICARE Maximum Allowable Charge:	**$150 (**15% of $1000)
YOU PAY: Total member out-of-pocket cost:	**$800**

Is that all I'll have to pay?

Not necessarily. If the provider does not participate with Medicare or TRICARE, you could be responsible for the entire bill.

But that will apply to my yearly out-of-pocket maximum, won't it?

No. Any deductible or cost share you pay for services received through the Point of Service benefit **do not apply to your yearly out-of-pocket maximum,** or "catastrophic cap." That means **there is no maximum limit to these charges**.

REFERRALS: Do I need to get a referral from my Primary Care Provider (PCP) when using my Point of Service benefit to go to an out-of-network doctor/facility?

You do not need to get a referral from your PCP to go to an out-of-network provider/facility when using your Point of Service benefit.

AUTHORIZATIONS: Do I need to get an authorization from the Martin's Point US Family Health Plan to use my Point of Service benefit to go to an out-of-network doctor/facility?
You may still need authorization from the US Family Health Plan for some services when using the Point of Service option. Examples of this include certain items of durable medical equipment, inpatient stays, services such as knee replacement surgery, etc. **When in doubt, you should always call Member Services to check.**

If I don't agree that a service should be covered under the Point of Service benefit, can I appeal that decision?
No. Per TRICARE, a Point of Service determination is not appealable.

Does the Point of Service benefit always apply if I see an out-of-network provider?
The Point of Service benefit **does not apply to**:

- Newborns and adopted children during the first 60 days after birth or adoption
- Emergency care
- Clinical preventive care received from a network provider
- The first eight outpatient behavioral health care visits to a network provider per fiscal year (October 1–September 30)
- If you have other primary health insurance
  If the care being sought is not part of the TRICARE benefit or is determined not to be medically necessary.

KNOW BEFORE YOU GO!
Please remember, the US Family Health Plan and the TRICARE Prime benefit are intended to help manage and provide continuity of your health care. The POS benefit allows you the choice to seek care outside of the network, but you should be aware of the costs if you do so.
If you have any questions, don't hesitate to call Member Services at 1-888-674-8734. We thank you for choosing Martin's Point US Family Health Plan to manage your health care.