
TRICARE SUPPLEMENT PLAN MEMBER HANDBOOK

Administered by Association & Society Insurance Corporation (ASI)
Underwritten by Monumental Life Insurance Company, Cedar Rapids, IA and
Transamerica Financial Life Insurance Company, Harrison, NY (NY residents only)
Sponsored by The American Military Retirees Association



Dear Valued Member:

We appreciate your enrollment in the voluntary TRICARE Supplement Plan. Combined with your TRICARE health benefit program, the TRICARE Supplement Plan is a valuable asset.

The TRICARE Supplement Plan is a voluntary payroll deduction benefit which is sponsored by the American Military Retirees Association (AMRA), administered by Association & Society Insurance Corporation (ASI) and underwritten by Monumental Life Insurance Company, Cedar Rapids, IA and Transamerica Financial Life Insurance Company, Harrison, NY (NY residents only), AEGON companies.

The TRICARE Supplement Plan is available to Commonwealth of Virginia employees, retirees, survivors and long-term disability (LTD) participants who are eligible for the State Health Benefit Program and TRICARE, the military health benefit program. Your eligible family members are also eligible to enroll. This supplement plan provides coverage that pays after TRICARE Standard, TRICARE Extra and TRICARE Prime pay.

Following enrollment in the TRICARE Supplement plan, you will receive your "Welcome Packet" which includes the following:

- Certificate of Insurance
- Member Handbook
- Member ID cards
- Claim forms

Please take a few moments to review these documents carefully. If there are inconsistencies between this handbook and the Certificate of Insurance, the Certificate will govern.

If you have questions not answered in this handbook, please feel free to call our Customer Service Department at 1-800-638-2610. Our Customer Service Representatives are available to assist you daily from 8:30 A.M. to 8:00 PM ET.

We look forward to serving your supplemental health insurance needs and providing you with quality benefits and service.

Sincerely

Plan Administrator

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IMPORTANT CONTACT INFORMATION

Customer Service Department

Toll-Free Phone #: 1-800-638-2610
Regular Fax #: 1-301-926-2621
Toll-free Fax #: 1-800-311-3124
Email: custsvc@asicorporation.com
Hours of Operation Monday – Friday, 8:30 a.m. to 8:00 p.m. ET

If you have questions regarding claims, or to request member ID cards, a handbook or claim forms call or email the Customer Service Department.

Claims Department

Regular Fax #: 1-301-926-2621
Toll-free Fax #: 1-800-310-5514
Claims Address Association & Society Insurance Corporation
Attn: Claims Department
P.O. Box 2510
Rockville, MD 20847

Client Services Department

Toll-Free Dedicated Phone #: 1-866-637-9911
Regular Fax #: 1-800-311-3126
Toll-free Fax #: 1-301-816-1171
Department Group Email: asi.research@asicorporation.com
Hours of Operation Monday – Friday, 8:30 a.m. to 5:30 p.m. ET

If you have questions regarding enrollment, eligibility, or to request a certificate of creditable coverage or portability, call or email the Client Services Department.

Client Services Dept Address Association & Society Insurance Corporation
Attn: Client Services Dept
P.O. Box 2168
Rockville, MD 20847

Corporate Office Address: Association & Society Insurance Corporation
2301 Research Blvd, Suite 300
Rockville, MD 20850

Web Site Address www.asicorporation.com

How to Find a Provider

Your healthcare providers must be certified/authorized by TRICARE in order for TRICARE to cover their services. To select a TRICARE-authorized provider, you may access a directory of TRICARE providers online at TRICARE's web site. You may also contact your local providers. However, prior to seeking non-emergency healthcare, be sure to verify that the providers are TRICARE-authorized.

IMPORTANT NOTICE

This handbook provides you with information on the TRICARE Supplement Plan and how it works with TRICARE, the Department of Defense's (DoD) health benefit program for the military community.

The TRICARE Supplement Plan is a wraparound to TRICARE similar to a Medicare wraparound supplement plan. It is the secondary payer of your medical benefits while TRICARE is the primary payer unless you have other health insurance (OHI). If you have OHI, the OHI pays primary to TRICARE, TRICARE pays secondary and the TRICARE Supplement Plan pays tertiary.

The TRICARE Supplement Plan also follows the eligibility requirements of TRICARE. Since this is a supplement to TRICARE you must follow the rules and procedures of TRICARE.

This TRICARE Supplement Plan provides coverage which helps to pay the balance of covered services after any one of the three TRICARE option pays. In this handbook you will be provided with information on covered benefits, exclusions and limitations under the TRICARE Supplement Plan, whom to call if you need assistance and how your claims should be submitted, along with basic information on the TRICARE program. For more detailed information on TRICARE, you may contact your regional contractor with questions or to request a copy of the TRICARE handbook or access it from the TRICARE web site at www.tricare.mil or the Palmetto Government Benefits Administrators (PGBA) web site at www.mytricare.com.

It is important for you to note that the TRICARE Supplement Plan also has different eligibility requirements from your employer's existing employer-sponsored plans.

Not all services are covered by the TRICARE Supplement Plan. There are plan specific exclusions and limitations on certain types of care. Since this plan pays after TRICARE, payment of services is dependent on TRICARE covering the service. Your claims must be submitted to TRICARE first. In most cases, you will need to submit a copy the TRICARE Explanation of Benefits (EOB) statement to the plan administrator before expenses can be considered by the supplemental plan.

If you were previously enrolled in an employer-sponsored plan providing primary benefits to TRICARE, you must inform TRICARE that you no longer have this coverage. To do so, complete the TRICARE Other Health Insurance (OHI) form available at the TRICARE web site. Please note that your TRICARE Supplement Plan is not considered to be other health insurance. It is a supplement plan specifically designed to pay after TRICARE pays.

This handbook does not discuss specific cost information. For this information, please ask your employer or call the plan administrator, ASI.

CORPORATE RELATIONSHIPS

Plan Administrator

Association & Society Insurance Corporation (ASI), Rockville, MD

Association & Society Insurance Corporation is a third party administrator specializing in the marketing and administration of group TRICARE Supplement Plans since 1975. ASI is the full service administrator of the TRICARE Supplement Plan underwritten by Monumental Life Insurance Company and Transamerica Financial Life Insurance Company (NY residents only), AEGON companies. ASI is well known for its knowledge and leadership in the TRICARE Supplement market for over 35 years.

ASI currently serves over 30 national organizations ranging in size from a few thousand to hundreds of thousands. ASI's client groups include many of the top ten defense contractors, as well as professional, social fraternal, military and trade associations, government agencies including states, cities, counties, school districts, federal credit unions and financial institutions from all over the United States.

ASI performs the usual functions of a major insurance company including:

Processing of claims

Billing and Premium Collection

Issuing ID cards and Certificate of Insurance

Providing quality customer Service

Marketing

Providing representatives to assist with Open Enrollment meetings and Benefits Fairs

At ASI, we are committed to providing you with a quality insurance product and quality customer service.

Plan Underwriters

Monumental Life Insurance Company, Cedar Rapids, IA, an AEGON company

Monumental Life Insurance Company is the plan underwriter of the TRICARE Supplement Plan for all states except New York. Monumental Life has provided insurance products since 1858. Since April 23, 2011, Monumental Life Insurance Company has been rated A+ by A.M. Best, (Superior, 2nd of 16 rating categories).

Transamerica Financial Life Insurance Company, Harrison, NY (NY residents only), an AEGON company

Transamerica Financial Life Insurance Company is the plan underwriter of the TRICARE Supplement Plan for residents of the State of New York only. Transamerica Financial has provided insurance products since 1961. Since April 23, 2011, Transamerica Financial Life Insurance Company has been rated A+ by A.M. Best, (Superior, 2nd of 16 rating categories).

Plan Sponsor

American Military Retirees Association

The American Military Retirees Association, Inc., (AMRA) is a non-profit corporation with National Headquarters located in Plattsburgh, New York. AMRA was incorporated in 1973 in New York State by and for all military retirees of the United States Armed Forces. The motivation to organize was the realization that there was not a single unified organization dedicated to protecting the benefits of all military retirees and veterans regardless of rank or branch of service.

The TRICARE Supplement Plan is offered under AMRA. Individuals who enroll in the TRICARE Supplement Plan automatically acquire membership in AMRA. Monthly membership dues are included in the total monthly premium that is paid to ASI and are transmitted to AMRA monthly.

If you are interested in learning more about AMRA, visit www.amra1973.org, or call AMRA at 1-800-424-2969 (be sure to inform the receptionist that you are a “corporate member”. After signing up with AMRA you will receive a membership card and information on AMRA’s other valuable member benefits.

In addition to the TRICARE Supplement Plan, the following is a brief description of some of the benefits available to AMRA members.

- TRICARE Supplement Plan
- A quarterly newsletter with feature articles and information on AMRA’s advocacy efforts (if your address is provided to AMRA)
- Weekly “Monday Morning Digest” e-newsletter with short reports on legislative activities, VA issues, and links to vital information that affect members on a daily basis (if your email address is provided to AMRA)
- National Legislative Advocacy Program. AMRA is a member of the National Military Veterans Alliance. National Headquarters provides resources/referral services for any questions you might have regarding your military benefits
- Vision care discount program at participating Wal-Mart vision centers.
- Red Roof Inn discount program.
- Discounts on Assisted Listening Devices through Williams Sound
- Avis/Budget Car Rentals
- Scholarship program for AMRA members, their spouses, dependent children and grand children
- Video Lending Library-documentaries and films on military topics
- Auto and Homeowner insurance through Liberty Mutual
- State-to-state moving discounts, Mortgage and real estate services through North American and Allied Van Lines
- Hotel discounts through “Choice Privileges” reward program.

Note: This information is current as of August 24, 2011 and is subject to change.

ELIGIBILITY

Who is Eligible?

To be eligible for enrollment in the TRICARE Supplement Plan, employees and retirees cannot be eligible for Medicare, must be under age 65, must be eligible for the State Health Benefits Program and fall into one of the following TRICARE eligibility categories:

- Military retirees entitled to retired, retainer or equivalent pay
- Spouses or surviving spouses of military retirees
- Retired Reserve members under age 60 (“Gray Area” retirees) and enrolled in TRICARE Retired Reserve (TRR)
- Spouses or surviving spouses of Retired Reserve members and enrolled in TRR
- Retired Reserve members between the ages of 60 and 65 with at least 20 years of creditable service
- Spouses or surviving spouses of Retired Reserve members

Exceptions to Age 65 Eligibility Rule

There are two exceptions to the age 65 eligibility rule. They are:

- 1) **Medicare Ineligibility:** Employees, retirees and/or spouses age 65 or older but ineligible for Medicare may enroll in the TRICARE Supplement Plan. These individuals must have received a Notice of Disallowance from the Social Security Administration.
- 2) **Reside Overseas:** Employees, retirees and/or spouses age 65 or older who reside outside the United States or its territories may enroll in the TRICARE Supplement Plan. Such individuals must be eligible for Medicare Part A and enrolled in Part B. Medicare does not cover medical expenses incurred outside the United States and its territories.

Eligible Dependents

Dependents are eligible to enroll if they are:

- Up to age 21 (23 if a full-time student), or
- Incapacitated and primarily dependent on the member for support and continue TRICARE eligibility, or
- Young adult dependents who are at least 21 (23 if a full-time student) but under age 26, and are enrolled in the TRICARE Young Adult (TYA) program. Coverage ends at 12:01 a.m. the night of the 26th birthday.

What Happens When Your Coverage Ends At Age 65?

If you become eligible for Medicare Part A, you must purchase Medicare Part B to retain your TRICARE eligibility. To avoid a break in coverage of your TRICARE benefits you must enroll in Medicare when you first become eligible. Medicare becomes your primary benefits provider. When your Medicare entitlement is registered in DEERS your TRICARE (Standard, Extra or Prime) automatically changes to TRICARE for Life (TFL) and becomes the secondary payer to Medicare.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

GENERAL INFORMATION ABOUT TRICARE

TRICARE is managed by the Department of Defense (DoD). It is the health benefits program for the military community serving eligible beneficiaries from any of the seven uniformed services (the Army, Air Force, Coast Guard, Marine Corp, Navy, Public Health Service Commissioned Corps or the National Oceanic and Atmospheric Administration).

TRICARE beneficiaries include (but are not limited to):

Retired service members
Eligible dependents of retired service members including Survivors
Some former spouses

Beneficiaries are eligible for TRICARE if they are registered in the Defense Enrollment Eligibility Reporting System (DEERS). DEERS is a computerized worldwide database of military sponsors, families and others who are entitled to TRICARE benefits. It is important for sponsors to keep their families' DEERS records up to date to remain eligible.

Updating DEERS Records

To add or delete family members, military sponsors should visit a local uniformed services personnel office. You can search for an office near you by ZIP code, city or state at www.dmdc.osd.mil/rsl. You should call the office first to verify location and business hours. To add or delete family members, you will need supporting documentation (marriage certificate, divorce decree, birth certificate, etc).

- Call the Defense Manpower Data Center Support Office at 1-800-538-9552 to update your address, email address, and phone numbers.
- Fax address, email address, or phone number change to the Defense Manpower Data Center Support Office at 1-831-655-8317 or mail to:

Defense Manpower Data Center Support Office
Attn: COA
400 Gigling Road
Seaside, CA 93955-6771

Visit www.tricare.mil/DEERS and follow the steps to update your address, email address, and phone number online.

To maintain eligibility for TRICARE, beneficiaries must be under age 65 and ineligible for Medicare. TRICARE beneficiaries who are eligible for Medicare based on age, disability or end-stage renal disease must be eligible for Medicare Part A and enrolled in Medicare Part B to keep TRICARE eligibility.

Understanding TRICARE

TRICARE is the Department of Defense's health benefit program for the military community.

The TRICARE program includes the following:

- TRICARE Standard and TRICARE Extra
- TRICARE Prime
- TRICARE Retired Reserve

TRICARE Standard and Extra

TRICARE Standard is a fee for service plan option available to retired military personnel, their spouses, surviving spouses and eligible family members. TRICARE Extra is a preferred provider option that works with TRICARE Standard.

- Requires no enrolment or enrollment fee
- Manage own health care
- No referral required for any type of service
- Freedom to seek care from any TRICARE-authorized provider your choose
- No network restrictions
- TRICARE-authorized network providers under TRICARE Extra
- Prior authorization necessary for some services
- TRICARE Extra is available in certain areas of the United States
- TRICARE Standard is available worldwide
- Deductible and cost shares apply
- Excess charges apply under TRICARE Standard for non-participating providers

TRICARE Prime

TRICARE Prime is similar to a Health Maintenance Organization (HMO) plan with a Point of Service (POS) option.

Features of TRICARE Prime:

- Requires enrollment and enrollment fees
- Must select a Primary Care Manager (PCM)
- Care managed by PCM
- Significant network restrictions
- Referrals required to see a specialist
- May seek care in a military treatment facility on a higher priority than Standard/Extra but lower priority than Active Duty personnel and their family members
- Copayments apply under Prime
- If no referral is received and POS used, high deductibles and cost shares apply
- Available only in specific geographic areas of the United States

TRICARE Retired Reserve (TRR)

TRICARE Retired Reserve is a premium-based health care plan available for purchase to qualified National Guard and Reserve members. The National Guard and Reserve include the Army National Guard, Army Reserve, Navy Reserve, the Marine Corps Reserve, Air National Guard, Air Force Reserve and the U.S. Coast Guard Reserve. TRR members are under age 60, qualified for non-regular retirement under Title 10, United States Code, Chapter 1223 and not eligible for, or enrolled in Federal Employees Health Benefits (FEHB) program.

Features of TRICARE Retired Reserve

- Must qualify for and purchase TRR to participate
- Must pay monthly premiums
- Deductibles and cost shares apply
- No referrals required
- No network restrictions
- Manage own health care
- Some services require prior authorization
- Receive care from any TRICARE-authorized provider (network or non-network)
- Freedom to choose own TRICARE provider
- Offers coverage similar to TRICARE Standard
- Available worldwide

TRICARE Regional Contractor

TRICARE is administered by the following three regional contractors:

TRICARE North Region which includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, and portions of Iowa (Rock Island Arsenal area), Missouri (St Louis area) and Tennessee (Ft. Campbell area only).

Regional Contractor: Health Net Federal Services, LLC
Phone: 1-877-874-2273
Web site: www.healthnetfederalservices.com

TRICARE South Region includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee (excluding the Ft. Campbell area) and Texas (excluding the El Paso area).

Regional Contractor: Humana Military Health Services, Inc
Phone: 1-800-444-5445
Web site: www.humana-military.com

TRICARE West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding the Rock Island Arsenal Area), Kansas, Minnesota, Missouri (excluding the St Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern Corner, including El Paso), Utah, Washington, and Wyoming.

Regional Contractor: TriWest Healthcare Alliance Corp.
Phone: 1-888-874-9378
Web site: www.triwest.com

Your regional contractor or contractor's web site will provide you with information on covered and non-covered services, referral and authorization requirements, etc.

TRICARE for Life (TFL) and Medicare

If you are eligible for Medicare Part A based on age, disability, or end-stage renal disease, you must enroll in Medicare Part B to continue TRICARE eligibility. TRICARE beneficiaries who become eligible for Medicare Part A and enrolled in Medicare Part B will have their TRICARE coverage automatically changed to TRICARE for Life (pays after Medicare). TRICARE for Life is secondary to Medicare. Beneficiaries who are entitled to Medicare based on age have a Medicare initial seven-month enrollment period.

- If your birthday is on the first of the month, the initial enrollment period begins four months before the month he/she turns 65. You should enroll no later than two months before the month you turn 65 to avoid a break in TRICARE coverage. You are eligible for Medicare on the first day of the month before you turn age 65.
- If your birthday falls on any day other than the first of the month, your initial enrollment period begins three months before the month you turn 65. Enroll no later than one month before your birth month to avoid a break in TRICARE coverage. You are eligible for Medicare on the first day of the month in which you turn age 65.

Medicare Contact Information

Online: www.medicare.gov
Phone: 1-800-633-4227
In Person: Go to your local Social Security Administration (SSA) office
Visit www.ssa.gov to locate an office near you or call SSA at 1-800-772-1213.

TRICARE for Life coverage begins on the same day Medicare Part A and Part B coverage begins.

TRICARE and Other Health Insurance (OHI)

Civilian health insurance or employer sponsored plans are primary to TRICARE. These plans are considered other health insurance. Under federal law, TRICARE is the secondary payer to other health insurance including Medicare. If a TRICARE beneficiary has OHI, the OHI including Medicare pays primary to TRICARE. The TRICARE Supplement Plan pays secondary to TRICARE. TRICARE Supplement Plans are not considered other health insurance.

Note: The determination of a person's TRICARE eligibility is by the Department of Defense (DoD) and is not the decision of your Employer, your Plan Administrator, ASI, or Plan Underwriter, Monumental Life Insurance Company or Transamerica Financial Life Insurance Company.

ENROLLMENT

If you are eligible for coverage under the State Health Benefit Program, under age 65, ineligible for Medicare and eligible for military benefits, you are eligible to enroll in the TRICARE Supplement Plan.

Enrollment extends to your eligible dependents. Retirees, LTD participants and survivors may also be eligible for coverage in the plan.

The coverage levels under the TRICARE Supplement Plan are as follows:

Employee Only/Retiree Group Enrollee Only

Employee/Retiree Group Enrollee plus One

Employee/Retiree Group Enrollee plus Two/More

Incapacitated Children

If on the date a child reaches age 21 or 23 (if a full-time student), the child is: (a) covered under the Policy; (b) mentally retarded or physically handicapped and incapable of earning his or her own living; and (c) unmarried and primarily dependent on you for support and maintenance; the child may continue coverage past policy age limits.

You must provide proof of incapacitation to your employer, prior to the child reaching the plan's limiting age. Your child's incapacitation must be approved by TRICARE and your employer.

Newborn Children

Newborn children not named on your enrollment form are automatically covered from birth for Injury or Sickness, including treatment of congenital defects and birth abnormalities for 31 days.

You must contact your HR Representative to have your newborn added for continued coverage beyond the 31 days indicated above. You must also make sure to contact DEERS to have your newborn children added for coverage under TRICARE.

Extended Coverage for Adult Dependents

A young adult dependent who is enrolled in the premium-based TYA program, is eligible to enroll in the TRICARE Supplement Plan. To confirm TYA enrollment, the young adult dependent must provide ASI with a copy of his/her TYA enrollment ID card.

Residing Outside the U.S. and its Territories

If you are age 65 or older and reside outside the United States or its territories, you must still enroll in Medicare Part B to continue your TRICARE eligibility. In this case, since Medicare coverage is not available outside the U.S. or the U.S. territories, TRICARE remains your primary health benefit provider as soon as your DEERS file is updated with your Medicare enrollment. You are then eligible to enroll in the TRICARE Supplement Plan.

If Not Eligible for Medicare

If you are age 65 or older and ineligible for Medicare, you must contact the Social Security Administration to obtain a Statement of Disallowance. As soon as your DEERS file is updated with the Statement of Disallowance from Social Security Administration, TRICARE remains as your primary health benefits option and you are eligible to enroll in the TRICARE Supplement Plan

Non-Duplication of Coverage Under Employer Health Program

If a claim payable under the Policy is also payable under an Employer Health Program with TRICARE as the secondary payor, we will limit our payment to an amount which, when added to the amounts paid by the Employer Health Program and TRICARE, will not exceed 100% of TRICARE Covered Expenses.

If You Have Other Health Insurance

If when you enroll in the TRICARE Supplement Plan, you are changing from using OHI to using TRICARE as primary, you must notify TRICARE of this change by completing the OHI change form for your region. Forms may be obtained by calling the regional contractor, accessing the contractor's web site or accessing TRICARE's web site at www.tricare.mil.

Express Scripts must also be notified of your change of insurance by calling 1-866-363-8667.

Coverage for Retirees, LTD Participants and Survivors

Retirees and LTD participants under age 65, eligible for coverage in the State Retiree Health Benefits Program, ineligible for Medicare and eligible for TRICARE may elect coverage under the plan if they enroll in the retiree group within 31 days of their retirement date. Eligible retirees who did not participate in the Health Plan as an active employee prior to retirement may enroll in single coverage at the time of retirement if they do so within 31 days of their retirement date.

Retirees, LTD Participants and Survivors must enroll for coverage through the State Health Benefit Program. However, they will be billed by and must make monthly premium payments directly to the Plan Administrator.

COORDINATING CARE

How the TRICARE Supplement Plan works with TRICARE

The TRICARE Supplement Plan and TRICARE are separate plans. However, TRICARE and the TRICARE Supplement Plan work together to maximize your benefits and minimize your out-of-pocket expenses. Not all services are covered by TRICARE and the TRICARE Supplement Plan.

Coordinating TRICARE, the TRICARE Supplement Plan and OHI

If you have OHI, your claims should be filed with the OHI first. If there is a balance on the claim, it should be filed with TRICARE for reimbursement. Be sure to include the explanation of benefits (EOB) statement from the OHI in your claim submission to TRICARE. If there is a cost share balance that you are responsible for paying after TRICARE pays, you may submit your claim including the TRICARE EOB to ASI for secondary claims filing of the TRICARE Supplement Plan benefits. If after TRICARE pays, there is no balance that you are responsible for paying, the TRICARE Supplement Plan will not pay.

Coordinating TRICARE and the TRICARE Supplement Plan outside the U.S. and its Territories

TRICARE Standard works the same overseas as it does in the United States. If you are enrolled in TRICARE Prime and travel overseas, TRICARE recommends that you change to Standard for the freedom and flexibility of selecting a provider.

How are Benefits Determined?

When you see a TRICARE-authorized provider, you have no out-of-pocket cost for most health care services covered by TRICARE and the TRICARE Supplement Plan. Your claim will be processed in the following ways:

TRICARE pays all but any deductible amount and the cost share or copayment. After TRICARE pays, the TRICARE Supplement Plan pays your TRICARE deductible, cost share or copayment amounts. You pay nothing for services covered by both TRICARE and the Supplement Plan.

1. If you receive care for services that are covered by TRICARE and by the TRICARE Supplement Plan, you have no liability.
2. If you receive care for services that are covered by TRICARE, but not covered by the supplement plan, you are responsible for any balance after TRICARE pays.
3. If TRICARE does not cover the service, the expense is also not covered by the TRICARE Supplement Plan. You are responsible for payment of such expenses.
4. If you have OHI, the order of benefits is:
 1. OHI primary
 2. TRICARE secondary
 3. TRICARE Supplement Plan tertiary

When TRICARE is your primary health benefit option, you must follow the TRICARE rules and procedures before seeking medical care. As the primary payer, TRICARE approves health care services for payment. If TRICARE determines that the service is not medically necessary or does not pay the claim for other reasons, then the TRICARE Supplement Plan also does not pay. If after further review, TRICARE pays the claim, then the TRICARE Supplement Plan will also pay the claim.

HOW TO FILE YOUR TRICARE SUPPLEMENT CLAIM

The TRICARE Supplement Plan covers services that are covered by TRICARE. It pays the following costs that you are responsible for paying after TRICARE pays:

- Deductibles
- Cost Shares
- Copayments
- Excess Charges

You must see providers that are TRICARE-authorized and your claims must be submitted to TRICARE first.

Claims Submission

According to TRICARE most providers file claims for TRICARE beneficiaries. Approximately, 90% of providers also file TRICARE Supplement claims to the Plan Administrator. Filing your TRICARE Supplement Claim will depend on whether or not you have selected a participating or non-participating provider and if the provider will or will not file your supplement claim.

Remember, your TRICARE Supplement Plan pays secondary to TRICARE. Therefore, your claims for medical expenses must be submitted to TRICARE for primary processing. After processing your claim, TRICARE will send you and your participating provider copies of your TRICARE Explanation of Benefits (EOB) statement. The TRICARE EOB shows the name of the service provider, date of service, billed amount, TRICARE Allowed Amount, payment, deductible and cost share amounts. Either you or your health care provider must submit claims to the Plan Administrator.

To obtain your supplement benefits, a claim should be submitted to the Plan Administrator either by you or your medical provider (doctor, lab, hospital, ambulance, etc.).

How to file a claim for Doctors/Hospital Cost Shares

Claims submission MUST include the following:

To File Claims for Cost Shares

1. Complete your claim form with your member ID number, name, address and patient's name, if applicable;
2. attach a copy of your provider's bill showing the diagnosis, provider's name, address and Tax identification number;
3. attach a copy of the corresponding TRICARE EOB. If payment should go to the provider, write "Pay Provider" on the EOB and
4. mail to the claims address below.

To file Claims for Prime copayments:

1. Complete your claim form with your Member ID number, name, address and patient's name, if applicable;
2. attach a copy of your Prime copayment receipt;
3. attach a copy of the corresponding provider's bill showing the diagnosis, provider's name, address and Tax identification number and
4. mail to the claims address below.

Prescription Drug Cost Shares (Network and Home Delivery)

To file Claims for Prescription Drug Copayments:

1. Complete your claim form with your Member ID number, name, address and patient's name, if applicable;
2. attach a copy of your prescription drug copayment receipt showing the name of the drug, date filled, referring doctor, NDC product number and copayment amount, or
3. request a print-out of your prescription drug charges from your pharmacy;
4. mail all the above information to ASI at the claims address indicated.

When a TRICARE Non-network Pharmacy is used:

1. Complete your claim form with your Member ID number, name, address and patient's name, if applicable;
2. attach a copy of the TRICARE EOB;
3. attach a copy of the prescription drug receipt (showing the name of the drug, date filled, referring doctor's name, NDC product number and billed amount) and
4. mail all the above information to ASI at the claims address indicated.

Please note: when purchasing prescription drugs, you must provide the pharmacy with your uniformed services ID card for claims filing to TRICARE. Most pharmacies will file your TRICARE claim. However, you will be required to file a claim with the supplement plan for reimbursement of your copayment amount.

Claim Submission Period

Claims must be submitted to ASI for reimbursement of your TRICARE out of pocket expenses. Either you or your healthcare providers may submit the claims. Claims must be submitted to the Plan Administrator within 15 months of the later of:

- a)The date of service (when using Prime copayment receipt);
- b)The date on which TRICARE processed the claim (date found on TRICARE EOB) or
- c)The date your prescription is purchased.

Expenses submitted more than 15 months after the dates mentioned above are not covered.

Claims submission address:

Association & Society Insurance Corporation
Claims Department
P.O. Box 2510
Rockville, MD 20847

When you see a TRICARE Provider the following should occur:

1. Give your provider a copy of your uniformed services ID card for primary claims filing to TRICARE,
2. a copy of your TRICARE Supplement Plan ID card for secondary claims filing to ASI, and
3. ask your provider to submit claims for you.

If your healthcare provider will not submit your supplement plan claim, you are responsible for submitting these claims to ASI.

Claims Payment Errors

Every effort is made to process claims promptly and correctly. If payments are made to you, or on your behalf, and ASI finds, at a later date, that the payments were incorrect, ASI will make any necessary adjustments. You or your provider must reimburse ASI for any overpayment. A written notice will be sent to you or the provider if repayment is required.

Claim Forms

Claim forms are included in your "Welcome Packet" issued to you following your enrollment. You may also download claim forms from ASI's web site at www.asicorporation.com or call us at 1-866-637-9911 to request them.

TRICARE Supplement Plan Explanation of Benefits (EOB)

The TRICARE Supplement Plan EOB is not a bill. It is an itemized statement that shows the action taken on your claim. You should always keep a copy of the EOB for your records.

After reviewing the EOB, if you believe your claim was incorrectly processed or denied, you have the right to request an appeal (see claims and appeal procedures section on page).

See Page 34 for a sample copy of a TRICARE Supplement Plan EOB.

HOW TO ACCESS CARE

TRICARE Providers

You may obtain healthcare services from any TRICARE-authorized provider. These include network, non-network, participating or nonparticipating providers. **TRICARE-authorized providers** meet TRICARE's licensing and certification requirements and are certified to provide care to TRICARE beneficiaries. **TRICARE network providers** sign a contract with the regional contractor to be part of the network of providers who participate in the TRICARE program.

You will receive care from a network provider if you:

- Use TRICARE Extra
- Use TRICARE Retired Reserve
- Enrolled in TRICARE Prime

TRICARE non-network providers do not sign a contract with the regional contractor. A non-network provider may be participating or non-participating. Non-network providers may determine whether they are participating or non-participating on a claim by claim basis.

A TRICARE participating provider agrees to file claims for the TRICARE beneficiaries and accepts the TRICARE allowed amount as payment in full and will not bill the patient for amounts above the TRICARE allowable.

A TRICARE non-participating provider does not agree to accept the TRICARE allowed amount as payment in full and may charge up to 115% of the TRICARE allowed amount. If the non-participating provider bills you for excess charges (amounts above the TRICARE allowed amount) for covered services, the TRICARE Supplement Plan will pay such amounts.

You will receive care from a non-network provider if you:

- Use TRICARE Standard
- Use TRICARE Retired Reserve
- Enrolled in TRICARE Prime and use the POS option

Finding a TRICARE Provider

You may locate a TRICARE provider by:

Network Providers:

- Contacting the regional contractor in the region where you reside
- Accessing your regional contractor web site (see page 6 for contact information)
- Accessing the TRICARE web site at <http://www.tricare.mil/providerdirectory/>

According to TRICARE, there are over 325,000 network providers in the United States and its territories.

Non-network Providers:

- Checking the yellow pages
- Checking AMA doctor finder
- Asking a friend, family member, coworker or your current provider
- Contacting a local provider and asking if he/she accepts TRICARE.

ADVANTAGES OF THE TRICARE SUPPLEMENT PLAN

- No pre-existing condition limitations
- No age banded rates
- Stable rates – no yearly rate increases
- One family rate
- No referrals required for specialists care
- No prior authorization necessary – as long as TRICARE authorizes the service, it will be covered by the TRICARE Supplement Plan.
- Pays the TRICARE deductible, cost shares and applicable excess charges for TRICARE covered services
- No supplement plan deductible
- Supplements all three TRICARE options
- Prompt claims processing –generally within 10 business days
- Claims timely filing requirement – within 15 months from the date TRICARE processed the claim (date on TRICARE EOB or date prescription is filled)
- Available in all states
- Worldwide coverage
- Guaranteed renewable - your plan administrator cannot cancel your coverage or increase your premiums based on the number of claims you file. Any rate change will apply to all members of the same class of insureds under your plan.

Enrolling in the TRICARE Supplement Plan helps to provide you with greater flexibility to seek care from any civilian TRICARE-authorized (network or non-network) provider.

Please note: the above information is applicable to the TRICARE Supplement Plan. TRICARE is your primary health benefit option, you must follow TRICARE's requirement for care.

Type of Care

The TRICARE Supplement Plan covers most services that are medically necessary and considered proven. TRICARE and the TRICARE Supplement Plan coverage include but are not limited to the following services:

Outpatient Services

- Ambulance Services
- Ancillary Services
- Durable Medical Equipment, prosthetics, orthotics and supplies (DMEPOS)
- Emergency Services
- Home Health Care
- Individual Provider Services
- Laboratory and X-ray Services

Inpatient Services

- Hospitalization
- Skilled Nursing Facility Care
- Ancillary Services

Behavioral Health Care Services

- Outpatient
- Inpatient
- Substance Use (alcoholism, drug addiction)

Prescription Drug Charges

- Civilian Retail Network Pharmacy (30-day supply)
- Civilian Retail non-network Pharmacy (30-day supply)
- Mail Order Pharmacy (90-day supply)

To learn more about the services covered by TRICARE, you may visit the TRICARE web site at www.tricare.mil .

Routine Physicals

Routine Sports physicals are not covered under the TRICARE Supplement Plan. However, the Plan covers comprehensive clinical preventative services after TRICARE covers these services. For clinical preventive exams to be covered by TRICARE, they must include an immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening.

School enrollment physicals for children ages 5-11 are covered.

Plan Benefits

The TRICARE Supplement Plan covers services that are covered by TRICARE.

The plan pays the following benefits after TRICARE Standard or Extra pays for Covered Expenses:

- 100% of the TRICARE Standard Outpatient Deductible of \$150 individual (maximum \$300 per family)
- 100% of the TRICARE Standard/Extra cost share/copayments
- 100% of Covered Expense in Excess of the TRICARE Allowed Amount

The plan pays the following benefits after TRICARE Prime or Point of Service (POS) pays for Covered Expenses:

- 100% of the TRICARE Prime copayment and cost shares
- 50% of the TRICARE POS Deductible of \$300 individual (\$600 family)
- 100% of the TRICARE POS cost share
- 100% of Covered Expense in Excess of the TRICARE Allowed Amount

Summary of Benefits Chart

See pages 20 – 23 for a more detailed summary of benefits provided under the TRICARE Supplement Plan.

Prescription Drug Coverage

The TRICARE Supplement Plan helps to pay the prescription drug copayments when you use the following:

TRICARE Retail Network Pharmacy – up to a 30-day supply for most medications

- \$5 for generic formulary medications.
- \$12 for brand name formulary medications.
- \$25 for non-formulary medications.

According to TRICARE there are over 60,000 retail network pharmacies in the United States and its territories.

When you use a retail network pharmacy, present the pharmacist with your uniformed services ID card for primary claims filing. Express Scripts is the administrator for the TRICARE prescription drug program. If you experience problems with filling your prescription at a retail network pharmacy, you must contact Express Scripts at 1-877-363-1303 or access the Express Scripts web site at <http://www.express-scripts.com/TRICARE>.

TRICARE Pharmacy Home Delivery – up to a 90-day supply for most medications

- \$9 for brand name formulary medications
- \$25 for non-formulary medications

Per TRICARE, you must register to use the Home Delivery option. You have three options for registering:

1. Online with Express Scripts using the TRICARE Mail Order activation process.
2. By phone – call 1-877-363-1303 to request a registration form.
3. By mail – download the registration form from TRICARE web site www.tricare.mil and mail to:
Express Scripts, Inc.
P.O. Box 52150
Phoenix, AZ 85072-9954

Note: Express Scripts require that you include the written prescription and appropriate copayment when you mail your registration to them.

TRICARE Non-network Pharmacy – up to a 30-day supply for most medications

- Pay the full price for your medication and file a claim with TRICARE for reimbursement.
- Reimbursement is subject to the TRICARE deductible or out-of-network cost shares and TRICARE required cost shares.

See TRICARE web site at <http://tricare.mil/mybenefit/home/Prescription/Claim> for information on filing a non-network claim. For more detailed information on the prescription drug coverage, contact Express Scripts at 1-877-363-1303 or access the Express Scripts web site at <http://www.express-scripts.com/TRICARE>.

SUMMARY OF PLAN BENEFITS

This chart shows what You Pay for Deductibles, Cost Shares, Copayments and Excess Charges after TRICARE Standard/Extra and the TRICARE Supplement Plan pay.

<u>Fiscal Year Deductible</u>	<u>TRICARE Standard Outpatient Deductible</u>	<u>TRICARE Supplement Plan</u>	<u>You Pay</u>
October 1 – September 30	\$150 per person/\$300 per family	Pays 100% of Standard Outpatient Deductible	\$0

<u>Type of Service</u>	<u>TRICARE Standard/Extra Pays</u>	<u>TRICARE Supplement Plan Pays</u>	<u>You Pay</u>
Inpatient Facility Services (Room, Board, Supplies and Staff services)	Standard: All but \$535 per day / 75% of Allowed Amount; Extra: All but \$250 per day / 80%; whichever is greater	Standard: \$535 per day or 25% cost share Extra: \$250 per day or 20% cost share	\$0
Inpatient Professional Services (Doctors and other inpatient services not billed by the hospital)	Standard: 75% Extra: 80%	Standard: 25% Extra: 20%	\$0
Emergency Room	Standard: 75% Extra: 80%	Standard: 25% Extra: 20%	\$0
Government Hospital	Standard/Extra: All but \$16.30 per day subsistence fee	Standard/Extra: \$16.30 per day subsistence fee	\$0
Skilled Nursing Facility (Inpatient)	Standard: 75% institutional services Extra: All but \$250 per day or 80% of institutional cost	Standard: 25% Extra: \$250 per day or 20% of institutional cost	\$0
Skilled Nursing Facility (Professional fees)	Standard: 75% Extra: 80%	Standard: 25% Extra: 20%	\$0
Outpatient Services (Office visits, Clinics, Labs, X-Rays, Surgeries)	Standard: 75% Extra: 80% After Standard Outpatient Deductible is met	Standard: 25% Extra: 20% Plus 100% Standard Outpatient Deductible and 100% of Covered Excess Charges	\$0
Ambulance Services	Standard: 75% Extra: 80% After Standard Outpatient Deductible is met	Standard: 25% Extra: 20% Plus 100% Standard Outpatient Deductible and 100% of Covered Excess Charges	\$0
Ambulatory Surgery (Same Day)	Standard: 75% Extra: 80% After Standard Outpatient Deductible is met	Standard: 25% Extra: 20% Plus 100% Standard Outpatient Deductible and 100% of Covered Excess Charges	\$0

<u>Type of Service</u>	<u>TRICARE Prime/POS Pays</u>	<u>TRICARE Supplement Plan Pays</u>	<u>You Pay</u>
Durable Medical Equipment	Standard: 75% Extra: 80% After Standard Outpatient Deductible is met	Standard: 25% Extra: 20% Plus 100% Standard Outpatient Deductible and 100% of Covered Excess Charges	\$0
Maternity Care	Standard: 75% Extra: 80% After Standard Outpatient Deductible is met	Standard: 25% Extra: 20% Plus 100% Standard Outpatient Deductible and 100% of Covered Excess Charges	\$0
Preventive Services	Standard: 75% Extra: 80% After Standard Outpatient Deductible is met	Standard: 25% Extra: 20% Plus 100% Standard Outpatient Deductible and 100% of Covered Excess Charges	\$0
Behavioral Health <u>Inpatient</u> (Nervous, Mental, Emotional Disorder, Alcoholism, Drug Addiction)	High Volume Standard: 75% Extra: 80% Low Volume Standard: All but \$202 per day or 75% of billed charges Extra: 80%	High Volume Standard: 25% Extra: 20% Low Volume Standard: \$202 per day or 25% of billed charges Extra: 80%	See Limitations on page 26
Behavioral Health <u>Outpatient</u> (Nervous, Mental, Emotional Disorder, Alcoholism, Drug Addiction)	Standard: 75% Extra: 80% After Standard Outpatient Deductible is met	Standard: 25% Extra: 20% Plus 100% Standard Outpatient Deductible and 100% of Covered Excess Charges Up to \$500 per Fiscal Year per	Amount above \$500 per Fiscal Year per person (see limitations on page 26)
Prescription Drugs Civilian Network – up to a 30-day supply	Standard/Extra: All but the copayment amounts of \$5 generic, \$12 brand name or \$25 non-formulary	Standard/Extra: Copayments of \$5 generic, \$12 brand name or \$25 non-formulary	\$0
Prescription Drugs Home Delivery – up to a 90-day supply	Standard/Extra: All but the copayment amounts of \$9 brand name or \$25 non-formulary	Standard/Extra: Copayments of \$9 brand name or \$25 non-formulary	\$0
Prescription Drugs Civilian Non-network - up to a 30-day supply	Standard only: all but the \$12 (20% generic/brand name) or \$25 (20% non-formulary) copayment, whichever is greater after Standard Outpatient Deductible	Standard only: \$12 generic/brand name (\$25 for non-formulary) or 20% of total cost plus 100% Standard Outpatient Deductible	\$0

SUMMARY OF PLAN BENEFITS

This chart shows what You Pay for Deductibles, Cost Shares, Copayments and Excess Charges after TRICARE Prime /Point-of-Service (POS) and the TRICARE Supplement Plan Pay.

<u>Fiscal Year Deductible</u>	<u>TRICARE POS Outpatient Deductible</u>	<u>TRICARE Supplement Plan</u>	<u>You Pay</u>
October 1 – September 30	\$300 per person/\$600 per family	\$150 individual /\$300 family	\$150 individual / \$300 family

<u>Type of Service</u>	<u>TRICARE Prime/POS Pays</u>	<u>TRICARE Supplement Plan Pays</u>	<u>You Pay</u>
Inpatient Facility Services (room, board, supplies and staff services)	Prime: All but \$11 copayment per day (\$25 minimum Charge POS: 50% Allowed Amount	Prime: \$11 copayment per day (\$25 minimum charge) POS: 50% cost share	\$0
Inpatient Professional Services (doctors and other inpatient services not billed by the hospital)	POS: 50% Allowed Amount	POS: 50% cost share	\$0
Emergency Room	Prime: All but \$30 copayment POS: 50% Allowed Amount	Prime: \$30 copayment POS: 50% cost share	\$0
Government Hospital	Prime: All but \$16.30 per day subsistence fee	Prime: \$16.30 per day subsistence fee	\$0
Skilled Nursing Facility (Inpatient)	Prime: All but \$11 per day (\$25 minimum charge POS: 50% Allowed Amount	Prime: \$11 per day (\$25 minimum charge POS: 50% cost share	\$0
Skilled Nursing Facility (Professional Fees)	POS: 50% Allowed Amount	POS: 50% cost share	\$0
Outpatient Services (Office visits, Clinics, Labs, X-Rays)	Prime: All but \$12 copayments POS: 50% after POS Deductible is met	Prime: \$12 copayments POS: 50% cost share and 50% POS Deductible plus 100% of Covered Excess Charges	50% POS Deductible
Ambulance Services	Prime: All but \$20 copayment POS: 50% Allowed Amount after POS Deductible is met	Prime: \$20 copayment POS: 50% cost share and 50% POS deductible plus 100% of Covered Excess Charges	50% POS Deductible
Ambulatory Surgery (Same Day)	Prime: All but \$25 copayment POS: 50% Allowed Amount after POS Deductible is met	Prime: \$25 copayment POS: 50% cost share and 50% POS Deductible plus 100% of Covered Excess Charges	50% POS Deductible

<u>Type of Service</u>	<u>TRICARE Prime/POS Pays</u>	<u>TRICARE Supplement Plan Pays</u>	<u>You Pay</u>
Durable Medical Equipment	Prime: 80% Allowed Amount POS: 50% Allowed Amount after POS Deductible	Prime: 20% copayment POS: 50% cost share plus 50% POS Deductible	50% POS Deductible
Maternity Care	POS: 50% Allowed Amount after POS Deductible	POS: 50% cost share plus 50% POS Deductible	50% POS Deductible
Preventive Services	POS: 50% Allowed Amount after POS Deductible when non-participating doctors are used	POS: 50% cost share plus 50% POS Deductible	50% POS Deductible
Behavioral Health Inpatient (Nervous, Mental, Emotional Disorder, Alcoholism, Drug Addiction)	Prime: All but \$40 copayment per day POS: 50% Allowed Amount	Prime: \$40 copayment per day POS: 50% cost share	See Limitations on page 26
Behavioral Health Outpatient (Nervous, Mental, Emotional Disorder, Alcoholism, Drug Addiction)	Prime: Group Therapy – all but \$17 per day. Individual/Family Therapy – all but \$25 per day POS: 50% after POS Deductible	Prime: Group Therapy - \$17 copayment per day Individual/Family Therapy \$25 copayment per day POS: 50% cost share plus 50% POS Deductible Up to \$500 per person per fiscal year	Amount above \$500 per Fiscal Year per person (see limitations on page 26)
Prescription Drugs Civilian Network – up to a 30-day supply	Prime: All but the copayment amounts of \$3 generic, \$9 brand name or \$22 non-formulary	Prime: \$3 generic, \$9 brand name or \$22 non-formulary copayment	\$0
Prescription Drugs Home Delivery – up to a 90-day supply	Prime: All but the copayment amounts of \$3 generic, \$9 brand name or \$22 non-formulary	Prime: \$3 generic, \$9 brand name or \$22 non-formulary copayment	\$0
Prescription Drugs Civilian Non-network - up to a 30-day supply	POS: all but the \$9 (20% brand name) or \$22 or 20% non-formulary) copayment, whichever is greater after POS Deductible is met	POS: \$9 brand name (\$22 for non-formulary) or 20% of total cost plus 50% of POS Deductible	50% POS Deductible

Reminder: The TRICARE Supplement Plan pays secondary to TRICARE. Expenses must be covered by TRICARE in order to be covered under the supplement plan. Your claims must be filed with TRICARE first.

REFERRALS AND AUTHORIZATIONS

Referrals

If you use TRICARE Standard and Extra, you do not need a referral to see a specialist since under these options you manage your own health care. You can see any TRICARE-authorized provider you choose.

If you are enrolled in TRICARE Prime, you must contact your PCM for a referral to see a specialist. If no referral is received, you are using the POS option.

Referrals are not required for the TRICARE Supplement Plan.

Prior Authorization

You or your provider may be required to obtain prior-authorization from TRICARE for certain services. No separate prior authorization is required by the TRICARE Supplement Plan. Check with your TRICARE Service Center (TSC) for detailed information about treatments, services and procedures that may require pre-authorization. You may wish to verify with TRICARE or your provider that approval was obtained or required. As long as TRICARE has approved and covered the services, the TRICARE Supplement Plan will pay the supplemental benefits

EXCLUSIONS AND LIMITATIONS

Exclusions

1. injury or sickness resulting from war or act of war, whether war is declared or undeclared;
2. intentionally self-inflicted injury;
3. suicide or attempted suicide, whether sane or insane (in Colorado and Missouri while sane);
4. routine physical exams, unless required for school enrollment (but not sports physicals) by a Covered Child age 5 through 11 and immunizations, except that these services are covered when rendered to a Covered Child who is less than 6 years of age;
5. domiciliary or custodial care;
6. eye refractions and routine eye exams except when rendered to a child up to 6 years from the child's birth;
7. eyeglasses and contact lenses;
8. prosthetic devices, except those covered by TRICARE;
9. cosmetic procedures, except those resulting from Sickness or Injury;
10. hearing aids;
11. orthopedic footwear;
12. care for the mentally incapacitated or physically handicapped if the care is required because of the mental incapacitation or physical handicap;
13. drugs which do not require a prescription, except insulin;
14. dental care unless such care is covered by TRICARE, and then only to the extent that TRICARE covers such care;
15. any Confinement, service, or supply that is not covered under TRICARE;
16. hospital nursery charges for well newborn, except as specifically provided under TRICARE;
17. any routine newborn care except Well Baby Care, as defined, for a child up to 6 years from the child's birth;
18. TRICARE eligible cost share and deductible amounts in excess of the TRICARE cap;
19. expenses which are paid in full by TRICARE;
20. treatment for the prevention or cure of alcoholism or drug addiction except as specifically provided under TRICARE and the Policy;
21. any part of a covered expense which the Covered Person is not legally obligated to pay because of payment by a TRICARE alternative program;
22. any claim under more than one of the TRICARE Supplement Plans, or under more than one Inpatient benefit or more than one Outpatient Benefit of the TRICARE Supplement Plans. If a claim is payable under more than one of the stated Plans or Benefits, payment will only be made under the one that provides the highest coverage.

Limitations

Nervous, Mental, Emotional Disorder, Alcoholism, and Drug Addiction Limits

The coverage provided under the Inpatient Benefits of the TRICARE Supplement for nervous, mental, emotional disorders, including alcoholism and drug addiction, is limited to:

- a)** 30 Inpatient treatment days for a
Covered Person age 19 or older; or
- b)** 45 Inpatient treatment days for a
Covered Person under age 19; per Fiscal Year

This Inpatient limit is based on the number of days TRICARE normally provides each Fiscal Year for such Confinements.

In rare instances, TRICARE extends these daily limits. If this occurs, we will limit the number of days that we provide for such Confinement to the lesser of:

- a)** the number of days TRICARE pays for such
Inpatient treatment during the Fiscal Year; or
- b)** 90 Inpatient days per Fiscal Year

The coverage provided under the Outpatient Benefits Of the TRICARE Supplement Plan for:

- a)** Nervous, mental and emotional disorders and or;
 - b)** Alcoholism and drug addiction;
- is limited to \$500 during any Fiscal Year for all such disorders.

TERMINATION AND PORTABILITY

Termination

A Covered Person's coverage under the Policy will cease on the first to occur of:

- 1) the date the Policy terminates or the date the Organization ceases to be a Participating Organization of the Policyholder;
- 2) the date the required premium is not paid, subject to the Grace Period provision;
- 3) the date you cease to be a member of the Organization;
- 4) the first day of the month on or next following the date the dependent ceases to be an Eligible Spouse or an Eligible Child;
- 5) the date we or the Organization cancel coverage for a Class of Eligible Person to which the Covered Person belongs;
- 6) the date the Covered Person becomes eligible for Medicare unless the Covered Person resides in an area where Medicare is not available, in which case coverage will not terminate until the Covered Person returns to residency in an area where Medicare is available;
- 7) if a child, the date the child attains age 21, age 23 if the child is enrolled full-time at a school of higher learning or age 26 if enrolled in TYA.
- 8) The date a Covered Person ceases to be covered under TRICARE.

Termination of coverage will be without prejudice to any claim which originated before the effective date of termination.

If you are terminating your TRICARE Supplement Plan coverage, you must notify your HR Representative, your Employer's Benefits Center; or Service Center who will submit your termination requests to ASI. Following receipt of your termination, you will be invited to continue your coverage on portability directly with the Plan Administrator.

Your ability to terminate coverage is limited to Open Enrollment periods and to events qualifying as a change in family status when termination of coverage is consistent with the change in family status.

Age 65

At age 65 when the employee and/or spouse become eligible for Medicare and TRICARE for Life, eligibility for the Supplement Plan ends. The TRICARE Supplement Plan will terminate automatically for employees or spouses and/or dependents who reach their maximum age. You will be notified by letter 60 days prior to your termination date of the pending termination.

If you or your spouse is ineligible for Medicare, you may continue coverage under the Plan past your 65th birthday. To continue coverage you must notify your Employer and provide them with your "Notice of Disallowance" from the Social Security Administration. Your employer will notify ASI of this information.

If your Employer will not continue coverage for your spouse and dependent children after you attain Medicare eligibility, you may choose to continue their coverage directly with ASI through portability.

Age 21/23

TRICARE Supplement coverage for dependent Children who attain age 21 will not end unless termination request is received from the Employee. Coverage will continue until under age 23 or when full-time student status ends, whichever comes first. For example, if your dependent child attains age 23 on February 1 but does not graduate until June, coverage ends at midnight on January 31. You will be notified of the pending termination sixty (60) days prior to the termination date. To continue coverage for your incapacitated dependent, contact your Employer with proof of your dependent's status.

Age 26

If your young adult dependent enrolls in TYA, he/she is eligible to enroll in the TRICARE Supplement Plan for extended coverage up to under age 26. Sixty (60) days prior to the 26th birthday you will be notified of your dependent's pending termination date.

Portability

The TRICARE Supplement Plan is portable. Portability is your right to continue enrollment in the plan, if you leave employment for any reason. Upon enrollment, you will be informed of this right.

This means that your and your spouse's TRICARE Supplement Plan coverage may be continued through ASI for as long as needed or until you attain Medicare eligibility, whichever comes first, providing your monthly premium is paid. Your dependent children's coverage can also be continued until their 21st (23rd birthday, if a full-time student) unless that child is mentally or physically incapacitated and continues eligibility for TRICARE through DEERS or enrolled in TRICARE Young Adult program.

Following receipt of a qualifying event (termination or leave of absence), you and/or your covered dependents will be notified within 14 days of your ability to continue on portability and be provided with the portability form.

When you enroll on portability you will not be billed any additional cost for administration. You will pay the same cost paid as an active employer except the premium will be post-tax. Your monthly premium cost should be paid directly to ASI by electronic fund transfer (EFT) from your checking account.

Note: Portability is not applicable to an employee, spouse or dependent child who no longer meets TRICARE eligibility requirements, e.g., an employee or spouse who attains his/her 65th birthday and is eligible for Medicare, a divorce spouse who loses TRICARE eligibility or a dependent child who is no longer registered in DEERS.

Continued Health Care Benefit Program (CHCBP)

CHCBP is a premium-based health care program administered by Humana Military Healthcare Services, Inc. TRICARE beneficiaries who qualify will be provided with continued health care coverage for 18 to 36 months after loss of military health benefits. CHCBP is available to unremarried former spouses and adult children who are no longer eligible for military benefits.

Although CHCBP is not a TRICARE program, the coverage, benefits, providers and program rules are similar to TRICARE Standard.

Those who purchase CHCBP coverage will apply for continued coverage under the TRICARE Supplement Plan for the same period of time as CHCBP.

CLAIMS AND APPEALS PROCEDURES

When will ASI Decide Your Claim

When ASI receives a claim, it will review the claims and determine if any additional information is needed. Once a claim is properly submitted, if the claim is wholly or partially denied, you will be notified of ASI's decision within a reasonable period of time, not to exceed thirty (30) days. If additional time is needed due to special circumstances, or if a hearing is necessary, you will be notified in writing of the reason for the extension before the end of the initial thirty (30) day period, and advised of when ASI expects to reach a decision.

ASI may request an additional fifteen (15) days to respond in writing to your claim before the expiration of the initial thirty (30) day period, and will explain the special circumstances that require the additional time. However, the decision on the initial claim will not exceed the total time period of forty-five (45) days to provide the requested information. ASI's time to decide the claim will be tolled pending receipt of the requested information.

Claim Denial and Review

If your claim is denied (in whole or in part) and you feel the denial is wrong, you can request an appeal. Your request must be in writing and must include the reasons you believe your claim was improperly denied. You may include additional information to support your claim. You will have one hundred eighty (180) days from the date you receive the notice to request your appeal of the denial (in whole or in part) of your claim.

During the course of the claim review, you have the right to see any non-privileged document or information that affects your specific claim. At your request, and free of charge, you will be given reasonable access to and copies of all documents, records, and other information relating to your claim for benefits that is non-privileged. The review will include any written comments or other items you submit to support your claim. The review will not give deference to the initial denied decision.

Appeals should be submitted to the following mailing address, email address or fax number:

Mailing address:

Association & Society Insurance Corp.
Claims Department
P.O. Box 2510
Rockville, MD 20847

Email address: custsvc@asicorporation.com

Toll free fax #: 1-800-311-3124

How Soon Must ASI Decide an Appeal

ASI will consider all available evidence in connection with the denied claim and issue a decision to you in writing within a reasonable period of time, but not later than sixty (60) days after ASI receives your request for review. The notification of the denial (in whole or in part) of your claim must advise you in writing or electronically of the reasons for the denial, and refer to the specific Plan provisions, and internal rules and guidelines on which the decision was based. You are entitled to receive copies of all non-privileged documents, records, and other information relating to your request and at no charge.

You must exhaust the claims appeal process before filing a suit for benefits. The review will include any written comments or other items you submit to support your claim. The review will not give deference to the initial denied decision.

Right to Receive and Release Necessary Information

The employer and Plan Administrator without consent or notice, release to or obtain from any insurance company, person or entity, any information that may be necessary to process a claim or obtain benefits. Any documentation not provided may result in a denial of a claim or benefit.

Time Limits on Legal Actions

No action in law or in equity may be brought until sixty (60) days after you have given Plan Administrator Proof of Loss. No such action may be brought after expiration of the applicable statute of limitations from the earlier of the date ASI receives Proof of Loss or the time within which Proof of Loss is required to be given.

ADDITIONAL INFORMATION

Qualified Medical Support Orders (QMCSO)

The Plan will comply with the terms of any Qualified Medical Child Support Order as long as the child is eligible for TRICARE. In general, a Qualified Medical Child Support Order creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient, the right to receive benefits for which a participant or beneficiary is eligible under the Plan. Upon the Plan's receipt of a medical child support order, the Participant whose benefits are or may be affected, and any alternate recipient named in the medical child support order, will be given a copy of the qualified medical child support order procedures adopted by the Plan. ASI will promptly review the order and, if it is "qualified" and satisfies the terms of the Plan, administer the order in accordance with its terms.

Right to Employment

This TRICARE Supplement Plan is strictly a voluntary undertaking on the part of your Employer and shall not be deemed to constitute a contract between the employer and any employee, or to be consideration for, or an inducement to, or a condition of employment of any employee. Nothing contained in the Plan shall be deemed to give any employee the right to be retained in the employ of the employer or to interfere with the right of the employer or to interfere with the right of the employer to discharge any employee at any time. No person shall have any right to any benefits under the Plan, except to the extent expressly provided herein.

Plan Amendment and Termination

The Employer has established this Plan with the intention of it being maintained for an indefinite period of time and subject to changes by the insurance companies and third party claims administrators. However, the Employer reserves the right in its sole discretion.

- a) To alter, amend, or terminate this Plan, in whole or in part, at any time,
- b) To alter, amend, or terminate retiree benefits (if any) of this Plan, in whole or in part, at any time, and
- c) To change, increase, or decrease Plan contributions (if any), in whole or in part, at any time.

Any amendment or creation of benefits in the Plan will be consistent with the provisions of any applicable collective bargaining agreement. The Plan is subject to policy provisions of the various insurance companies and third party claims administrators providing their respective coverage.

Administration

ASI is both the Plan Administrator and the Claims Administrator for the TRICARE Supplement Plan. The Plan administrator has full discretion and authority to: administer the Plan; interpret the plan; determine eligibility based on TRICARE's eligibility requirements and your employer's eligibility requirements; determine the status and rights of participants, beneficiaries and other persons; make rulings; make regulations and prescribe procedures status and rights of participants, beneficiaries and other persons; to make rulings; make regulations and prescribe procedures; needed information; prescribe forms; exercise all of the power and authority contemplated by the Internal Revenue Code with respect to the Plan; employ or appoint persons to help or advise in any administrative functions; appoint investment managers and trustees; and generally do anything needed to operate, manage and administer the Plan. The Plan Administrator reserves the right to change employee contributions.

ASI is the Claims Administrator for both initial claims and appeals. For deciding both initial claims and appeals, ASI has full discretion and authority to interpret the Plan, to determine eligibility for and the amount of benefits as indicated in the Certificate of Insurance, and to determine the status and rights of participants, beneficiaries and other persons. ASI's determinations are final and may not be overturned by a court of law unless arbitrary and capricious.

The Plan is fully insured and underwritten by the Insurer, Monumental Life Insurance Company and Transamerica Financial Life Insurance Company for NY residents only. Monumental Life Insurance Company and Transamerica Financial Life Insurance Company have financial responsibility for and full discretion and authority to determine the benefits.

The Plan has other advisors and service providers. The Plan Administrator may delegate responsibilities to others. Any allocation of delegation must be done in writing and kept with the records of the Plan.

Each fiduciary is solely responsible for its own improper acts or omissions. A fiduciary is not liable for breach of fiduciary duty committed before it became, or after it stopped being a fiduciary.

Cooperation

As a condition to obtaining benefits under this Plan, you agree to cooperate in the Plan's administration and to complete documents or fulfill other requests by the Plan administrator. Applying for or accepting benefits constitute agreeing to this provision.

Assistance with Your Questions

If you have questions about your Plan or about your rights or if you need assistance, contact the Plan Administrator at the following address:

Association & Society Insurance Corporation
Client Services Department
P.O. Box 2168
Rockville, MD 20847

If you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance on Inquiries, Pension and Welfare Benefits Administration U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 2010.

Qualifying Mid-Year Event

Changes to your membership may be made once you experience a valid qualifying change of status. See your Benefits Administrator with questions.

Open Enrollment

You may make changes to your membership or health benefits plan during Open Enrollment which is in the spring.

SAMPLE SCHEDULE OF INSURANCE AND ID CARDS

John A Doe
 1234 Any Street
 Any Town, USA 12345

SCHEDULE OF INSURANCE

American Military Retirees Association (MZ0925783H0000A)

MEMBER ID

111111

EFFECTIVE DATE

10/01/2011

Insurance Benefits Effective

ASI TRICARE Supplement Plan

Member	(Comprehensive)	YES
Spouse	(Comprehensive)	YES
Child	(Comprehensive)	YES

This Schedule Supercedes And Replaces Any Schedule Previously Issued.

This Schedule Was Prepared on 9/15/2011.

Premiums or Benefits May Change on Any Renewal Date.

Voluntary Benefits Provided by an Employer

FRONT OF ID CARDS

TRICARE/CHAMPVA SUPPLEMENT PLAN

Group #: C000-B
Member ID #: 111111
Policy #: MZ0925783H0000A
Member John A Doe
Coverage Member, Spouse, Child

Benefits, Eligibility and Claim Forms: www.asicorporation.com

Customer Service: 1-800-638-2610

TRICARE/CHAMPVA SUPPLEMENT PLAN

Group #: C000-B
Member ID #: 111111
Policy #: MZ0925783H0000A
Member John A Doe
Coverage Member, Spouse, Child

Benefits, Eligibility and Claim Forms: www.asicorporation.com

Customer Service: 1-800-638-2610

BACK OF ID CARDS

This card may be used to provide information regarding your coverage. This card is not a guarantee of coverage. Be sure your provider of care references your Member Number when submitting claim for benefits. Forward all claims to Administrator, not the insurance company.

NOTE TO HOSPITAL: If you wish to verify insurance coverage, call 1/800-638-2610 or access the website on the front of this card.

FORWARD ALL CLAIMS TO:

Association & Society Insurance Corp.
 P.O. Box 2510
 Rockville, MD 20847-2510

This card may be used to provide information regarding your coverage. This card is not a guarantee of coverage. Be sure your provider of care references your Member Number when submitting claim for benefits. Forward all claims to Administrator, not the insurance company.

NOTE TO HOSPITAL: If you wish to verify insurance coverage, call 1/800-638-2610 or access the website on the front of this card.

FORWARD ALL CLAIMS TO:

Association & Society Insurance Corp.
 P.O. Box 2510
 Rockville, MD 20847-2510

SAMPLE TRICARE SUPPLEMENT PLAN EXPLANATION OF BENEFITS (EOB) STATEMENT

Employer Name Underwriter Name Administered BY: Association & Society Insurance Corporation P.O. Box 2510 Rockville, MD 20847-2510 301-816-0045 800-638-2610 Mr. John Doe 1234 Any Street Any Town, USA 12345	PREPARED: 11/1/2011 Claim No. 20111 11700129.00 DAS POLICYHOLDER: John A Doe CLAIMANT: John A Doe PATIENT #: 0000111 MEMBER ID: 111111 COVERAGE: C000-B MZ0925783HXXXX CHECK NUMBER: Payment of benefits for services, as described below, has been made to your provider.
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Provider Benefit Type	Dates of Service From	To	Amount Billed	Primary Approved	Primary Payments	Primary Deduct	ASI Deduct	Excess	Non-Covered	Benefit Issued	Remark (Over)
Markway Regional Hospital Hospital Charge	10/10/11	10/10/11	238.00	115.60	0.00	115.60	0.00	0.00	0.00	115.60	

Year-To-Date ASI Deductible Applied: \$0.00 – Family; \$0.00 – Individual

Front – Explanation of Benefits Statement

- | | | | | |
|---|---|--|--|---|
| 1. Amounts Shown as "Non-Covered" were incurred prior to your effective date of coverage. Also, see remark #99 below.
2. Amounts shown as "Non-Covered" were incurred after termination of your coverage. Also, see remark #99 below.
3. Amounts shown as "Non-Covered" are service dates which fall within the time frame your coverage was not in force.
4. TRICARE reduced payment for failure to obtain Pre-Authorization. The provider cannot bill for the differences.
5. Amounts shown as "Non-Covered" are not covered expenses under your plan. See EOB comments.
6. Plan pays inpatient charges only.
7. Plan pays TRICARE Prime so-pays only.
10. Pharmacy receipt shows the total cost, not the TRICARE/CHAMPVA co-pay. Submit co-pay receipt of the TRICARE/CHAMPVA Explanation of Benefits for Reimbursement.
11. Pharmacy submission must include the name of drug, prescribing physician, date, fee and co-pay. | 12. Eligible Charges for Mental/Nervous conditions are limited to amount specified in your policy. The "Non-Covered" amount exceeds the plan maximum.
13. Your plan previously reimbursed the TRICARE/CHAMPVA Catastrophic Cap benefit. Please refer to TRICARE/CHAMPVA for review.
14. Total liability for services by providers who choose not to participate in TRICARE is limited to 115% of the allowable amount.
16. Please submit an itemized bill for services rendered by this provider. See EOB comments.
20. Please provide the diagnosis for this date of service.
21. Amounts shown as "non-Covered" relate to a condition that was treated prior to the effective date of coverage. Please refer to the Pre-Existing Condition provision of your policy.
22. Amounts shown as "Non-Covered" relate to a condition that was treated prior to the effective date of your increased benefits. Your increased benefit is subject to new Pre-Existing Condition period. Please refer to the Pre-Existing Condition provision of your policy. | 30. Charges submitted have been applied towards your plan deductible.
31. The Charges were previously considered with covered expenses applied to your plan deductible.
32. The charges were previously denied as your policy does not reimburse the TRICARE/CHAMPVA deductible.
33. Your policy does not reimburse the TRICARE fiscal year or CHAMPVA calendar year deductible.
34. The maximum TRICARE/CHAMPVA deductible payable under the plan was previously considered.
35. The TRICARE Point of Service deductible is not a covered expense under your plan.
36. The maximum TRICARE deductible covered under your plan was applied to your plan deductible.
40. This is an adjustment audit to issue additional benefits.
41. The Charges previously denied have been reconsidered and the attached check represents the benefits. | 50. This plan is a TRICARE/CHAMPVA supplement. All charges must first be processed by TRICARE or CHAMPVA.
51. Please furnish us with a copy of the Explanation of Benefits for the payment by TRICARE/CHAMPVA so that we can determine our liability.
52. the TRICARE Explanation of Benefits is incomplete. Please send us a copy showing the TRICARE allowed amount, amount paid, deductible and cost share.
53. These charges were previously considered. Please see EOB comments.
54. Claims must be received in a timely fashion to be eligible for consideration under your coverage.
55. Your policy does not provide benefits for services denied by TRICARE/CHAMPVA. Refer to your TRICARE/CHAMPVA Explanation of Benefits.
56. TRICARE denied as duplicate of a previously processed charge. Submit statement showing TRICARE's actual allowance and payment | 57. The TRICARE/CHAMPVA allowed amount has been paid in full by TRICARE/CHAMPVA. Therefore, no payment is due under your supplement plan.
60. Amount shown as "Non-Covered" represents payment by your Other Insurance Carrier.
70. Benefits are being issued to Insured member as we are unable to assign benefits to the provider without a complete address and tax identification number.
71. Your claim was separated for processing purposes and prompt handling. You will receive more than one Explanation of Benefits.
72. Due to lack of responses to our request for additional information, your file is being closed. Letter of explanation will follow. |
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Back – Explanation of Benefits Statement

99. Within 180 days after receipt of the Explanation of Benefits, you may request a review of the handling of this claim in connection with charges which were denied in accordance to plan provisions and limitations. If there are any such questions, please submit your comments in writing, or request a review of pertinent documents upon which the decision was based, and the matter will be given further consideration. Be sure to refer to the "Claim Submission Number".
- IL. If you wish to take this matter up with the Illinois Department of Insurance, you may contact The Consumer Division at 100 W. Washington St., Chicago, IL 60601 or 320 W. Washington St., Springfield, IL 62627
- CA. You may also have this matter reviewed by the California Department of Insurance by writing directly to them at the following address: California Department of Insurance, Consumer Service Division, 300 South Spring Street, 11th Floor, Los Angeles, CA 90013.
- WV. If you wish to contact the West Virginia Office of the Insurance Commissioner, the following contact information is provided: Telephone: Toll Free 1-888-TRY WVIC (888-879-9842), TTY 1-800-435-7381. Facsimile 304-558-4965, Website www.wvinsurance.gov. Correspondence: West Virginia Offices of the Insurance Commissioner, ATTN: Consumer Service Division, P.O. Box 50540, Charleston, West Virginia 25305-0540.
- MD. APPEALS PROCEDURE NOTICE**
 If you feel your claim has been improperly denied, you have the right to file an appeal with the Company. We are available to discuss with you the position we have taken on your claim. You may reach us at: Association & Society Insurance Corporation, 2301 Research Blvd, Ste 300, Rockville, MD 20850; Toll Free Phone: 1-800-638-2610, Facsimile: 1-800-310-5514, Email address: custsvc@asicorporation.com. You may file a complaint with the Maryland Insurance Administration without filing an appeal with the Company if the coverage decision involves an urgent medical condition for which care has not been rendered. The Health Advocacy Unit is available to assist in mediating and filing an appeal. The contact information for the Maryland offices is shown below for convenience. The Maryland Insurance Administration: Maryland Insurance Administration, Appeal and Grievance Unit 200 St Paul Place, Suite 2700, Baltimore MD 21202. Phone: 410-468-2000, Toll Free: 1-800-492-6116, Facsimile: 410-468-2270. Health Advocacy Unit: Maryland Health Education and Advocacy Unit, Consumer Protection Division, Office of the Attorney General, 200 St Paul Place - 16th Floor, Baltimore, Maryland 21202 Toll Free Phone: 1-877-261-8807, Hot Line Number: 410-528-1840, Facsimile: 410-576-6571, Email address: consumer@oag.state.md.us.
- NY. You can resolve most questions about our processing decisions by calling our Customer Service Department at 1-800-638-2610. If you still have concerns you have a right to file a written appeal with us. Write to us and tell us why you disagree with our decision. Please submit your written appeal to us within 180 days and provide any documentation or medical records that you feel may have a bearing on our decision. We will notify you in writing with: a request for additional information or; our decision within 30 days of the date we receive your written appeal request. Should you wish to take this matter up with the New York State Insurance Department, you may write to or visit the Consumer Services Bureau, New York State Insurance Department at: 25 Beaver Street, New York, NY 10004. Agency Building One; Governor Nelson A Rockefeller Empire State Plaza, Albany NY 12257; Walter J. Mahoney Office Building, 65 Court Street, Buffalo, NY 14202.
- WI. APPEAL OF CLAIM DENIAL: The Covered Person or his representative has the right to appeal the denial of any benefits for a claim under this Policy. To appeal a denial, the Covered Person or his representative must submit a written request for a review of the benefit denial. The request should be accompanied by any supporting material and mailed to Association & Society Insurance Corporation, 2301 Research Blvd, Ste 300 Rockville, MD 20850. Within 30 days after receiving the request, Association & Society Insurance Corporation will notify the Covered Person or his representative of the result of this review.

COMPLIANCE INFORMATION

Social Security Number Confidentiality

It is the policy of Association & Society Insurance Corporation ("ASI") to protect the confidential nature of social security numbers of our insured members. We assign a unique identifier (Member ID Number) to each employee enrolled in the TRICARE Supplement Plan. This Member ID Number can be found on the insured member's ID cards (see sample ID cards on page 33).

The collection and use of insured members' social security numbers are limited to only as reasonably necessary for proper administration of ASI's business, including the following:

- a) as a means of identifying an individual for whom a unique identification number is not yet assigned
- b) for internal verification or administrative purposes
- c) as alternate means to a database, not primary means

We will not accept employees' social security number transmitted by unsecured means.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) was enacted on August 21, 1996. The purpose is to protect employees against fraud and abuse and improve portability of health insurance coverage.

The corporate TRICARE Supplement Plan available to you on a voluntary basis through your employer complies with HIPAA in the following ways:

1. It does not have a pre-existing condition limitation.
2. If you terminate coverage, you will be furnished with a certificate of creditable coverage upon request.
3. Information collected from your medical providers who submit claims will be disclosed to others in accordance with the guidelines set forth in HIPAA.

When you apply for coverage, you agree that the Plan Administrator may request any medical information or other records from any source when related to claims submitted to ASI for services you receive. By accepting the coverage through your employer, you authorize any individual, association, or firm which has diagnosed or treated your condition to furnish the Plan Administrator with necessary information, records, or copies of records. This authorization extends to any person or organization which has any information or records related to the service received or the diagnosis and treatment of your condition.

If the Plan Administrator asks for information and does not receive it, payment cannot be made. The claim will be processed only when the requested information or record has been received and reviewed.

The Private Health Information use and disclosure is regulated by HIPAA. ASI is fully compliant with the Privacy Policy and with the Electronic Health Care Transaction and Code Sets Standards. ASI will also continue to comply with the Social Security Number Confidentiality.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is provided to you in connection with your health plan from one of the following affiliated insurance companies (referred to as “we” or “us”):

Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company

This notice applies only to the following Health Plans: Dental, Extended Hospital Expense Rider, Limited Benefit Medical Expense (Retiree Medical), Limited Medical Benefits (Mini-med), Long Term Care, Medicare Supplement, Prescription Drug Coverage, Student Health, Supplemental Medical Expense and TRICARE.

Effective Date: This Notice is effective April 14, 2010.

Our Commitment to Your Privacy

Maintaining the privacy of your protected health information is a high priority to us. In conducting our business, we will create records regarding you and the services we provide to you. We are required by law to maintain the confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We will abide by the terms of this Notice of Privacy Practices so long as it remains in effect.

We reserve the right to change our privacy practices and apply the changes to any protected health information received or maintained by us prior to the date of such change. If a privacy practice is materially changed, we will provide you with a revised Notice of Privacy Practices. In the event applicable law prohibits or materially limits the use or disclosure of your protected health information; we will comply with the more stringent law. You may request a paper copy of our most current notice at any time by contacting Customer Service at 1-800-752-9797. If you have requested a copy of this Notice by e-mail or other electronic means, you also have the right to request a paper copy at any time.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing such use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

We May Use and Disclose Your Health Information in the Following Ways:

1. **Treatment.** We do not make treatment decisions, but we may disclose your information to those who do. For example, we may disclose information regarding your benefits to doctors or health care facilities involved in your care.
2. **Payment.** We will make uses and disclosures of your protected health information as necessary for payment purposes. For instance, we may use information regarding your medical procedures and treatment to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf.
3. **Health Care Operations.** We will use and disclose your protected health information as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, enrollment, underwriting, reinsurance, compliance auditing, rating, and other functions related to your health plan.
4. **Family and Friends Involved in Your Care.** With your approval, we may disclose your protected health information to designated family, friends, and others who are involved in your care or in the payment for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information.

5. **Business Associates.** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, etc. We may use and disclose your protected health information to one more of these outside persons or organizations that assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your protected health information.
6. **Information Received Pre-Enrollment.** We may request and receive from you and your health care providers protected health information prior to the issuance of a certificate or policy of insurance to you and to determine your rates. We will protect the confidentiality of that information in the same manner as all other protected health information we maintain and, if a certificate or policy of insurance is not issued to you, we will not use or disclose the information about you we obtained for any other purpose.
7. **Plan Sponsors.** We may also use or disclose protected health information to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.
8. **Health-Related Benefits and Services.** We or our business associates may also contact you regarding health-related benefits and services that may be of interest to you.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

Your protected health information may be used or disclosed as applicable without your authorization in the following circumstances: for any purpose when required by law; for public health activities as required by law if we suspect child abuse or neglect or believe you to be a victim of abuse, neglect, or domestic violence; as required by law for governmental health oversight agency conducting audits, investigations or civil or criminal proceedings; if required by a court or an administrative ordered subpoena or discovery request (in most cases you will have notice of such disclosure); as required by law for certain law enforcement purposes; about deceased persons to coroners, health examiners, and funeral directors consistent with law; if necessary for organ and tissue donation or transplant; for certain government-approved research purposes; upon reasonable belief to avert a serious threat to health or safety; for specialized government functions (such as military personnel and inmates in correctional facilities); national security or intelligence activities or to workers' compensation agencies if necessary to make a benefit determination.

Your Privacy Rights

You have the following rights as an individual with respect to the protected health information we maintain about you:

1. **Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your protected health information for treatment, payment, or health care operations by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests; however, we are not required to agree to the restriction and we retain the right to terminate a restriction if we believe such termination is appropriate. In the event of a termination by us, you will be notified. You also have the right to terminate a restriction, in writing or orally. You may obtain a Request for Restriction form by contacting Customer Service at 1-800-752-9797.
2. **Confidential Communications.** You may request that we communicate with you about your health information in a particular manner or at a certain location. For instance, you may wish to receive communications from us at your work location rather than your home. We will evaluate all such requests; however, we must only accommodate your written request if you state that your life could be endangered by the disclosure of your protected health information. You may obtain a Request for Confidential Communication form by contacting Customer Service at 1-800-752-9797.
3. **Access.** You have a right to access much of the protected health information that we retain on your behalf. We may charge a fee for the costs of copying, mailing/postage, labor and supplies associated with your request but, you will be notified in advance of any such fee. You may obtain a Request for Access form by contacting Customer Service at 1-800-752-9797.

4. **Amendment.** You have the right to request that health information we maintain about you be amended or corrected. We will give each request consideration; however we are not obligated to make requested amendments. All amendment requests must be in writing, signed by you or your representative and state the reason(s) for the request. If an amendment or correction is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain a Request for Amendment form by contacting Customer Service at 1-800-752-9797.
5. **Accounting.** You have the right to receive an accounting of certain disclosures made by us of your health information. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a Request for Accounting of Disclosure form by contacting Customer Service at 1-800-752-9797.
6. **Complaints.** If you believe your privacy rights have been violated, you can file a complaint in writing. Send your complaint to: Consumer Affairs Department, 2700 W. Plano Parkway-3D, Plano, Texas 75075. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

Additional Information

If you have any questions or need further assistance regarding this Notice, you may contact our Consumer Affairs Department at 972-881-6688.

GENERAL DEFINITIONS

Confined or Confinement means being an Inpatient in a Hospital or Skilled Nursing Facility due to Sickness or Injury.

Copayment/Cost Share means the amount that a Covered Person is required to pay for services received from a TRICARE provider, whether expressed as a copayment or cost share or percentage of the contracted fee for the service.

Covered Excess Charges means the difference between the TRICARE Allowed Amount for an expense and the actual charge, but only if the (a) allowed portion is a Covered Expense and (b) the non-participating provider or supplier will not reduce the Covered Person's charge to the Allowed Amount.

Covered Expense means the reasonable expense incurred by a Covered Person for needed medical or surgical treatment, services or supplies. The expense must be: (a) incurred for the sole purpose of treating The Covered Person's Injury or Sickness; (b) prescribed by the Covered Person's attending physician, except for routine nursing services; and (c) incurred while the Covered Person is an Inpatient in the Hospital to be covered under an Inpatient Benefit; or (d) incurred while the Covered Person is not Confined as an Inpatient in a Hospital to be covered under an Outpatient Benefit. In addition, the expense must be incurred: (a) by the Covered Person while the Covered Person is covered under such benefit; (b) for a Confinement, service, or supply that is covered under TRICARE.

Covered Person means you, your Eligible Spouse and Eligible Child, while such person is covered under the Policy.

Daily Subsistence Fee means the current amount that the Department of Defense determines is applicable to a day of confinement in a Military Treatment Facility a Uniformed Services Hospital.

Employer Health Program means a program issued to or sponsored by a Covered Person's employer which provides coverage for basic hospital, medical or surgical expenses incurred as a result of injury or sickness. Such program may be an insurance policy, a hospital or medical service contract, a Blue Cross or Blue Shield contract, a medical practice or other prepayment plan, or a managed care plan.

Fiscal Year means the Federal Government's 12-month accounting period. Currently, that is the period from October 1st of one year to September 30th of the next year.

Government Hospital means a Service Hospital or any other hospital owned by the Federal Government including Veterans Administration Facilities.

Hospital means an institution which TRICARE recognizes as a hospital.

Injury means bodily injury of a Covered Person Resulting from an accident.

Inpatient means Confinement in a Hospital or Skilled Nursing Facility for which the Covered Person is charged at least one full day's room and board.

Insured Person means you (your or yours), a Member of the Organization named on the Schedule.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Act of 1965, as amended.

Member means you (your or yours), a member of the Organization.

Organization means the Participating Organization named on the Schedule.

Outpatient means a Covered Person's treatment for Injury or Sickness on a day that Covered Person is not Confined.

Outpatient Deductible means the Outpatient Deductible, as defined and determined by TRICARE.

Period of Confinement means an interval of time during which the Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility. A Period of Confinement: (a) begins on the date the Covered Person is admitted to a Hospital or Skilled Nursing Facility while the Covered Person is covered by the Policy; and (b) ends on the date the Covered Person is discharged from the Hospital or Skilled Nursing Facility.

Provider means a doctor, clinic, team of doctors, nurse practitioner, physician assistant, hospital, laboratory, ambulance company, or supplier of medical equipment that delivers medical services or supplies.

Plan Administrator means: Association & Society Insurance Corporation, P.O. Box 2510, Maryland 20847

Point of Service means TRICARE Prime enrollees have the freedom to receive services without a referral or authorization.

Sickness means: (a) a Covered Person's sickness or disease including pregnancy; or (b) Well Baby Care, as defined.

Skilled Nursing Facility means one which: (a) is approved by Medicare or is qualified to receive approval by Medicare if so required; (b) operates pursuant to law; (C) primarily and continuously provides skilled nursing care and related services to persons convalescing from Sickness or Injury on an Inpatient basis for which a charge is made; (d) provides 24-hour-a-day nursing service by or under the supervision of registered nurses (R.N.); (e) provides adequate procedures for the administration of drugs; (f) maintains daily medical records of each patient; and (g) provides each patient with a planned program of medical care and treatment by or under the supervision of a Physician. Skilled Nursing Facility does not mean: (a) a hospital; (b) a place for rest, custodial care, or the aged; or (c) a place for the treatment of mental disease, drug addicts or alcoholics.

TRICARE Allowed Amount means the amount TRICARE determines is a reasonable charge for a Covered Expense. It may be less than the actual charge. The TRICARE Allowed Amount will not exceed the TRICARE DRG Amount, if the Covered Expenses are subject to the TRICARE DRG.

TRICARE Cap means the amount TRICARE determines is the limit for expenses applied to the TRICARE Outpatient Deductible and TRICARE Covered Expenses subject to coinsurance for all members of a family in a Fiscal Year. After a family has incurred Covered Expenses which meet the TRICARE Cap, TRICARE will increase its rate of payment to 100% of the TRICARE Allowed Amount for all members of such family.



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Sponsored by The American Military Retirees Association

This handbook reflects the most current description of benefits, limitations and exclusions under your plan as of September 23, 2011.