Chapter 1 Section 26

Supplemental Insurance

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Revision:

1.0 APPLICABILITY

The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

TRICARE recognition of what is a supplemental insurance plan.

3.0 POLICY

3.1 A supplemental insurance plan is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services or items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental insurance plans; general indemnity plans, and those offered through a direct service Health Maintenance Organization (HMO).

3.2 An indemnity supplemental insurance plan must meet all of the following criteria:

3.2.1 It provides insurance coverage, regulated by state insurance agencies, which is available only to beneficiaries of TRICARE.

3.2.2 It is premium-based and all premiums relate only to TRICARE supplemental coverage.

3.2.3 Its benefits are limited to non-covered services, to the deductible and cost-share portions of the predetermined allowable charges, and to amounts exceeding the allowable charges for covered services.

3.2.4 It provides reimbursement by making payment directly to the TRICARE beneficiary or to the participating provider.

3.2.5 It does not operate in a manner which results in lower deductibles or cost-shares than those imposed by law, or that waives the legally imposed deductibles or cost-shares.

3.3 A supplemental insurance plan offered by a HMO must meet all of the following criteria:

3.3.1 The HMO must be authorized and must operate under relevant provisions of state law.

3.3.2 The HMO supplemental plan must be premium-based and all premiums must relate only to TRICARE supplemental coverage.

3.3.3 The HMO's benefits, above those which are directly reimbursed by TRICARE, must be limited predominantly to services not covered by TRICARE and TRICARE deductible and cost-share amounts.

3.3.4 The HMO must provide services directly to TRICARE beneficiaries through its affiliated providers who, in turn, are reimbursed by TRICARE.

3.3.5 The HMO's premium structure must be designed so that no overall reduction in the amount of the beneficiary deductibles or cost-shares will result.

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