CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP)
SUMMARY

WHAT IS THE CHCBP?

The Continued Health Care Benefit Program (CHCBP) is a program of temporary health benefit coverage for certain eligible individuals who lose military health benefits. The CHCBP is premium based, with the medical benefits under this program mirroring the benefits offered in the TRICARE Standard Program and functioning under most of the rules and procedures of TRICARE Standard.

ARE THERE SPECIFIC ENROLLMENT REQUIREMENTS?

Yes. Beneficiaries must elect coverage in the CHCBP within 60 days following: (1) loss of entitlement to the Military Health System; or (2) being notified of the CHCBP. Beneficiaries may not select the effective date of their CHCBP policy; the period of coverage must begin on the day after loss of military entitlement.

WHO IS ELIGIBLE?

(1) The sponsor; (2) certain unremarried former spouses; (3) a child who loses military benefits due to his or her age; and (4) a child placed in the legal custody of the sponsor.

WHAT ARE THE ENROLLMENT CATEGORIES?

CHCBP provides two types of coverage plans: individual and family. Individual coverage is available to the sponsor, an unremarried former spouse, and a child losing military benefits due to age. Family coverage is only available to the separating service member and his or her family members. Once the election is made, the sponsor's enrollment category can be changed from individual to family coverage under the following conditions: (1) birth of a child; (2) marriage of the sponsor; (3) legal adoption of a child by the sponsor; or (4) placement by a court of a child as a legal ward in the home of the sponsor. If one of the above events has occurred, the former member can change his or her enrollment from individual to family coverage, effective as of the date of the qualifying event. The sponsor must send a written request to Humana Military Healthcare Services, Inc., Attn: CHCBP, P.O. Box 740072, Louisville, KY 40201, no later than 60 days from the qualifying event and must include sufficient documentation to support the change in enrollment categories.

HOW DOES ONE ENROLL IN THE CHCBP?

In order to enroll in the CHCBP, an eligible individual must submit a completed enrollment application form, proof of eligibility, and payment in full for the first 90 days of coverage (check or money order made payable to the United States Treasury). The enrollment form may be requested from Humana Military Healthcare Services, Inc., by writing or calling them. The enrollment form can also be found on the Web at www.tricare.osd.mil or www.humana-military.com.

PROOF OF ELIGIBILITY:

Proof of eligibility must be submitted with the completed enrollment application and payment. The documentation that is required is shown in Sections 6(1) through 6(5) of the enrollment application, depending on the category of the individual applying. Additional information and documentation may be requested to confirm the applicant's eligibility.

HOW LONG IS COVERAGE OFFERED?

CHCBP coverage ranges from a period of 18 to 36 months, depending on the category of the beneficiary. Former active duty members and their family members are entitled to purchase up to 18 months of coverage. All other eligible beneficiaries are entitled to 36 months of coverage. Certain former spouses may be eligible for coverage beyond 36 months. All former spouses should review the criteria for extended coverage before enrolling in CHCBP to determine their eligibility for continued coverage beyond 36 months. CHCBP coverage is offered in increments of 90 days, renewable up to the total number of months referenced above.

WHAT DOES CHCBP COVERAGE COST?

The cost of CHCBP coverage depends on the category of enrollment, either individual or family. The premium for individual coverage is $933.00 per quarter and the premium for family coverage is $1,996.00 per quarter.

HOW IS COVERAGE RENEWED?

At least thirty days prior to the expiration of the current coverage period, a renewal notice will be sent to the enrollee. The enrollee must return the renewal notice and payment in full, by check, money order or major credit card, no later than 30 days after the end of the current coverage period. Failure to renew within the required time will result in the permanent loss of entitlement to purchase any additional CHCBP coverage.

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SUMMARY *(Continued)*

ARE PREMIUMS REFUNDABLE?

Refunds of premiums paid for CHCBP coverage are not refundable other than in extraordinary circumstances, e.g., if the enrollee is no longer eligible for CHCBP coverage.

WHAT BENEFITS ARE OFFERED?

Health care coverage under the CHCBP mirrors the coverage of the TRICARE Standard benefit, which covers a majority of medical conditions. However, for some types of treatment, coverage can be limited. Prior to enrolling in the CHCBP, interested beneficiaries are encouraged to contact a TRICARE Service Center to ask specific questions regarding TRICARE Standard coverage.

WHAT ADDITIONAL COSTS ARE THERE?

When medical care is received, the beneficiary will be responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. For detailed information concerning the amounts of cost-shares and deductibles, beneficiaries are encouraged to contact a TRICARE Service Center nearest their home.

HOW TO FILE A CLAIM:

Enrollees may request the provider to file medical claims on their behalf. If the provider does not file the claim, the enrollee will have to do so. It is helpful to attach a copy of the CHCBP enrollment card to the claim. Information regarding where to submit a claim can be found at the TRICARE Web Site www.tricare.osd.mil or by contacting either Humana Military Healthcare Services, Inc., or a TRICARE Service Center nearest the enrollee's residence.

If there are any problems with the processing of a CHCBP claim, the enrollee should contact the claims processor. If that is not successful, the enrollee may then write to the TRICARE Management Activity at the following address:

Beneficiary and Provider Services
TRICARE Management Activity
16401 East Centretech Parkway
Aurora, CO 80011-9066

HOW CAN PROVIDERS VERIFY CHCBP ELIGIBILITY?

Providers may call 1-800-444-5445 to verify the eligibility of the beneficiary or to obtain basic CHCBP information.

WHAT STEPS SHOULD ACTIVE DUTY MEMBERS TAKE WHEN SEPARATING FROM THE MILITARY?

Current active duty members anticipating separation from the military should ensure they participate in pre-separation counseling, which will provide information regarding various benefits available to members after leaving the military. Former members must also ensure that their correct status is recorded in DEERS upon separation.

HOW TO OBTAIN INFORMATION ABOUT CHCBP:

Humana Military Healthcare Services, Inc., provides administrative and educational support for the CHCBP. As part of this effort, they operate a toll-free line 24 hours a day. Beneficiary Service Representatives are available Monday through Friday 8:00 a.m. to 7:00 p.m. Eastern Time (except holidays).

ADDITIONAL INFORMATION:

Write or call:

Humana Military Healthcare Services, Inc.
Attn: CHCBP
P.O. Box 740072
Louisville, KY 40201

1-800-444-5445

or visit their Web Site at:
www.humana-military.com

CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) APPLICATION

Form Approved
OMB No. 0704-0364
Expires Jun 30, 2002

PLEASE DO NOT RETURN YOUR APPLICATION TO THE ABOVE ADDRESS. RETURN COMPLETED APPLICATION WITH PREMIUM PAYMENT TO: Humana Military Healthcare Services, Inc., Attn: CHCBP, P.O. Box 740072, Louisville, KY 40201.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1086 and E.O. 9397.
PRINCIPAL PURPOSE(S): This form is used by certain former military health care beneficiaries to apply for coverage under the Continued Health Care Benefit Program (CHCBP). Please see 32 C.F.R. 199.20(d) for a list of the eligible beneficiaries.
ROUTINE USE(S): Disclosure may be made to Federal, state, local, foreign government agencies, private business entities and individual providers of care on matters relating to entitlement, fraud, program abuse, program integrity, or civil and criminal litigation related to the operation of the Continued Health Care Benefit Program.
DISCLOSURE: Voluntary; however, failure to furnish all requested information will result in the applicant not being enrolled in the Continued Health Care Benefit Program.

1. APPLICANT NAME *(Last, First, Middle Initial)*	2. TELEPHONE NO. *(Include Area Code)* a. HOME / b. WORK
3. RESIDENCE ADDRESS *(Street, Apartment No., City, State, ZIP Code)*	4. MAILING ADDRESS *(If different from Residence Address)*

5. SERVICE MEMBER SPONSOR THROUGH WHOM YOU QUALIFY *(If different from Applicant)*	
a. NAME *(Last, First, Middle Initial)*	b. SPONSOR'S SOCIAL SECURITY NUMBER

6. PERSON(S) TO BE ENROLLED IN CHCBP *(Including Applicant)*

	a. NAME *(Last, First, Middle Initial)*	b. SSN OF INDIVIDUAL	c. DATE OF BIRTH *(YYYYMMDD)*	d. SEX *(M/F)*
(1) SPONSOR *(Submit copy of DD214 - Member 4 Copy)*				
(2) DEPENDENTS *(Submit copy of DD214 - Member 4 Copy) (Sponsor must enroll for dependents to be enrolled. List all family members. Use a separate sheet of paper if more space is needed.)*				
(3) UNREMARRIED FORMER SPOUSE *(Submit copy of final divorce decree.)*				
(4) CHILD LOSING MILITARY BENEFITS DUE TO AGE* *(Submit copy of Military ID Card)*				
(5) CHILD LOSING MILITARY BENEFITS FOR ANY OTHER REASON* *(Submit copy of proof of event that resulted in loss of benefits.)*				

** Children age 21 (23 if a full-time student) losing military coverage must apply separately for their own individual policy. If more than three children, use separate sheet of paper.*

7. TOTAL THREE-MONTH PREMIUM ENCLOSED: *(Individual three-month premium is $933.00. Family three-month premium is $1,996.00.)*

$ _____ PREMIUM PAID IS FOR: ☐ INDIVIDUAL COVERAGE ☐ FAMILY COVERAGE

PAID BY: ☐ CHECK ☐ MONEY ORDER *(Check/money order payable to the United States Treasury)*

8. APPLICANT'S SIGNATURE AND DATE

By signing this form, the applicant is certifying that the information provided on this form is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal law.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

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Retain this copy