MBA's TRICARE Supplement Insurance Plan

This supplement plan gives you valuable protection that doesn't cost a lot. In fact, the plan helps reduce or completely eliminate your costs for:

Prescriptions and medication

Hospital stays

Excess charges

Doctor visits

Outpatient surgery

Emergency room

Choose a supplement plan based on one of the TRICARE options you're enrolled in:

1. **SELECT**
2. **PRIME**
3. **RESERVE SELECT**

Military Benefit Association is a nonprofit organization of military personnel and civilian employees of the United States Government and their spouses. We offer our members an attractive package of insurance and other benefits. Established in 1956, MBA is proud to have served hundreds of thousands of members who defend and protect our Nation.

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The MBA TRICARE Supplement Insurance Plan gives money back for covered out-of-pocket medical costs to MBA members and their families who are covered by TRICARE. Those costs include both inpatient and outpatient services.

Who Is Eligible?

If you're under age 65 and enrolled in TRICARE, you can obtain this coverage. Your spouse (under age 65 and eligible for TRICARE, not separated or divorced) and unmarried dependent children up to age 21, or 23 if a full-time student are eligible.

A child covered by the TRICARE Young Adult Program and under age 26 may enroll. If both spouses are eligible members, they may not enroll as dependents of each other. This avoids duplicate coverage. Dependent children may only be covered once under the plan. A member's newborn child who is born while the member is covered by this policy is automatically covered for the first 31 days following their birth. Coverage may be continued by enrolling the child in the member's plan within 31 days of the child's birth.

What Is Covered?

The Supplement pays eligible out-of-pocket expenses, after any applicable deductible, as follows:

- 100% of copays and Cost-shares for TRICARE
- 100% of Excess Charges above the TRICARE Select Allowable Amount, not to exceed the legal limit of 115% of the TRICARE Allowable Amount
- 100% of Cost-shares and Excess Charges for Prime Point of Service
- 100% of the daily subsistence from a government facility
- The daily inpatient charges from the first day

MONTHLY PREMIUM RATES – Rates and/or benefits may be changed on a class basis. Rates are based on the attained age of the insured person and increases as you enter each new age category.

	TRICARE PRIME	TRICARE SELECT IN/OUTPATIENT OPTIONS		
		$500 Deductible	$200 Deductible	$0 Deductible
Retired Member under age 46	$11.78	$18.62	$23.45	$29.67
46-50	13.92	24.41	27.61	38.89
51-55	18.11	31.94	36.75	50.47
56-60	19.61	40.25	43.24	63.70
61-64	24.28	48.84	52.02	77.76
Spouse of Retired Member under age 46	15.97	22.46	32.15	46.99
46-50	18.24	26.44	38.16	55.28
51-55	21.42	30.51	44.76	64.98
56-60	23.39	36.43	52.46	76.10
61-64	25.30	42.26	60.78	88.05
Each Child of Retired Member	9.46	20.44	23.16	36.81
Reservist, Spouse of Reservist or Spouse of Active Duty Member	N/A	10.93	14.33	16.56
Each Child of Reservist or Active Duty Member	N/A	7.15	9.83	11.26

NOTE: If selecting the MBA's $200 or $500 Deductible Options, the insured must also satisfy MBA's deductible before any benefits are payable.

Definitions

Eligible Charges – Charges that you incur while insured under this Plan that are considered covered medical care/services under TRICARE.

Excess Charges – Charges that you legally have to pay that are in excess of the TRICARE Allowable Amount, not to go over the legal limit of 115% of the TRICARE allowable amount.

Deductible – The amount that TRICARE (Select) requires you to pay for outpatient care each calendar year before the program begins to make payments.

MBA's Supplemental Deductible Options – The amount you elect to pay for medical care during a benefit period. This is before the Supplemental Plan pays.

Deductible Plan Options – $0, $200 or $500 (limited to two deductibles per family per benefit period).

Cost-share – The percentage of the charges you must pay after satisfying the outpatient deductible amount.

Hospital – an institution that TRICARE recognizes as a hospital.

Confined or Confinement – being an inpatient in a Hospital (or Skilled Nursing Facility) due to sickness or injury.

Skilled Nursing Facility – does not include a hospital, a place for rest, custodial care, or the aged, or a place for the treatment of mental disease, substance abuse or alcohol dependency.

MBA's Supplemental Insurance Deductible Options

The MBA TRICARE Supplemental Deductible Amount is the annual amount an insured must pay for Eligible Charges. This happens before Supplement benefits are paid. If you choose the $500 Deductible Plan, it would be $500 per person and a maximum of $1,000 per family. If you choose the $200 Deductible Plan, it would be $200 per person and a maximum of $400 per family. The MBA Supplement Deductible is in addition to any TRICARE deductible that the person is required to pay.

Pre-existing Conditions Limitation

If you or your covered dependents received medical care for an injury or sickness during the six months before the date your coverage begins, that condition won't be covered. Coverage of that condition won't start until the person has been enrolled in the plan for six months.

Effective Date

Coverage will become effective on the first day of the month on or next following the date your enrollment form and first premium are received. If on the date that you're to become covered under the policy you're confined in a Hospital, your coverage will be deferred until the first day after you're discharged.

Termination of Coverage

You can keep MBA's TRICARE Supplement until you reach age 65 or become eligible for Medicare. This stands as long as you remain an MBA member, premiums are paid, and the policy remains in effect. Your dependents can keep their coverage as well. This stands as long as they meet eligibility standards and premiums are paid.

Exclusions

The Policy does not cover:

1. intentionally self-inflicted injury;
2. suicide or attempted suicide, whether sane or insane (in Missouri, while sane);
3. the following services:
   a) routine physical exams, unless required for school enrollment (but not sports physicals) on a Covered Child aged 5 through 11; and
   b) immunizations; except that these services are covered when:
      a) rendered to a Covered Child who is less than 6 years of age; or
      b) ordered by a Uniformed Service for a Covered Spouse or Child of an Active Duty Member for such spouse or child's travel outside the United States due to the Member's assignment;
4. domiciliary or custodial care;
5. eye refractions and routine eye exams except when rendered to a child up to 6 years from his or her birth.
6. eyeglasses and contact lenses;
7. prosthetic devices, except those covered by TRICARE;
8. cosmetic procedures, except those resulting from Sickness or Injury while a Covered Person;
9. hearing aids;
10. orthopedic footwear;
11. care for the mentally incapacitated or physically handicapped if:
    a) the care is required because of the mental incapacitation or physical handicap; or
    b) the care is received by an Active Duty Member's child who is covered by the "Program for the Handicapped" under TRICARE
12. drugs which do not require a prescription, except insulin;
13. dental care unless such care is covered by TRICARE, and then only to the extent that TRICARE covers such care;
14. any confinement, service, or supply that is not covered under TRICARE;
15. Hospital nursery charges for a well newborn, except as specifically provided under TRICARE;
16. any routine newborn care except Well Baby Care, as defined, for a child up to 6 years from his or her birth;
17. expenses in excess of the TRICARE Cap;
18. expenses which are paid in full by TRICARE;
19. any expense or portion thereof which is in excess of the Legal Limit;
20. any expense or portion thereof applied to the TRICARE Outpatient Deductible;
21. treatment for the prevention or cure of alcoholism or drug addiction except as specifically provided under TRICARE and the Policy;
22. any part of a covered expense which the Covered Person is not legally obligated to pay because of payment by a TRICARE alternative program.

If you are not already an MBA member when you enroll for coverage, you will automatically become a member as long as you meet one of the following criteria:

- Personnel who are on active duty in the United States Army, Navy, Air Force, Marine Corps, Coast Guard, or Public Health Service; the National Oceanic and Atmospheric Administration, or Cadets or Midshipmen attending any of the United States Military Service Academies.
- Personnel who are entitled to receive pay in any of the Reserve Components of the United States Uniformed Services, or who are full time civilian employees of the U.S. Government and U.S. citizens, or spouses and dependents of persons who qualify for membership.
- Personnel who have retired from active duty with pay in one of the United States Uniformed Services and persons who have been honorably discharged from active duty.

How to Enroll

1. **Complete the attached enrollment form. Be sure to initial, sign and date where indicated.**

2. **Determine your method of payment: billing cycle (Check), Electronic Funds Transfer (EFT) or credit card. If paying by billing cycle, enclose one or more month's premium with the enrollment form.**

3. **Mail the completed enrollment form to:**

   Military Benefit Association
   P.O. Box 221110
   Chantilly, VA 20153-1110

Proof of Coverage

A Certificate of Insurance will be sent to you stating the features of coverage. It will also state to whom the benefits are payable.

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. This program may vary and may not be available to residents of all states.

30-Day Free Look Guarantee

Upon receipt of your Certificate of Insurance, if for any reason you are not satisfied with the Plan, you may return your Certificate within 30 days and your premium will be promptly refunded – minus any claims paid – no questions asked.

Producer's Compensation Disclaimer

Military Benefit Association is compensated for the placement of insurance and for the services it provides to customers on behalf of the insurance company, in addition to other compensation it may receive. This is a participating group policy under which dividends and/or experience credits may be paid to Military Benefit Association.

P.O. Box 221110
Chantilly, VA 20153-1110

1-800-336-0100 • www.militarybenefit.org

TRICARE Form Series includes SRP-1269, or state equivalent.

Policies are underwritten by Hartford Life and Accident Insurance Company, Home Office Hartford, CT.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company, Hartford, CT 06155.
Policy # AGP-5859

EFT Authorization

Name and address of Bank, Savings & Loan, Credit Union, etc., where you have a personal checking account. (Attach a voided check.)

Routing/Transit Number (First 9 digits from the lower left corner of your personal check).
If your checking account is through a Credit Union, contact them for the number.

Checking Account No.

Member's Name (Please Print)

Member's Social Security No.

Please deduct my EFT Payments for TRICARE Supplement

Signature (as it appears on depository records)

Date

IMPORTANT: Remember to attach a voided check to this authorization.

I hereby authorize Military Benefit Association to initiate on or after the second day of each month debit entries to my checking account indicated below and on the attached voided check, and I hereby authorize the depository institution named below to debit the same from my account. Said debits shall be for the amount(s) of my monthly TRICARE premium payments at the regular rates applicable to these premiums. It is understood that the amounts of these debits will be adjusted by MBA in accordance with any applicable premium increases or decreases. My premium is due and payable on the first of each month. I agree to have two months premium deducted for my first EFT payment if I have not enclosed an initial payment with my enrollment form. I further agree that if any such debit should be dishonored, whether with or without cause and whether intentionally or unintentionally, MBA and the depository institution shall be under no liability whatsoever even if termination of insurance results. This agreement is to remain in full force and effect until MBA has terminated it upon 60 days notice to me, or received notification from me of its termination in such time and manner as to afford MBA a reasonable opportunity to act on it.

Credit Card Authorization

Member/Applicant Name as it appears on card (please print)

Member MIN/SSN

Billing Address | City | State | Zip

I authorize Military Benefit Association to charge my:

SELECT TYPE OF CARD: ◯ VISA ◯ Master Card ◯ Discover

Alt/Cell Number

Card Number

Expiration Date

Quarterly Payment *(Monthly Premium x 3)* $

Semi-Annual Payment *(Monthly Premium x 6)* $

Annual Payment *(Monthly Premium x 12)* $

Please charge my card automatically for recurring payments. ◯ Yes ◯ No
You will not be billed for future payments, they will be deducted automatically.

SIgnature *(as it appears on depository records)*

Date

I hereby authorize Military Benefit Association to initiate charges to the credit card indicated above. These charges will be for the amount(s) of my premium payments based on the frequency selected above at the regular rates applicable to these premiums. It is understood that the amounts of these debits will be adjusted by MBA in accordance with any applicable premium increases or decreases. My premium is due and payable on the first of each month depending on the frequency of payment that I select above. I agree that if any such debit is dishonored, whether with or without cause and whether intentionally or unintentionally, MBA and the depository institution shall be under no liability whatsoever even if termination of insurance results. This agreement is to remain in full force and effect until MBA has terminated it upon 60 days notice to me, or received notification from me of its termination in such time and manner as to afford MBA a reasonable opportunity to act on it.

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The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company, Hartford, CT 06155. Policy # AGP-5859

Enrollment Form

TRICARE Supplement Insurance Plan
Enrollment Form
Group Policyholder: Military Benefit Association
Policy # AGP-5859

Member Information

Name of Military Member

Date of Birth

Sex: ◯ Male ◯ Female

Address (Street, City, State, ZIP)

Telephone #

SSN

Rank/Branch of Service/Duty Status *(Active/Retired)*

Date Expected to Retire or Separate From Service

Email

Coverage Information

◯ TRICARE Select Retiree

◯ TRICARE Select Active Duty Family Plans

◯ TRICARE Reserve Select

Deductible Option: ◯ $500 ◯ $200 ◯ $0

◯ TRICARE Prime Supplement

I hereby enroll for the following coverage (check all that apply):

◯ Member

◯ Spouse Name: ______________________________

◯ Dependents

◯ Age 21-25 (if enrolled in TRICARE Young Adult)

Method of Premium payments: ◯ EFT ◯ Credit Card ◯ Billing Cycle (Check)

Are you enrolling within 30 days of the date your employer health insurance ends because you are no longer an eligible participant in that program?

◯ Yes ◯ No

Have you enrolled in the TRICARE Reserves Select within the past 30 days?

◯ Yes ◯ No

Dependent Children

If Family coverage is desired, please complete the following:

Spouse Name

Date of Birth

Child Name

Date of Birth

Child Name

Date of Birth

Child Name

Date of Birth

I hereby certify that the above statements are complete and true to the best of my knowledge. I hereby elect to enroll in insurance indicated under the TRICARE Supplement program, underwritten by the Hartford Life and Accident Insurance Company. I understand that my coverage will become effective the first of the month following your receipt of my acceptance certificate and first premium payment. I further understand that during the first 6 months of coverage this policy will not cover pre-existing conditions, i.e., injury or sickness for which medical advice or treatment has been received during the 6 months immediately preceding the effective date of this coverage. (California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.) For residents in all states except FL, PA, NJ and WA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete, or misleading information may be committing a crime and may be subject to civil or criminal penalties, depending upon state law. For FL Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any materially false, incomplete or misleading information is guilty of a felony of the third degree. For PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I further understand that if any person to be covered under this policy is hospital-confined on the date this insurance goes into effect, such effective date of coverage will be deferred until the person's final discharge from the hospital. I represent that to the best of my knowledge and belief, all statements and answers recorded on this form are true and complete.

Member Signature ______________________ Date __________

Spouse Signature (if enrolling) ______________________ Date __________

Send Enrollment Form to:

Military Benefit Association
P.O. Box 221110
Chantilly, VA 20153-1110

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