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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 142
6010.51-M
JUNE 7, 2012

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: MAIL DELIVERY QUALITY CODE (MDQC)

CONREQ: 15805

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change revises the referenced Manuals to require use of the Mail Delivery Quality Code (MDQC) when processing returned mail or verifying addresses. An updated MDQC will prevent mailings to the beneficiary such as enrollment cards and letters. The MDQC field automatically resets whenever the address is updated.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 159 and Aug 2002 TSM, Change No. 97.


Reta M. Michak
Director, Operations Division

ATTACHMENT(S): 39 PAGES
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

CHANGE 142
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CHAPTER 6

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3.1.1. Approximately one half of the Direct Care PCMs rotate or move each year. This will require the contractor to move the enrollee panels associated with those PCMs. Through a government-provided application, batch PCM reassignment moves will be accomplished based on parameters determined by the MTF. Those parameters include:

- DMIS ID to DMIS ID
- PCM ID to PCM ID
- Health Care Delivery Program (HCDP)
- Sex of beneficiary
- Unit Identification Code (UIC) (active duty only)
- Age of beneficiary
- Sponsor Social Security Number (SSN) (for family moves)
- Name of beneficiary

The contractor will perform Direct Care PCM reassignment moves within three working days of the effective date of the PCM's reassignment.

4.0. ENROLLMENT BY INDIVIDUAL OR FAMILY UNIT

Enrollment shall be on an individual or family basis. For newborns and adoptees see the TPM, [Chapter 10, Section 3.1](#).

5.0. ENROLLMENT PROCESSING

In accordance with the agreement with the MTF Commander and the appropriate RD and the provisions in the RD Requirements, the contractor shall be responsible for enrollment processing and for coordinating enrollment processing with the MTF, the appropriate RD, and DEERS. The contractor shall enter enrollments into DEERS using the government-furnished systems application. The contractor shall perform the following specific functions related to enrollment processing:

5.1. The contractor shall collect PSA enrollment applications at the TRICARE Service Centers (TSCs) or other sites mutually agreed to by the contractor, RD, and the MTF Commander, or by mail. The contractor shall collect non-PSA enrollment applications by mail or other means determined by the contractor.

5.2. Family members of active duty E-1 through E-4 who reside within the PSA of a military medical treatment facility and who are not already enrolled in TRICARE Prime shall be encouraged to enroll upon in-processing or when otherwise identified as a candidate for enrollment in accordance with the provisions of [paragraph 10.0](#).

5.3. At the time of enrollment processing, the contractor shall access DEERS to verify eligibility of enrollees and shall update the residential mailing address and any other fields for which they have update capability on DEERS. If the enrollment form does not contain a mailing address, the enrollment form should be developed for a mailing address. *If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.5, paragraph 1.3.1., Addresses.* Enrollees may submit a temporary address (i.e., Post Office

Box, Unit address, etc.), until a permanent address is established. Temporary addresses must be updated with the permanent address when provided to the contractor by the enrollee in accordance with the TSM, [Chapter 3, Section 1.5](#). Contractor shall not input temporary addresses **not** provided by the enrollee. If the DEERS record does not contain an address, or if the application contains information different from that contained on DEERS in fields for which the contractor does not have update capability, the contractor shall contact the beneficiary by telephone within five calendar days outlining the discrepant information and requesting that the beneficiary contact their military personnel information office.

5.4. The contractor shall electronically submit to DEERS updated records of enrollees and disenrollees using the government-furnished systems application DOES. MCSCs shall utilize DOES to correct system level Primary Care Information Transfer (PIT) enrollment data discrepancies (i.e., missing data), when PIT data discrepancies are communicated to the MCSC.

6.0. ENROLLMENT APPLICATIONS

The TRICARE Prime Enrollment Application and PCM Change Form (one combined form) and the TRICARE Prime Disenrollment Form will be provided by the government to the contractor via the DoD web site. The government will review and consider recommended changes and modifications to these forms from the contractors annually during a designated review cycle. The government will provide notification to the contractors at least 30 days prior to the beginning of the review period.

7.0. ENROLLMENT PERIOD

7.1. Effective Date Of Enrollment

Enrollment may occur any time during the contract period; however, all new enrollment periods shall coincide with the fiscal year. The incoming contractor shall inherit enrollments at transition that were established based on an enrollment year period. The incoming contractor shall align these enrollments to the fiscal year upon renewal of the enrollment period. The effective date of enrollment for ADSMs shall be the date the contractor receives the signed enrollment application. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. All other enrollment periods shall begin on the first day of the month following the month in which the enrollment application and enrollment fee payment are received by the contractor. If an application and fee are received after the 20th day of the month, enrollment will be on the first day of the second month after the month in which the contractor received the application. Enrollees who transfer enrollment continue with the same enrollment period. The enrollment transfer, however, is effective the date the gaining contractor receives a signed enrollment application or transfer application. See TPM, [Chapter 10, Sections 2.1 and 5.1](#) for information on Transitional Assistance Management Program (TAMP) and other changes in status. An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

7.2. Enrollment Expiration

No later than 30 calendar days before the expiration date of an enrollment, the contractor shall send the appropriate individual (sponsor, custodial parent, retiree, retiree family member, survivor or eligible former spouse, etc.) a written notification of the pending expiration and renewal of the TRICARE Prime enrollment, and a bill for the enrollment fee, if applicable (since ADSMs must be enrolled but their family members need not be, there is no action required if an ADSM does not have enrolled family members). The bill shall offer the various payment options: annual, quarterly or monthly. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date. The contractor shall automatically renew enrollments upon expiration unless the enrollee declines renewal, is no longer eligible for Prime enrollment, or fails to pay the enrollment fee on a timely basis, including any grace period allowed. The contractor shall allow a 30 calendar day grace period beginning the first day following the last day of the enrollment period. If the enrollee requests disenrollment during this grace period, the contractor shall disenroll the beneficiary effective retroactive to the enrollment period expiration date. The contractor may pend claims during the grace period to avoid the need to recoup overpayments. If an enrollee does not respond to the re-enrollment notification and fails to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee has declined re-enrollment. The contractor shall disenroll the beneficiary retroactive to the enrollment expiration date. DMDC sends written notification to the beneficiary of the disenrollment and the reason for the disenrollment within five business days of the disenrollment transaction.

7.3. Disenrollment

The contractor shall automatically disenroll beneficiaries when an enrollment fee payment, either the entire annual amount or an installment payment, is not received by the 30th calendar day following the annual expiration date or the due date for the installment payment. After the 30th calendar day, the contractor shall disenroll the beneficiaries with a disenrollment effective date retroactive to the annual renewal date or the payment due date, whichever applies. Prior to processing a disenrollment with a reason of “non-payment of fees,” the MCSC or Uniformed Services Family Health Plan (USFHP) provider must reconcile their fee payment system against the fee totals in DEERS. Once the MCSC confirms that the payment amounts match, the disenrollment may be entered in DOES. The disenrolled beneficiary will be responsible for the deductible and cost-shares applicable under TRICARE Extra or Standard (depending on the provider’s status) for any health care received during the 30 day grace period. In addition, the beneficiary shall be responsible for the cost of any services received during the 30 day grace period that may have been covered under TRICARE Prime but are not a benefit under TRICARE Extra or Standard, e.g., preventive care.

7.4. Enrollment Lockout

7.4.1. The contractor shall “lockout” or deny re-enrollment for a period of 12 months from the effective date of disenrollment for the following beneficiaries:

- Retirees and/or their family members who voluntarily disenroll prior to their annual enrollment renewal date;

- ADFMs (E-5 and above) who change their enrollment status (i.e., from enrolled to disenrolled twice in a given year) for any reason during the enrollment year (October 1 to September 30) (refer to this chapter and the TPM, [Chapter 10, Section 2.1](#) and [3.1](#)); and
- Any beneficiary disenrolled for failure to pay required enrollment fees during a period of enrollment.

NOTE: The 12 month lockout provision does not apply to ADFMs whose sponsor's pay grade is E-1 through E-4.

7.4.2. Beneficiaries who decline re-enrollment during their annual renewal period are not subject to the 12 month enrollment lockout. At the end of an annual enrollment period, if the beneficiary declines to continue their enrollment and subsequently requests re-enrollment, a new enrollment form is required and the contractor shall process the request as a "new" enrollment. (If an enrollee did not respond to a re-enrollment notification and failed to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee declined re-enrollment.)

7.4.3. The contractor shall not grant waivers to the 12 month lockout provision. TRICARE Regional Office (TRO) Directors may grant waivers to the lockout provisions in extraordinary circumstances.

8.0. ENROLLMENT FEES

8.1. General

The contractor shall collect the enrollment fee payment from the TRICARE Prime enrollee, and report enrollment fees to DEERS (see the TSM, [Chapter 3](#)). The Prime enrollee shall select one of the three payment fee options on the Prime Enrollment Application Form:

8.1.1. Annual Payment Fee Option

Annual installment will be collected in one lump sum. For initial enrollments and re-enrollments that are not yet aligned to the fiscal year, the contractor shall prorate the fee from the enrollment date to September 30. The contractor shall accept payment of the annual enrollment fee by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/MasterCard).

8.1.2. Quarterly Payment Fee Option

Quarterly installments are equal to one-fourth ($\frac{1}{4}$) of the total annual fee amount. For initial enrollments and re-enrollments that are not yet aligned to the fiscal year, the contractor shall prorate the quarterly fee to covering the period until the next fiscal year quarter (e.g., January 1, April 1, July 1, October 1) and collect quarterly fees thereafter through September 30. The contractor shall accept payment of the quarterly enrollment fee by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/MasterCard).

8.1.3. Monthly Payment Fee Option

Monthly installments are equal to one-twelfth (1/12) of the total annual fee amount. Monthly enrollment fees must be paid-through an allotment from retirement pay or through Electronic Funds Transfer (EFT) from the enrollee's designated financial institution.

8.1.3.1. Enrollees who elect the monthly fee payment option must pay the first quarter installment (first three months) at the time the enrollment application is submitted to allow time for the allotment or EFT to be established. The contractor shall accept payment of the first quarterly installment by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/MasterCard).

8.1.3.2. The contractor shall be responsible for verifying the information necessary to initiate monthly allotments and EFTs.

8.1.3.3. The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT. In the event that there are insufficient funds to process a monthly EFT, the contractor may assess the account holder a fee of up to 20 U.S. dollars.

8.1.3.4. Allotments from retired pay will be coordinated through the contractor with the Defense Finance and Accounting Service (DFAS), U.S. Coast Guard (USCG), or Public Health Service (PHS), as appropriate (see the TSM, [Chapter 1, Section 1.1, paragraph 8.10.](#) for Payroll Allotment Interface Requirements). The contractor shall process all allotment requests submitted by beneficiaries.

8.1.3.5. The contractor shall also research all requests that have been rejected or not processed by DFAS, USCG, or PHS. If the contractor's research results in the positive application of the allotment action, the contractor shall resubmit the allotment request.

8.1.3.6. Within five business days, the contractor will notify the beneficiary of rejected allotment requests and issue an invoice to the beneficiary for any outstanding enrollment fees due. The contractor will respond to all beneficiary inquiries regarding allotments.

NOTE: During the enrollment year to fiscal year alignment process, (which occurs upon an initial enrollment or upon the first re-enrollment performed by the MCSC) enrollment fees will be prorated to the end of the current fiscal year (September 30th). The next enrollment period will begin on October 1st. At that point, the enrollment year is considered aligned with the fiscal year.

8.2. Member Category

The sponsor's member category on the effective date of the initial enrollment, as displayed in DOES, shall determine the requirement for an enrollment fee.

NOTE: Unremarried *Former Spouses (URFSs)* became sponsors in their own right as of October 1, 2003. However, although sponsors in their own right, they cannot "sponsor" any family members, including children. Enrolled *URFSs* must pay an annual individual enrollment fee. Children of *URFSs* residing with the *URFS*, and whose eligibility for benefits

is based on the ex-spouse (former sponsor) are identified under the ex-spouse's (former sponsor's) on DEERS and the enrollment record for the ex-spouse. A family enrollment fee must be collected and applied under the ex-spouse (former sponsor's) enrollment, in addition to the individual enrollment fee collected for the *URFS*'s enrollment fee. For example, a contractor will collect the annual enrollment fee for an *URFS*, now a sponsor in their own right. The contractor will also collect an annual family enrollment fee for the eligible (as determined by the status of the ex-spouse [former and original sponsor] and not the *URFS*) children living with the *URFS*.

8.3. Overpayment of Enrollment Fees

8.3.1. Prior to October 1, 2012

If enrollment fees are overpaid during the payment of installments during an enrollment year, contractors can maintain a credit of those fees and apply the credit to any outstanding payments due. If credits of the overpayment of enrollment fees are not maintained, contractors are required to refund any overpayments of \$1 or more. When TRICARE Prime enrollment changes from a family to an individual prior to annual renewal, the unused portion of the enrollment fee will be prorated on a monthly basis and shall be applied toward a new enrollment period.

8.3.2. On or After October 1, 2012

Effective with enrollment fees that are to be applied on or after October 1, 2012, the contractor shall update DEERS with the fee amount collected and DEERS will calculate the paid through date and notify the contractor. DEERS will only extend the paid through date to cover the current enrollment year, plus two future fiscal years. DEERS will store amounts that cannot cover one month's fees or amounts that extend the paid through date beyond two fiscal years in the future as a credit. Additionally, funds applied that would move the paid through date beyond the policy end date will be stored as a credit. (The exception is when Prime policies end mid-month; DEERS will set a paid through date to the end of that month). Also, if there is a 100% fee waiver with an end date that exceeds more than two fiscal years in the future, the paid period can extend beyond the two fiscal years and any monies sent to DEERS will be applied as a credit. The contractor shall refund any credits that extend beyond two future fiscal years of \$1 or more on a current enrollment. The contractor shall update DEERS with any fee amount refunded within 30 calendar days.

8.4. Medicare Part B - Fee Waiver

Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, is entitled to a waiver of an amount equivalent to the individual TRICARE Prime enrollment fee. Hence, individual enrollments for such beneficiaries will have the enrollment fee waived. A family enrollment in TRICARE Prime, where one family member is under age 65 and maintains enrollment in Medicare Part B, shall have one-half of the family enrollment fee waived; the remaining half must be paid. For a family enrollment where two or more family members are under age 65 and maintain enrollment in Medicare Part B, the family enrollment fee is waived regardless of the number of family members who are enrolled in addition to those entitled to Medicare Part B.

8.5. Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Services Members and their Dependents

Effective Fiscal Year (FY) 2012, beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their dependents, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying Prime plan. (This does not include TRICARE Young Adult (TYA) plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime. The fee for the dependent(s) of a medically retired Uniformed Services member shall not change if the dependent(s) is later re-classified a survivor.

8.6. Mid-Month Enrollees

The contractor shall collect any applicable enrollment fee from the mid-month enrollee at the time of enrollment; however there will be no additional enrollment fee collected for the days between the effective enrollment date and the determined enrollment date. The determined enrollment date shall be determined using the existing 20th day of the month rule (e.g., A member submits a request to remain in Prime prior to his retirement date which is May 15th. The effective enrollment date will be May 15th and the determined enrollment date will be June 1st. If the retirement date is May 27th, the effective enrollment date will be May 27th and the determined enrollment date will be July 1st). For enrollments on/after October 1, 2012, DEERS will calculate the paid through dates based on the enrollment fee amount entered in DEERS by the contractor. Reference the TPM, [Chapter 10, Section 3.1](#).

8.7. Monthly Reports (On or After October 1, 2012)

DEERS will report the following on a monthly basis:

- Current policies that are two months past due (paid period end date more than two months in the past)
- Any policies where the paid period end date exceeds the policy end date
- Policies where the paid period end date meets the policy end date but a credit exists
- Terminated policies where the paid period end date does not meet the policy end date

These reports will be provided before the 10th day of each month. The contractor is required to analyze and correct all report accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if

necessary. For enrollment fee payments effective on or after October 1, 2012, the contractor shall update DEERS with any fee amount refunded within 30 calendar days.

9.0. ENROLLMENT/NETWORK PROVIDER TYPE ASSIGNMENT DURING IN-PROCESSING

9.1. The MCSCs shall provide a process to enroll eligible beneficiaries into TRICARE programs using the TRICARE enrollment form. All TRICARE enrollments shall be performed through the government furnished DEERS application. Enrollment will include designation of a Primary Care Location in accordance with MTF MOUs. The Network Provider Type assignment shall be accomplished based on utilizing a MOU, to be developed between each MTF within their region, appropriate RD and the MCSC, to prescribe the Primary Care Location assignment business rules. Family members of active duty E-1 through E-4 who reside within the PSA of a MTF and who are not already enrolled in TRICARE Prime should be encouraged to enroll upon in-processing or when otherwise identified as a candidate for enrollment in accordance with the provisions of [paragraph 10.0](#).

9.2. The MCSCs shall administer the TRICARE enrollment form, verify accuracy of information and initiate the enrollment process through the DEERS enrollment application.

9.2.1. The equipment needed to run the DEERS desktop enrollment application shall be furnished by the MCSC and shall meet technical specifications in the TSM, [Chapter 3](#).

9.3. The MCSC representative will provide a current Primary Care Location listing to the enrollee during enrollment processing, and will provide guidance to the enrollee related to Primary Care Location selection. The MCSC representative will assign enrollees to Primary Care Locations until maximum capacity is reached. In accordance with approved MTF MOUs, the MTF will provide a listing of Primary Care Locations with associated groups.

9.4. The Defense Manpower Data Center (DMDC) will centrally print the Universal TRICARE Beneficiary Card generated from DMDC/DEERS enrollment data on a regular basis at the intervals and events required under current contract requirements. DMDC will centrally mail all Universal TRICARE Beneficiary Cards directly to the enrollee at the residential mailing address specified on the enrollment application. The return address on the envelope mailed by DMDC will be that of the respective MCS contractor. In the case of receiving returned mail, the MCSC shall develop a process to fulfill the delivery of the Universal TRICARE Beneficiary Card to the enrollee.

10.0. ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

10.1. Section 712 of the National Defense Authorization Act (NDAA) for FY 1999 modified Chapter 55 of Title 10, United States Code (USC) by adding a new section 1079a which provides for TRICARE Prime enrollment for active duty families of E-1 through E-4 in certain circumstances.

10.2. When family members of E-1 through E-4 reside in a PSA of a military medical treatment facility offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a PCM located in the military medical treatment facility. Such family members may, however, specifically decline

such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently disenroll may re-enroll at any time.

10.3. Enrollment processing and allowance of civilian PCM assignments will be in accordance with the MOU between the contractor and the MTF. The completion of an enrollment application is a prerequisite for enrollment of such family members.

10.4. The primary means of identification and subsequent referral for enrollment will occur during in-processing. These non-enrolled families may also be referred to the local TSC by the MTF, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers et. al.

10.5. The local TSC will provide enrollment information and support the family member in making an enrollment decision (i.e., to enroll in TRICARE Prime or to decline enrollment). The contractor shall inform the family members of the benefits and opportunities that accompany Prime enrollment and will give them the opportunity to select or be assigned an MTF PCM, select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime. The effective date of enrollment shall be determined by the actual date of the enrollment application and consistent with current TRICARE rules (i.e., the "20th of the month" rule, as applied under the current contract arrangements).

10.6. The education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment (e.g., guaranteed access, the support of a PCM, etc.), shall reinforce that enrollment is at no cost for family members of E-1 through E-4, and shall discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the "20th of the month" rule, as applied under the current contract arrangements).

10.7. Eligibility effective dates will be assigned consistently with all other TRICARE Prime enrollment policies, i.e., enrollments received on or before the 20th day of the month will become effective on the first day of the following month, etc. These enrollments and enrollment refusals should not be tracked, or the enrollees identified differently than enrollments initiated through any other process, such as the MCSC's own marketing efforts.

10.8. Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures.

10.9. Contractors are not required to screen every TRICARE claim on an automated basis to determine whether it may be for treatment of a non-enrolled ADFM of E-1 through E-4, living in a PSA. Rather, they are to support the prompt and informed enrollment of such individuals when they have been identified by DoD in the course of such a person's interaction with the military health care system or personnel community, and have been referred to the contractor for enrollment.

11.0. TRICARE ELIGIBILITY CHANGES

11.1. Refer to the TPM, [Chapter 10, Section 3.1](#) for information on changes in eligibility. The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining (for example, a retiree or a family member who is 64 years of age, a TAMP beneficiary, etc.) to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly), as allowable under current instructions. If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility. DEERS will calculate the paid through date based on the enrollment fee amount entered in DEERS by the contractor, which in this circumstance, should cover the period of the beneficiary's eligibility. The contractor shall refund any overpayment of \$1 or more that DEERS does not use to extend the paid through date to the policy end date (or the last day of the month in which a Prime policy ends). The contractor shall update DEERS with any fee amount refunded within 30 calendar days.

11.2. Contractors shall reimburse the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees (and their families) who have been recalled to active duty and report such reimbursements to DEERS within 30 calendar days. Contractors shall calculate the reimbursement using monthly prorating as defined in [Appendix A](#). If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its PCM, if possible. Any enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period.

11.3. The contractor shall reimburse enrollment fees when a written request with a copy of the death certificate have been received. Reimbursements shall be prorated on a monthly basis. This applies to an individual enrollment and to family enrollments that become individual plans upon the death of one or more family members. For individual enrollments, the contractor will refund remaining enrollment fees when the executor of the estate request reimbursement. For family enrollments, the contractor will make the necessary adjustments to convert the family enrollment to an individual enrollment when notified of the death of one of the two family enrollees. Enrollment fees for family enrollments of three or more members are not impacted upon the death of only one member. The contractor shall update DEERS with any amount refunded within 30 calendar days.

11.4. The contractors shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based on disability, End Stage Renal Disease (ESRD), or upon attaining age 65 and have Medicare Part B coverage. The contractor shall calculate the refund using monthly prorating as defined in [Appendix A](#). The contractor shall update DEERS with any amount refunded within 30 calendar days.

11.4.1. For Prime enrollees who become Medicare eligible upon attaining age 65 and maintain their Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts whose health care delivery began after March 31, 2004. The contractor shall utilize its files to substantiate any claim of overpayment.

11.4.2. For Prime enrollees who are under 65 years of age and become Medicare eligible due to disability or ESRD and have maintained their Medicare Part B coverage, refunds are required for overpayments starting on the date the enrollee has Medicare Part B, but no earlier than March 26, 1998. Beneficiaries must provide sufficient documentation to support the overpayment for a refund. The contractor shall supplement the beneficiaries' documentation using DEERS and any available internal files, both from the current and prior contracts.

11.4.3. The contractor is not required to research their files to identify these individuals. If the contractor receives a refund request, then the contractor shall refund the unused portion of the enrollment fee determined to be an overpayment in accordance with policy. The contractor shall update DEERS with any amount refunded within 30 calendar days. Beneficiaries age 65 and over who are not entitled to premium free Medicare Part A remain eligible for TRICARE Prime.

NOTE 1: Medicare eligible ADFMs age 65 and over are not required to have Medicare Part B to remain enrolled in TRICARE Prime. To maintain TRICARE coverage upon the sponsor's retirement, they must enroll in Medicare Part B during Medicare's Special Enrollment Period prior to their sponsor's retirement date. (The Special Enrollment Period is available anytime the sponsor is on active duty or within the first eight months of the sponsor's retirement. If they enroll in Part B after their sponsor's retirement date, they will have a break in TRICARE coverage).

NOTE 2: Medicare eligibles age 65 and over who are not entitled to premium-free Medicare Part A are not required to have Medicare Part B to remain enrolled in TRICARE Prime. Because they may become eligible for premium-free Medicare Part A at a later date, under their or their spouse's SSN, they should enroll in Medicare Part B when first eligible at age 65 to avoid the Medicare surcharge for late enrollment.

11.5. The contractor shall include full and complete information about the effects of changes in eligibility and rank in all beneficiary education materials and briefings.

12.0. WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION

The WII program provides a continuum of integrated care from the point of injury to the return to duty or transition to active citizenship for the Active Component (AC) or the Reserve Component (RC) service members who have been activated for more than 30 days. These AC/RC service members, referred to as ADSMs, have been injured or become ill while on active duty and will remain in an active duty status while receiving medical care or undergoing physical disability processing. WII programs vary in name according to Service. The Service shall determine member eligibility for enrollment into a WII program, as well as whether or not to utilize these enrollments.

To better manage this population, a secondary enrollment classification of HCDP Plan Coverage Codes, WII 415 and WII 416 were developed. The primary rules apply to the WII HCDP codes:

- ADSMs must be enrolled to a TRICARE Prime program prior to, or at the same time, as being enrolled into a WII 415 or WII 416 program.

- A member cannot be enrolled in WII 415 and WII 416 programs at the same time.
- WII 415 and WII 416 enrollments will terminate at the end of the member's active duty eligibility, when members transfer enrollment to another MTF, change of a plan code, or at the direction of the Service-specific WII entity.
- Any claims processed for WII 415/416 enrollees shall follow the rules associated with the primary HCDP Plan Coverage Code, such as TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Overseas Program (TOP) Prime, or TRICARE Puerto Rico Contract (TPRC). All claims will process and pay under Supplemental Health Care Program (SHCP) rules. DEERS will not produce specific enrollment cards or letters for WII 415/416 enrollment.

WII 415/416 TRICARE Encounter Data (TED) records shall be coded with the WII 415/416 HCDP Plan Coverage Code; however, the Enrollment/Health Plan Code data element on the TED record shall reflect the appropriate value for the primary HCDP Plan Coverage Code. For example, a TED record for a WII 416 enrollee with primary enrollment to TPR would reflect the HCDP Plan Coverage Code of "416" but the Enrollment/Health Plan Code would be coded "W TPR Active Duty Service Member".

12.1. WII 415 - Wounded, Ill, And Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))

12.1.1. Service defined eligible ADSMs assigned to a WII 415 Program such as a MEDHOLD or WTU shall be enrolled to TRICARE Prime or TOP Prime prior to, or at the same time, as being enrolled into the WII 415. Members cannot be enrolled to the WII 415 without a concurrent TRICARE Prime or TOP Prime enrollment. Service appointed WII case managers as determined by the Services, will coordinate with the MTF to facilitate TRICARE Prime PCM assignments for WII 415 members. The contractor shall then assign a PCM in accordance with the MTF MOU and in coordination with the WII case manager. WII 415 enrollment will not run in conjunction with TAMP and members enrolled in TPR, TRICARE Global Remote Overseas (TGRO), or TPRC are not eligible to enroll in the WII 415.

12.1.2. The Service-specific WII entity will stamp the front page of the DD Form 2876, enrollment application form, with WII 415 for new enrollments that begin after the DEERS implementation date. The enrollment form will then be sent to the appropriate contractor or TRICARE Area Office (TAO) who shall perform the enrollment in the DOES and include the following information:

- WII 415 HCDP Plan Coverage Code
- WII 415 Enrollment Start Date (Contractors may change the DOES defaulted start date, which may or may not coincide with the Prime Enrollment Start Date. The start date can be changed up to 289 days in the past or 90 days into the future.)

12.1.3. WII 415 enrollments will be in conjunction with an MTF enrollment only, not to civilian network PCMs under TPR enrollment rules. DEERS will end WII 415 enrollments upon loss of member's active duty eligibility. WII 415 program enrollments will not be

portable across programs or regions. TAOs will enter WII 415 enrollments through DOES for Outside the Continental United States (OCONUS) regions.

12.1.4. The contractors shall accomplish the following functions based on receipt of notification from the Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- MCSC can request Policy Notification Transaction (PNT) resend
- Modify begin date
- Modify end date

12.1.5. Service WII entities will provide contractors/TAOs a list by name and SSN of those ADSMs currently assigned to their WII program at the time the program is implemented by DEERS. The contractors/TAOs shall enter these ADSMs into DOES as enrolled in WII 415 with a start date of the date of implementation, unless another date, up to 289 days in the past, is provided by the WII entity.

12.2. WII 416 - Wounded, Ill, And Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))

12.2.1. Service defined eligible ADSMs may be assigned to a WII 416 Program such as the Army's CBHCO and receive required medical care near the member's home. The service member shall be enrolled to TRICARE Prime, TPR, TGRO, or TPRC prior to or at the same time as being enrolled into WII 416. Members cannot be enrolled to the WII 416 program without a concurrent Prime, TPR, TGRO, or TPRC enrollment. Service appointed case managers will coordinate with the contractor or MTF to facilitate TRICARE Prime or TPR PCM assignments for eligible beneficiaries. The contractor shall then assign a PCM based on the MTF MOU and in coordination with the WII entity (e.g., CBHCO). WII 416 enrollments will not run in conjunction with TAMP.

12.2.2. The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. The enrollment form will then be sent to the appropriate contractor or TAO who shall perform the enrollment in the DOES and include the following information:

- WII 416 HCDP Plan Coverage Code
- WII 416 Enrollment Start Date (Date received by the contractor or the date indicated by the Service-specific WII Program which can be up to 289 days in the past, or 90 days in the future.)

An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

12.2.3. WII 416 enrollments can be in conjunction with an MTF, TPR, TGRO, or TPRC enrollment. DEERS will end WII 416 enrollments upon loss of member's active duty eligibility. WII 416 program enrollments will not be portable across programs or regions. TAOs will enter WII 416 enrollments through DOES for OCONUS regions.

12.2.4. The contractors shall accomplish the following functions based on receipt of notification from Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- Contractors can request PNT resend
- Modify begin date
- Modify end date

12.2.5. Service-specific WII entities will provide contractors/TAOs a list by name and SSN of those ADSMs currently participating in their WII program at the time the program is implemented by DMDC. The contractors/TAOs shall enter these ADSMs into DOES as enrolled to WII 416 with a start date as the date of implementation, unless another date up to 289 days in the past is provided by the Service-specific WII program entities.

13.0. TRICARE POLICY FOR ACCESS TO CARE (ATC) AND PRIME SERVICE AREA (PSA) STANDARDS

13.1. This policy requires that non-active duty beneficiaries in the continental United States (CONUS) and Hawaii who reside more than 30 minutes travel time from a MTF to which they desire to enroll must request waivers of the ATC drive-time standards through an MTF Commander to effect enrollment to that MTF. The Commander (or local designee) may approve waivers only for those who they determine will drive less than 100 miles to the MTF to visit their PCM. The TRO Director may approve waiver request from beneficiaries who desire to enroll to the MTF and who reside 100 miles or more from an MTF only if the MTF Commander (or local designee) wishes to accept the enrollment request based on the MTF's capacity and capabilities.

13.2. Due to the unique health care delivery challenges in Alaska, the requirement to request a waiver of ATC standards for beneficiaries residing in Alaska is waived.

13.3. Enrollment Of Beneficiaries Residing More Than 30 Minutes Travel Time From A MTF

13.3.1. The MCSC shall process all requests for enrollment to an MTF in accordance with the MOU between the MCSC and the MTF.

13.3.2. If a beneficiary residing more than 30 minutes travel time from the MTF has requested enrollment or a portability transfer to the MTF, before effecting the enrollment, the MCSC shall ensure that the applicant has waived travel time ATC standards either by signing Sections V and VI of the DD Form 2876 enrollment application (this includes an electronic signature offered by and collected by the contractor) or by requesting enrollment via the BWE service. For each approved enrollment to an MTF, whether by DD Form 2876 or BWE, the MCSC shall retain the enrollment request in a searchable electronic file until 24 months after the beneficiary is no longer enrolled to the MTF. The MCSC shall provide the retained files to the successor contractor at the end of the final option period.

13.3.2.1. The MCSC shall notify the MTF Commander (or local designee) when a beneficiary residing 100 miles or more from the MTF, but in the same region, requests a new enrollment or portability transfer to the MTF. Such notification is not necessary if the MOU has already established that the MTF Commander will not accept enrollment of beneficiaries who reside 100 miles or more from the MTF. The MCSC shall make any required notification by any mutually agreeable method specified in the MOU. The MCSC shall not make the MTF enrollment effective unless notified by the MTF to do so.

13.3.2.2. The MTF Commander will notify the TRO Director of their desire to enroll a beneficiary who resides more than 100 miles from the MTF and request approval for the enrollment. The TRO Director will make a determination on whether or not to approve or deny the enrollment and notify the MTF Commander of their decision by a mutually agreeable method.

13.3.2.3. To estimate the travel time or distance between a beneficiary's residence and an MTF the MCSC must use at least one web-based mapping program of the MCSC's choosing. The choice of program(s) is at the discretion of the MCSC, but the MCSC must use a consistent process to determine the driving distance for each enrollee applicant who may reside more than 30 minutes travel time from the MTF. In making this determination the MCSC shall compute the time or distance, as applicable, between the enrollee's residence and the MTF. It is not acceptable to use a geographic substitute, such as a zip code centroid. If an enrollee applicant resides within a zip code previously determined to lie entirely within 30 minutes travel time from the MTF, the MCSC need not compute the travel time for that applicant, nor need the distance from the MTF be computed if the residence is in a zip code previously determined to lie entirely beyond 100 miles from the MTF. The MCSC shall compute the travel time or distance if the enrollee applicant resides in a location not included among those identified in the MOU as containing beneficiaries whom the MTF Commander is willing to consider for enrollment.

13.3.2.4. When the enrollment requires the MTF Commander or TRO Director to consider a request for waiver of travel time access standards, the MCSC's contractual requirement for processing timeliness of an enrollment request will begin when MCSC has obtained direction from the MTF Commander about waiver approval or disapproval.

13.3.3. An approved waiver for a beneficiary residing less than 100 miles from the MTF remains in effect until the beneficiary changes residency location.

13.3.4. The MTF Commander, in the MOU, may specify that enrollment of some or all current enrollees who reside 100 or more miles from the MTF, but in the same region, are not

to be renewed at the end of the enrollment period, even if they have previously waived the travel time standard. The MOU shall document a rationale, based on the MTFs capacity and capabilities, for disqualification of re-enrollment that is consistent with the priority, by beneficiary category, for enrollment specified in [32 CFR 199.17\(c\)](#). The MCSC shall inform such beneficiaries no later than two months prior to expiration of the current enrollment period that they are disqualified for renewal of enrollment to the MTF, provide the rationale for this (as documented in the MOUs), and explain that disqualification for re-enrollment is based upon priority, by beneficiary category, for enrollment specified in [32 CFR 199.17\(c\)](#).

13.3.5. If the MCSC determines there is no signed travel time waiver on file for a current MTF enrollee who resides more than 30 minutes from the MTF, the MCSC shall, at the next annual TRICARE Prime enrollment renewal point, require the beneficiary to submit a new DD Form 2876, with the beneficiary's signature in both Sections V and VI. The MCSC will notify the beneficiary of this waiver documentation requirement no later than two months before expiration of the beneficiary's enrollment.

13.3.6. When beneficiary requests are denied for enrollment to an MTF or when a beneficiary is notified that they are disqualified for re-enrollment to an MTF, the MCSC shall inform the beneficiary of alternative options for enrollment. The beneficiary may in lieu of enrollment to the MTF enroll to a different MTF if available within travel time access standards or enroll to a network PCM if they live within a PSA or live outside a PSA with existing excess enrollment capacity and within 100 miles of a network PCM. The beneficiary must also be made aware of the option to participate in TRICARE Extra, TRICARE Standard, or the USFHP where available.

13.3.7. The MCSC shall apprise the MTF Commander (or local designee) of all enrollees to the MTF who have waived their rights to the travel time access standard. The MCSC shall separate the information into two categories, those who reside within 100 miles of the MTF and those who reside 100 miles or more from the MTF. The notification shall be by any mutually agreeable means specified in the MOU between the MTF Commander and the MCSC.

13.3.8. If the MCSC determines that a beneficiary's residential address, as recorded in the DEERS, is not within the same region as the MTF to which the beneficiary is enrolled and is located outside the MTF PSA, the MCSC shall inform the beneficiary of the discrepant address situation. The MCSC shall not wait for the next annual TRICARE Prime renewal point before contacting the beneficiary. If the beneficiary confirms the DEERS-recorded address is incorrect, the MCSC shall request the beneficiary update DEERS with correct information. If the MCSC determines the beneficiary resides either outside the region in which the beneficiary is enrolled or more than 100 miles outside the MTF PSA, the MCSC shall inform the beneficiary no later than two months prior to expiration of the current enrollment period that the beneficiary's enrollment will not be renewed in a region in which the beneficiary does not reside. The MCSC shall provide information necessary for the beneficiary to contact the MCSC for the region in which the beneficiary resides to request enrollment in that region.

6.6. Verification Of Provider's Compliance With The Beneficiary Signature On File Requirement

The contractor shall verify beneficiary signature on file compliance using the postpayment audit requirement in [Chapter 1, Section 4, paragraph 4.1.](#), and the audit procedures in [Chapter 14, Section 4, paragraph 3.0.](#)

7.0. UNACCEPTABLE SIGNATURES

A provider or an employee of an institution providing care to the patient may not sign the claim form on behalf of the beneficiary under any circumstances. Nor can an employee of a contractor execute a claim on behalf of a beneficiary (unless such employee is the beneficiary's parent, legal guardian, or spouse). Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and/or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness. If the beneficiary is unable to sign due to an incapacitating condition/illness, the provider can annotate in the Signature Box on the TRICARE claim form "Unable to sign." A letter from the provider shall be attached to the claim form describing the physical and or mental incapacitating illness. For those illnesses which are temporary, the letter needs to specify the inclusive dates of the illness.

8.0. BENEFICIARY SIGNATURE WAIVER

8.1. Administrative Tolerance - Certain Ancillary Services

Claims for inpatient anesthesia, laboratory and other diagnostic services in the amount of \$50 or less, provided by physician specialists in anesthesiology, radiology, pathology, neurology and cardiology should not be returned for beneficiary signature unless required by state law or contractor corporate policy. Claims submitted by an institution when the claim is for those specific ancillary services cited above, should be included in this tolerance if the services were performed in an institution other than the institution in which the beneficiary is receiving inpatient care.

8.2. Beneficiary (Sponsor, Guardian Or Parent Moved) Unable To Locate

Requirements for a beneficiary's (sponsor, guardian or parent) signature should be waived in the following situations for claims received from non-network participating providers. The contractor should grant a waiver after the procedures described below have proven unsuccessful. If unable to obtain a signature because the beneficiary has moved and left no forwarding address, the contractor shall attempt to obtain the address by telephone or from internal files, or DEERS. *If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TRICARE Systems Manual (TSM), Chapter 3, Section 1.5, paragraph 1.3.1., Addresses.* If a new address is obtained, the original claim should be returned to the beneficiary or sponsor with a request for signature. If the claim was submitted by a provider, a **copy**, with the diagnosis and any sensitive information deleted, shall be sent to the beneficiary or sponsor. If the signature is not obtained because the new address is still not

valid and the patient cannot otherwise be located, the contractor should grant a signature waiver for a participating provider. Nonparticipating provider claims must be denied. However, if the address is valid, and the contractor knows, through the claim development process, that the beneficiary or sponsor does not wish to file a claim, the claim(s) must be denied whether or not the provider participates. If the contractor obtains a new address, this address cannot be released to the provider.

9.0. NETWORK PROVIDER SIGNATURE

Signature requirements for network providers are dependent upon the provisions of the agreement and administrative procedures established between the providers and the contractor.

10.0. NON-NETWORK PROVIDER SIGNATURE

The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. The provider's signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim. The provider's signature is also required to certify services rendered when a provider completes a nonparticipating claim for the beneficiary. If the provider does not sign, the contractor may contact the provider by telephone to verify the delivery of services or return the claim for signature. A claimant may also attach an itemized bill on the letterhead/billhead of the provider verifying delivery of services.

10.1. Facsimile Or Representative Signature Authorization

In lieu of a provider's actual signature on a TRICARE claim, a facsimile signature or signature of a representative should be accepted if the contractor has on file a notarized authorization from the provider for use of a facsimile signature ([Chapter 8, Addendum A, Figure 8-A-2](#)) or a notarized authorization or power of attorney for another person to sign on his or her behalf ([Chapter 8, Addendum A, Figure 8-A-3](#)). The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated. The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by "POA" (Power of Attorney), or similar indication of the type of authorization granted by the provider.

10.2. Verification Of Provider Signature Authorization

In the absence of any indication to the contrary, contractors should assume the proper authorization is on file, validating through file checks, those claims containing facsimile and representatives' signatures which are included in their quality control audit, and program integrity samples. The contractor should remind providers of the requirement for current signature authorizations through at least annual notice in routine bulletins or newsletters and at other appropriate times when contacts are made. The contractor may

return a claim with a request for the signature authorization when it is found that there is no authorization on file or it is out-of-date:

- Send a request to the provider advising of the need for authorization and;
- Set a utilization flag on the provider's file to stop further payment to the provider when the proper signature is not on the claim, pending receipt of the authorization.
- Advise the provider that if the authorization is not received, it will be necessary to deny the claim or to process it as a nonparticipating claim, depending on the information available to make a payment determination.
- Schedule a contractor representative visit to resolve any problem which may develop in the unlikely event a provider chooses not to cooperate.

10.3. Certification Of Source Of Care

Source of care certification is used to help determine the correct payee on the participating UB-92/UB-04 and the CMS 1500. The CMS 1450 UB-04 has eliminated the provider's signature block FL from the form. As a work around, the NUBC has designated FL 80, Remarks, as the location for the signature, if signature on file requirements do not apply to the claim. Submission of the UB-04 claim form by an institution or provider certifies the institution or provider is complying with all the TRICARE certifications on the reverse of the claim. Provider signature on file requirements apply to the claims if not signed. If signed by the provider and the certification is unaltered, issue payment to that provider. If signed with alteration of the certification, issue payment to the beneficiary (parent/legal guardian of minor or incompetent). If unsigned and an itemized billing on the provider's letterhead is not attached, return the claim.

NOTE: For procedures in case of any irregularities, refer to [Chapter 14](#), Program Integrity.

4.1.4.2. If TRS member-only coverage was in effect on the date of the member's death, DEERS will terminate coverage with an effective date coinciding with the date of death. Eligible family members may purchase coverage by completing a TRS request. The TRS request required by [paragraph 4.1.](#) must be either received in the TSC or postmarked no later than 60 days after the date of death of the Selected Reservist. DMDC will issue letters to survivors advising them of the option to purchase coverage.

4.2. Changes in TRS Coverage

Once TRS coverage is in effect, TRS members, which include TRS-covered survivors, may request the following types of changes.

4.2.1. Type of Coverage Changes

A TRS member/survivor may change TRS type of coverage following procedure for a QLE specified in [paragraph 4.1.2.](#) or procedures for open enrollment specified in [paragraph 4.1.3.](#) The contractor shall follow procedures specified in [paragraph 5.5.](#) for premium adjustments resulting from changes in coverage.

4.2.2. Addition Of Family Members to TRS Member and Family Coverage

TRS members/survivors may request to add eligible family members to an existing TRS member and family coverage plan at any time, once eligibility for the family is established. Eligibility is established by going to a military personnel office with RAPIDS capability to appropriately update DEERS. The effective date of coverage for the added family member(s) shall follow procedures specified in [paragraphs 4.1.2.](#) or [4.1.3.](#) The TRS request must be either received in the TSC or postmarked NLT 60 days after that date.

4.2.3. TRS Newborn/New Child Policy

4.2.3.1. A newborn/new child will be covered from the date of birth/custody only if, (a) the TRS member registers the newborn/new child in DEERS within 60 days of birth/custody, and (b) the TRS request is either received in the TSC or postmarked NLT 60 days after the date of birth/custody. The contractor shall handle claims associated with the newborn/new child as specified in [paragraph 6.0.](#) The contractor shall make adjustments in premiums as specified in [paragraph 5.5.](#)

4.2.3.2. TRS members who reside overseas may have difficulty in obtaining the documentation required to register a newborn/new child in DEERS. As with all other late submissions of enrollment requests, the member may submit a request for reconsideration to the appropriate TRICARE Regional Director (RD) (or their designee), or the TRICARE Area Office (TAO) Director consistent with [paragraph 4.5.1.](#)

4.3. Processing

4.3.1. The contractor shall process all TRS transactions through DOES for members or survivors with a DEERS residential address in the contractor's region. The contractor shall process TRS requests received along with *the initial* premium payment ([paragraph 4.1.](#)) NLT *10 business* days after receipt.

4.3.2. If the contractor is unable to enroll the member/survivor in DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premium, or (e) the initial premium payment not being in the correct amount; the contractor shall return a copy of the original application and any incorrect premiums to the member, within 10 business days, with an explanation of what is needed for the contractor to accept the application for processing.

4.4. Termination of TRS Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 business days after the effective date of the termination or after receipt of the Policy Notification Transaction (PNT) notifying the contractor of a termination, whichever is later. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund. *If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.5, paragraph 1.3.1., Addresses.*

4.4.1. Loss of TRS Eligibility

The effective date of termination for a member covered under TRS shall be the effective date of the loss of their qualifications for TRS coverage. The Selected Reserve member or their family members will not incur a lockout when coverage is terminated due to loss of TRS eligibility.

4.4.1.1. Sponsor Loss of Eligibility

When a sponsor's eligibility is terminated at a date other than the anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor of the terminated coverage. When a sponsor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage.

4.4.1.2. Individual Family Member or Survivor Loss of Eligibility

In the case of a family member or survivor losing eligibility in DEERS, DEERS will send the contractor an unsolicited PNT advising the contractor to terminate coverage for that individual. When an individual family member's or survivor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage. The contractor shall terminate coverage for the family member(s) or survivor(s) as appropriate.

4.4.2. Member or Survivor Gains Other TRICARE Coverage

No lockout shall be applied for termination due to the gain of other TRICARE coverage.

4.4.2.1. If a TRS member gains other TRICARE coverage for a period of 30 days or less, TRS coverage will continue unchanged.

4.4.2.2. If a TRS member or survivor gains other TRICARE coverage for a period of more than 30 days DEERS will terminate TRS coverage in accordance with [paragraph 4.4.1.1](#). The contractor must be aware of the fact that DEERS may reflect Active Duty Service Member (ADSM) and Active Duty Family Member (ADFM) TRICARE coverage before the member actually reports for active duty.

4.4.2.3. If a TRS member gains other TRICARE coverage via a family member, the member and family members may terminate coverage under TRS without incurring a lockout.

4.4.3. Failure to Make Payment

4.4.3.1. Failure to pay monthly premiums in accordance with the procedures in this chapter shall result in termination of coverage. The effective date of termination is the paid-through date. The contractor shall automatically terminate coverage of the TRS member, all covered family members and survivors if the monthly premium payment is not received by the last day of the month following the due date for the monthly premium payment. After the last day of the month, the contractor shall terminate coverage with a termination effective date retroactive to the paid-through date. DMDC sends written notification to the beneficiary of the termination and the reason for the termination. Until the termination action is processed, the contractor may pend any claims received for health care furnished to the TRS member, family members and/or survivors during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The TRS member, family members and/or survivors will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pended, the contractor shall initiate recoupment of health care costs following the procedures in [Chapter 11, Section 4](#).

4.4.3.2. A contractor shall apply a TRS purchase lockout for the RC member and/or family members and/or survivors whose coverage is terminated for failure to make a payment. The lockout shall be for a period of 12 months from the effective date of termination. The DMDC written notification of termination (see [paragraph 4.4.3.1](#).) includes notice of the 12 month lockout period.

4.4.4. Member/Survivor Request for Voluntary Termination

A contractor shall apply a TRS purchase lockout to all beneficiaries covered under the TRS plan for a period of 12 months from the effective date of terminations initiated by the TRS member or survivor.

4.4.4.1. Termination of Existing Plan(s)

The contractor shall accept requests for termination of coverage from TRS members at anytime. The effective date of termination is either (a) the last day of the month in which the request was postmarked or received in the TSC or (b) the last day of a future month as specified in the request given that the request was postmarked or received in the

TSC in the month preceding the requested month of termination. The contractor shall apply a TRS purchase lockout to all beneficiaries covered by the TRS plan for a period of 12 months from the effective date of terminations initiated by the TRS member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1.](#)) includes notice of the 12 month lockout period.

4.4.4.2. Termination of an Individual's Coverage

The contractor shall accept requests for termination of coverage for individual family members from TRS members at anytime. The effective date of termination is either (a) the last day of the month in which the request was postmarked or received in the TSC or (b) the last day of a future month as specified in the request, if the request was postmarked or received in the TSC in the month preceding the requested month of termination. The contractor shall apply a TRS purchase lockout to individual family members or survivors whose TRS coverage was terminated upon request for a period of 12 months from the effective date of termination initiated by the TRS member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1.](#)) includes notice of the 12 month lockout period.

4.4.4.3. Cancelled Eligibility and Enrollment

When the contractor receives a PNT for a cancelled enrollment, the contractor will generate a letter notifying the covered member of the cancellation and refund any unused portion of the premium payment. The contractor shall update DEERS with any premium amount refunded within 30 calendar days. No lockout shall be applied for a cancelled enrollment.

4.4.5. TRS Survivor Coverage Termination

If TRS coverage is continued as described in [paragraph 4.1.4.1.](#) and the survivors do not wish to keep the coverage, the survivors must submit a request in writing, in accordance with procedures described in [paragraph 4.1.4.1.](#), to be received by the contractor no later than 60 days after the date of death in order to terminate coverage retroactive to the day after the member's death. Alternatively, the survivor may request to terminate coverage in accordance with [paragraph 4.4.4.](#) Otherwise, DEERS will terminate TRS survivor coverage six months after the date of the member's death. Refunds of premiums will be handled as specified in [paragraph 4.4.](#)

4.5. Exceptions

4.5.1. Reconsiderations of Member's Survivor's Actions

The contractor shall advise TRS members/survivors that all reconsideration requests for either (a) refusal of late submission of requests or (b) lockouts shall be submitted to the appropriate TRICARE RD, or their designee, or the TAO Director for determination. The TRICARE RD, or their designee, or the TAO Director will issue decisions within 10 calendar days of receipt of all reconsideration requests. If changes are to be made to a member's/survivor's coverage as a result of a reconsideration determination, the TRICARE RD, or their designee, or the TAO Director will send instructions to the contractor. The

contractor shall carry out such instructions NLT 10 calendar days after receipt from the TRICARE RD, or their designee or the TAO Director. The TRICARE RD, or the designee, or the TAO Director may authorize an “override” of information contained on DEERS, pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.

4.5.2. Administrative Issues

The TRICARE RD, or their designee, or the TAO Director will notify the contractor when the government determines that an administrative situation occurred that prevented a member’s or survivor’s request from being accepted for processing according to submission deadlines specified in this section.

5.0. PREMIUM BILLING AND COLLECTION

The contractor shall perform all premium and billing functions required for TRS. Members/survivors are responsible for all applicable premium payments for the type of coverage elected (i.e., TRS member-only or TRS member and family). All billing will be monthly; neither annual nor quarterly billings are authorized. Premium related transactions shall be reported through the enrollment fee payment interface (see the TSM, [Chapter 3, Section 1.5, paragraph 1.2.8.2.](#)).

5.1. Jurisdiction for Premium Billing and Collection

5.1.1. The particular contractor servicing the address for the TRS member or survivor shall perform premium billing and collection functions for the TRS member/survivor. The contractor shall identify the financially responsible individual for survivor plans from the survivors actually covered by TRR in descending order of precedence:

- Spouse
- Oldest Enrolled Child (or Legal Guardian as applicable)

5.1.2. As part of each applicable monthly bill, the contractor shall provide the opportunity for the TRS member/financially responsible survivor to submit a change of address to the servicing contractor. At any time the servicing contractor notices that a new address is in another TRICARE region or outside the 50 United States or the District of Columbia, the contractor shall initiate the actions necessary in DOES to transfer premium collection and other applicable administrative services to the new servicing contractor. The jurisdiction shall be based on the TRS member’s or financially responsible survivor’s reported new address. Any TRS member/financially responsible survivor may transfer to a new region at any time. The gaining contractor shall perform the premium collections for future payments. If the beneficiary’s account is overdue (without a current paid-through date) and the gaining contractor needs to disenroll, they then have to void the transfer and contact the original contractor to disenroll for the paid-through date.

5.1.3. All unsolicited PNTs for TRS members/survivors will be evaluated to determine if residential address changes require a transfer of premium collection and other applicable administrative services to another contractor for servicing. If a transfer is indicated, the contractor will follow requirements specified in [paragraph 5.1.2.](#)

5.2. Issuance of Bills

All applicable direct bills for premium payments shall be issued on the 10th calendar day of each month, or the next business day, for the following month. All direct bills shall be for full month premiums and/or prorated amounts, if applicable, and shall reflect a due date of the last day of each billing month. Direct bills shall reflect all payments received through no less than the fifth day of the month. The following statement will appear on all direct bills: "Selected Reserve members (but not survivors) eligible for a health plan under 5 USC 89 (FEHBP) are not eligible for TRS and must submit a TRS request to terminate TRS coverage".

5.3. Premium Collection

The contractor shall credit the TRS member/survivor for premium payments received. All bills shall specify that the premium payment is due for receipt by the contractor NLT the last calendar day of the current month for the following month of coverage. In the case of a start date of coverage at anytime other than the first of a month, the first bill generated by the contractor shall include the prorated amount on a daily basis necessary to synchronize billing to the first of the month. The daily prorated amount shall be equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month. The amount of the initial premium payment due may be printed on the prescribed form. For enrollments effective on or after October 1, 2012, DEERS will prorate the premium due for mid-month enrollments from the effective date of coverage to the end of that first enrollment month, e.g., from the 18th of the month to the 31st.

5.3.1. The contractor shall accept payments by personal check, cashier's check, money order, credit/debit card (i.e., Visa/MasterCard), and Electronic Funds Transfer (EFT). (Effective January 1, 2013, all premium payments (after the initial payment required in [paragraph 4.1.](#)) must be made by either recurring EFT or Recurring Credit/Debit Card (RCC) (i.e., Visa/MasterCard).) An EFT payment or a RCC payment shall be processed within the first five business days of the month of coverage. The contractor shall not generate monthly bills on or after January 1, 2013, except when having to correct a problem establishing or maintaining the EFT or RCC payment. The contractor shall advise members/survivors at the time of EFT/RCC election that an insufficient funds fee of up to \$20 U.S. will be assessed, if sufficient funds are not available.

5.3.2. The contractor shall be responsible for initiating EFTs and automatic credit/debit card payments with the member's/survivor's financial institution upon request, or when required, by the TRS member/survivor.

5.3.3. The contractor shall direct bill the TRS member/survivor when a problem occurs in initially setting up the EFT or RCC payments when there are insufficient funds to process a monthly EFT. The contractor may apply a fee of up to \$20 U.S. for insufficient funds. The contractor shall include notice of the fee of up to \$20 U.S. when billing the member/survivor. If the contractor is unable to obtain the requested premium payment from the TRS member's/survivor's account for any reason after an EFT or RCC payment is established, the TRS member will be responsible for paying the overdue premiums and any insufficient funds fee by means of direct billing.

5.3.4. Premium payments shall be made payable to the contractor servicing the member's/survivor's coverage as specified in [paragraph 5.1.](#)

5.4. Annual Premium Adjustment

5.4.1. Contractors shall include advance notification of annual premium adjustments on the October, November and December monthly bills. (The October notification may not include the actual premium rates for the new year). The notification shall include the new amount for member only and member and family coverage. For those members/survivors not receiving a monthly bill, the contractor shall issue a notice advising the member/survivor of the adjusted premium amount at the same time the October, November and December bills are mailed and shall initiate all actions required to allow the continuation of the EFT transaction or RCC payment with the adjusted premium amount.

5.4.2. For premium adjustments that go into effect at any time other than January the first, the government will provide instructions about notification of members/survivors.

5.5. Premium Adjustments from Changes Associated with QLEs

5.5.1. When a QLE is processed that changes the premium, the effective date of the premium change shall be the date of the QLE.

5.5.2. If the change from a QLE results in an increase in the premium, the contractor shall adjust the next bill or electronic payment, to include any underpaid amount (prorated to the day as specified in [paragraph 5.3.](#)), to the effective date of the change.

5.5.3. If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent bills or electronic payment until all of the overpayment is exhausted.

5.6. Terminations and Premium Adjustments

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of termination as specified in [paragraph 4.4.](#)

5.7. Online Transactions

In addition to requirements specified in [paragraph 5.0.](#) and its subordinate paragraphs, the contractor may provide online capability for TRS members/survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

6.0. CLAIMS PROCESSING

6.1. The contractor shall process TRS claims under established TRICARE Standard and TRICARE Extra ADFM cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRS.

6.2. The contractor shall pend all claims for health care provided to a newborn/new child of a TRS member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRS member has an unregistered newborn/new child the contractor shall notify the TRS member of the requirement to enroll the newborn/new child in DEERS and submit a request form for the newborn/new child NLT 60 days after birth/custody. When the member completes the process specified in [paragraph 4.2.3.2.](#), the contractor shall process any claims associated with the newborn/new child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.2.](#), the contractor shall deny any claims associated with the newborn/new child's health care.

6.3. Premium payments made for TRS shall not be applied to the fiscal year deductible or catastrophic cap limit.

6.4. Non-Availability Statements (NASs) requirements shall apply to TRS members, family members, and survivors in the same manner as for ADFMs under TRICARE Standard/Extra.

6.5. Medicare is the primary payer for TRICARE beneficiaries who have Medicare eligibility. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in [Chapter 20, Section 3](#). The MCSCs shall follow procedures established in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#) regarding dual-eligibles' claims processing.

6.6. If the contractor receives a PNT notifying them of a retroactive TRS disenrollment the contractor shall initiate recoupment of claims paid, if appropriate, as specified in [Chapter 11](#).

6.7. If at anytime the contractor discovers that the Selected Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD or their designee or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#). and its subordinate paragraphs for loss of TRS eligibility. If any other actions are to be taken by the contractor as a result of this discovery, the TRICARE RD or their designee or TAO Director will send instructions to the contractor.

7.0. COMMUNICATIONS AND CUSTOMER SERVICE

In addition to communications and customer service functions specified throughout this chapter, the contractor shall perform communications and customer service functions to the same extent as they do for TRICARE Standard and TRICARE Extra.

7.1. Customer Education

7.1.1. Information materials (i.e., public notices, flyers, informational brochures, etc.) will be developed and printed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of Communications and Customer Service (C&CS). The contractor shall distribute all documents associated with the TRS Program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRS Handbook and other information materials may be ordered through the usual TMA Communication and Customer Service ordering process.

7.1.2. Upon start of coverage under TRS the contractor shall mail one copy of the TRS Handbook to each new TRS member/survivor with TRS member-only coverage and one copy to the household of each TRS member with TRS member/survivor and family coverage. The contractor shall send additional handbooks upon request, such as when survivors or TRS members and covered family members live in different locations (split coverage).

7.2. Customer Service

The contractor shall provide all customer service support in a manner equivalent to that provided TRICARE Standard beneficiaries. When the contractor receives an inquiry involving TRS eligibility or qualifications, the contractor shall refer the inquiry to the member's RC.

8.0. ANALYSIS AND REPORTING

TRS workload shall be included, but not separately identified in all reports.

9.0. PAYMENTS FOR CONTRACTOR SERVICES RENDERED

9.1. Claims Reporting

The contractor shall report TRS program claims according to [Chapter 3](#). The contractor shall process payments on a non-financially underwritten basis for the healthcare costs incurred for each TRS claim processed to completion according to the provisions of [Chapter 3](#).

9.2. Fiduciary Responsibilities

9.2.1. The contractor shall act as a fiduciary for all funds acquired from TRS premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

9.2.2. Either a separate non-interest bearing account shall be established for the collection and disbursement of TRS premiums or the account used for TRICARE Retired Reserve (TRR) premium collections, when established, shall be used for TRS premiums as well. The contractor shall deposit premium collections to the established account within one business day of receipt.

9.2.3. The contractor shall wire-transfer the premium collections and net of refund payments, monthly to a specified government account as directed by TMA-Contract Resource Management (CRM) Finance and Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the TMA-CRM F&AO, by e-mail, within one business day of the deposit specifying the date and amount of the deposit, as well as its purpose (i.e., TRS premiums). Premiums for TRS and TRR, when established, may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been

transferred to TMA Office of General Counsel - Appeals, Hearings & Claims Collection Division (OGC-AC) shall be wire-transferred separately. The contractor shall notify TMA-CRM F&AO and TMA OGC-AC by email within one business day of the day of deposit, specifying the sponsor name, sponsor Social Security Number (SSN) (last four digits), payment amount, payment date, date case was transferred to TMA OGC-AC and the date and amount of the deposit.

9.2.4. The contractor shall maintain a system for tracking and reporting premium billings, collections, and starts of coverage. The system is subject to government review and approval.

9.2.5. The contractor shall electronically submit monthly reports of premium activity supporting the wire transfer of dollars to the Contracting Officer (CO).

10.0. DELINQUENT PREMIUMS

10.1. The contractor shall no longer collect delinquent premiums with two exceptions:

- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members have entered into installment payment agreements.
- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members received health care services during the grace period.

10.2. The contractor shall terminate collection of delinquent premiums for all other cases within 60 days through an adjustment to the account and issue written notification to the debtor that collection has been terminated. Language for a sample letter is included at [Addendum A, Figure 24-A-1](#). A summary report of all cases terminated shall be provided to the OGC within 30 days following termination of all cases. Such report shall include the sponsor's name, SSN, debt amount and date closed.

10.3. The contractor shall be responsible for coordinating with DEERS to ensure coverage dates for all TRS members and/or family members are correct. The coverage dates in DEERS will not be changed for those members and/or family members who have entered into installment payment agreements or for cases in which TRS members and/or family members obtained medical services during the grace period. OGC will provide the premium paid-through dates to the contractor for cases for which the premiums were not collected by OGC so that DEERS can be updated accordingly.

4.2.2. Addition of Family Members to TRR Member and Family Coverage

TRR members/survivors may request to add eligible family members to an existing TRR member-and-family coverage plan at any time, once eligibility for the family is established. Eligibility is established by going to a military personnel office with RAPIDS capability to appropriately update DEERS. The effective date of coverage for the added family member(s) shall follow procedures specified in [paragraphs 4.1.2. or 4.1.3.](#) The TRR request must be either received in the TSC or postmarked NLT 60 days after that date.

4.2.3. TRR Newborn/New Child Policy

4.2.3.1. A newborn/new child will be covered from the date of birth/custody only if, (a) the TRR member registers the newborn/new child in DEERS within 60 days of birth/custody, and (b) the TRR request is either received in the TSC or postmarked NLT 60 days after the date of birth/custody. The contractor shall handle claims associated with the child as specified in [paragraph 6.2.](#) The contractor shall make adjustments in premiums as specified in [paragraph 5.5.](#)

4.2.3.2. TRR members who reside overseas may have difficulty in obtaining the documentation required to register a newborn/new child in DEERS. As with all other late submissions of completed TRR request forms, the member may submit a request for reconsideration to the appropriate TRICARE Regional Director (RD) (or their designee), or the TRICARE Area Office (TAO) Director consistent with [paragraph 4.5.1.](#)

4.3. Processing

4.3.1. The contractor shall process all TRR transactions through DOES for members or survivors with a DEERS residential address in the contractor's jurisdiction. The contractor shall process TRR requests received along with two months premium payment (as required) NLT 10 business days after receipt.

4.3.2. If the contractor is unable to enroll the member/survivor in DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premiums payment, or (e) an underpayment of the initial premium payment; the contractor shall return a copy of the original application and any premium payments to the member, within 10 business days, with an explanation of what is needed for the contractor to accept the application for processing.

4.4. Termination Of TRR Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 business days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the contractor of a termination, whichever is later. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund. *If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.5, paragraph 1.3.1., Addresses.*

4.4.1. Loss of TRR Eligibility

The effective date of termination for a member or survivor covered under TRR shall be the effective date of the loss of his or her qualification for TRR coverage. No lockout shall be applied for termination due to loss of TRR eligibility.

4.4.1.1. Sponsor Loss of Eligibility

When a sponsor's eligibility is terminated at a date other than the anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor of the terminated coverage. When a sponsor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage.

4.4.1.2. Individual Family Member or Survivor Loss of Eligibility

In the case of a family member or survivor losing eligibility in DEERS, DEERS will send the contractor an unsolicited PNT advising the contractor to terminate coverage for that individual. When an individual family member's or survivor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage. The contractor shall update the fee system based on the terminated coverage for the family member(s) or survivor(s) as appropriate.

4.4.2. Member Gains Other TRICARE Coverage

No lockout shall be applied for termination due to a gain of other TRICARE coverage.

4.4.2.1. If a TRR member gains other TRICARE coverage for a period of 30 days or less, TRR coverage will continue unchanged.

4.4.2.2. If a TRR member or survivor gains other TRICARE coverage for a period of more than 30 days; DEERS will terminate TRR coverage in accordance with [paragraph 4.4.1.1](#). The contractor must be aware of the fact that DEERS may reflect Active Duty Service Member (ADSM) and Active Duty Family Member (ADFM) TRICARE coverage before the service member actually reports for active duty.

4.4.2.3. If a TRR member gains other TRICARE coverage via a family member, the member and family members may terminate coverage under TRR without incurring a lockout.

4.4.3. Failure to Make Payment

4.4.3.1. Failure to pay monthly premiums in accordance with the procedures in this chapter shall result in termination of coverage. The effective date of termination is the paid-through date. The contractor shall automatically terminate coverage of the TRR member, all covered family members and survivors if the monthly premium payment is not received by the last day of the month following the due date for the monthly premium payment. After the last day of the month, the contractor shall terminate coverage with a termination effective

4.1.1.1.2. For applications with a TYA effective date starting on or before May 1, 2011, the contractors shall extend the TYA application deadline until May 31, 2011. For TYA applications received on or after June 1, 2011, [paragraph 4.1.1.1.1.](#) will be followed.

4.1.1.2. TYA Prime Plans

4.1.1.2.1. TYA Prime effective dates will be determined in accordance with [Chapter 6, Section 1, paragraph 7.1.](#)

4.1.1.2.2. Young adult dependents may qualify to purchase TOP Prime or TOP Prime Remote plan coverage (see the TRICARE Policy Manual (TPM), [Chapter 12, Section 3.2.](#)).

4.1.2. Continuation Coverage

A young adult dependent may purchase TYA coverage with an effective date immediately following the termination of coverage under another TRICARE program, including the CHCBP. The TYA application required by [paragraph 4.1.](#) along with an initial payment (*see paragraph 4.1.*), must either be received in the TSC, entered into the BWE application, or postmarked NLT 30 days following termination of coverage. See [paragraph 10.0.](#) and the TPM, [Chapter 10, Section 4.1,](#) for information regarding termination of CHCBP coverage and refund of CHCBP premiums. If the young adult dependent does not meet the requirement for continuation or retroactive coverage, the application will be processed as an open enrollment application.

4.1.3. Retroactive TYA Standard/Extra Coverage

A qualified young adult dependent may elect retroactive TYA Standard/Extra coverage effective as of January 1, 2011, if the dependent was eligible as of that date. If retroactive coverage is elected, TYA Standard/Extra premiums must be paid for the time period between January 1, 2011, and the date of the election, along with at least the *initial payment* (*see paragraph 4.1.*). If retroactive coverage is requested but the young adult dependent was not eligible for TYA Standard/Extra coverage on January 1, 2011, then the date the young adult dependent became eligible for TYA Standard/Extra coverage shall be used as the coverage effective date. Premiums are to be prorated as necessary for the time period between the coverage effective date and the date of election, which includes at least the *initial payment* (*see paragraph 4.1.*). No purchase of retroactive coverage may take place after September 30, 2011. Retroactive coverage is limited to the TYA Standard/Extra benefit only. See [paragraph 10.0.](#) and the TPM, [Chapter 10, Section 4.1,](#) for information regarding termination of CHCBP coverage and refund of CHCBP premiums.

4.1.4. Changing Coverage Within Same Contractor

4.1.4.1. Upon receipt of an application, qualified dependents already enrolled in a TYA plan and who are current in their premium payments may elect to change to another TYA plan for which the qualified dependent is eligible based on the sponsor's eligibility and the geographic location of the qualified young adult dependent. Changes in coverage are effective following the application processing time frames listed in [paragraph 4.1.1.](#)

4.1.4.2. If the premium amount changes, the contractor will adjust future premiums by applying any overages to future TYA premium payments, and adjusting the Electronic Funds Transfer/Recurring Credit/Debit Card (EFT/RCC) payments so the young adult dependent is not over or undercharged for the coverage requested.

4.1.5. Transfer of Coverage to Another Contractor

Young adult dependents desiring to transfer TYA coverage to another contractor must submit a new application to the desired contractor. Transfer of TYA coverage to another contractor is only permitted if the young adult dependent is current with their premiums. The gaining contractor shall process transfer requests within 10 calendar days.

4.2. Processing

4.2.1. The contractor shall process all TYA transactions through Web DOES for young adult dependents with a residential address as indicated by the TYA purchaser on the TYA application in the contractor's jurisdiction. The contractor shall process TYA requests received along with the initial payment (see [paragraph 4.1.](#)) NLT 10 calendar days after receipt.

4.2.2. The contractor shall assign Primary Care Managers (PCMs) to purchasers of TYA Prime coverage per [Chapter 6](#).

4.2.3. If the contractor is unable to enroll the young adult dependent in DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premiums payment, or (e) an underpayment of the initial premium payment; the contractor shall provide notification to the young adult dependent, initiated within 10 calendar days, with an explanation of what is needed for the contractor to accept the application for processing and return any premium payments if appropriate.

4.3. Termination Of TYA Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 calendar days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the young adult dependent's contractor of a termination, whichever is later. Premium refunds, to include an explanation of the premium refund, will be sent to young adult dependent's residential address unless an alternate mailing address has been provided. *If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.5, paragraph 1.3.1., Addresses.* The contractor shall also update DEERS with any premium amount refunded within 30 calendar days.

4.3.1. Loss Of TYA Qualification

At any time a young adult dependent ceases to meet all eligibility qualifications, coverage under the TYA program shall terminate. This could be due to the sponsor's losing

eligibility for care. The effective date of termination shall be the date upon which the young adult dependent ceased to meet any of the prerequisite qualifications. If a subsequent change in circumstances occurs such as losing eligibility for an eligible employer-sponsored plan, the young adult dependent may qualify again to purchase coverage under the TYA program. Young adult dependents who age out of TYA at age 26 may be eligible to purchase CHCBP coverage (see TPM, [Chapter 10, Section 4.1](#)).

4.3.1.1. Change in Sponsor Status

4.3.1.1.1. A change in sponsor status (active to retired; active duty to the Reserve Component (RC), etc.), may require the young adult dependent's coverage to be transferred to another TYA coverage plan or cause the TYA coverage to be terminated.

4.3.1.1.2. TYA Standard/Extra Coverage

4.3.1.1.2.1. When a sponsor's status changes, coverage under a TYA Standard/Extra coverage will be transferred in DEERS by DMDC to an appropriate TYA Standard/Extra plan consistent with the new sponsor status unless the uniformed service sponsor is not eligible for TRICARE coverage or the RC uniformed service sponsor is not enrolled in TRR or TRS. DEERS will send the contractor with whom the young adult dependent is enrolled an unsolicited PNT advising the contractor of the transferred coverage.

4.3.1.1.2.2. When a sponsor status changes and the coverage cannot be transferred, DEERS will terminate the coverage. If the termination date is different from the anticipated end date, DEERS will notify the contractor via an unsolicited PNT that the coverage is terminated. The contractor shall update their fee system as appropriate. DMDC will send a Certificate of Creditable Coverage (CoCC) to the young adult dependent.

4.3.1.1.2.3. Upon receipt of an unsolicited PNT with an updated enrollment end reason code and an enrollment extension end reason code indicating a TYA individual is again eligible for TYA coverage after termination due to a change in sponsor status, the contractor will contact the TYA individual within 10 calendar days using their best business practice to offer enrollment assistance if TYA coverage has not already been re-established.

4.3.1.1.3. TYA Prime Coverage

4.3.1.1.3.1. When a sponsor's status changes, coverage under TYA Prime plans is terminated in DEERS by DMDC. If termination is at a date other than the anticipated end date, DEERS will send the contractor with whom the young adult dependent is enrolled (and MTF if MTF enrollee) an unsolicited notification advising of the terminated coverage. The contractor shall update the fee system based on the terminated coverage for the young adult dependent as appropriate. DMDC will send a CoCC to the young adult dependent advising them of the termination of coverage.

4.3.1.1.3.2. If TYA eligibility is re-established subsequent to a termination due to a sponsor status change, DMDC will send an unsolicited PNT with an updated enrollment end reason code and an enrollment extension end reason code. Upon receipt of an unsolicited PNT with an updated enrollment end reason code and an enrollment extension end reason code indicating a young adult dependent is again eligible for TYA coverage after termination due

to a change in sponsor status, the contractor will contact the young adult dependent within 10 calendar days using best business practices to offer enrollment assistance if TYA coverage has not already been re-established.

4.3.1.2. Sponsor Loss Of Eligibility

When a sponsor's eligibility is terminated, coverage under TYA is also terminated. If a young adult dependent's enrollment is terminated at a date other than the anticipated end date, DEERS will send the contractor with whom the young adult dependent is enrolled an unsolicited PNT advising the contractor of the terminated coverage. The contractor shall update the fee system based on the terminated coverage for the young adult dependent as appropriate. When eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage. DMDC will send a CoCC to the young adult dependent.

4.3.1.3. Young Adult Dependent Loss Of Eligibility

When a young adult dependent's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage. If a young adult dependent's coverage is terminated at a date other than the anticipated end date, DEERS will send the contractor with whom the young adult dependent is enrolled an unsolicited PNT advising the contractor of the terminated coverage. The contractor shall update the fee system based on the terminated coverage for the young adult dependent as appropriate. DMDC will send a CoCC to the young adult dependent.

4.3.2. Lockout

Young adult dependents whose TYA coverage is terminated for failure to pay premiums will not be allowed to purchase coverage again under TYA for a period of 12 months following the effective date of termination. If a young adult dependent requests a new enrollment and a lockout exists, the contractor must send the request to the waiver approval authority (TRICARE Regional Director (RD), the TRICARE Area Office (TAO) Director, Uniformed Services Family Health Plan (USFHP) Program Office (PO), or their designees) for review and action.

4.3.2.1. Reinstatement

4.3.2.1.1. If it is determined that an error was made by someone other than the young adult dependent (i.e. the contractor, payment agencies, etc.), upon beneficiary request, the contractor will notify the waiver approval authority. The waiver approval authority may direct the young adult dependent to be reinstated with no lapse in coverage (contingent on payment of required premiums). No new application form will be necessary.

4.3.2.1.2. If it is determined that the young adult dependent failed to pay fees due to extraordinary circumstances and continuous coverage is warranted, upon beneficiary request, the contractor will notify the waiver approval authority. The waiver approval authority may direct the young adult dependent to be reinstated (contingent on payment of required premiums) with no lapse in coverage. No new application form will be necessary. A

reinstatement request must be received by the contractor NLT 90 days after the end of the month during which the last full premium was paid. Upon direction of the waiver approval authority, continuous coverage may be reinstated upon payment of the appropriate premiums. Premium payments, including current requirements, must be received by the contractor within 30 days of the beneficiary notification of approval for reinstatement. However, if payment has not been made by the 30th day, then coverage will be deemed to be terminated as of the paid-through date and no claims may be paid for care rendered after the date of termination.

4.3.2.2. Young Adult Dependent Gains Other TRICARE Coverage

No lockout shall be applied for termination due to a gain of other TRICARE coverage.

4.3.2.3. Young Adult Dependent Gains Own Eligible Employer-Sponsored Coverage

No lockout shall be applied for termination due to eligibility for medical coverage offered from an eligible employer-sponsored plan. The young adult dependent shall notify the contractor in writing within 30 calendar days when he or she is eligible or enrolled in an eligible employer-sponsored health plan offered by his or her employer.

4.3.2.3.1. If a young adult dependent becomes eligible under an eligible employer-sponsored health plan based on the young adult dependent's employment for a period of 30 days or less, TYA coverage will continue unchanged.

4.3.2.3.2. Upon written notification from a young adult dependent that he or she is eligible for medical coverage via an eligible employer-sponsored health plan for a period of more than 30 days, the contractor will terminate the TYA coverage using Web DOES without applying a lockout.

4.3.2.4. Young Adult Dependent Loses Eligibility Due To Non-Payment Of TRS Or TRR Premiums By Their Sponsor

No lockout shall be applied for young adult dependents of a TRS or TRR sponsor that was disenrolled and locked out for failure to pay TRS or TRR premiums. However, until the TRS or TRR-eligible sponsor restores TRS or TRR coverage, the young adult dependent does not qualify to purchase TYA coverage.

4.4. Failure To Make Payment

4.4.1. Failure or refusal to pay monthly premiums and/or any outstanding insufficient fees in accordance with the procedures in this chapter shall result in termination of coverage absent approval of a waiver. The effective date of termination is the paid-through date. The contractor shall terminate coverage of the young adult dependent if the monthly premium payment is not received by the last day of the month following the due date for the monthly premium payment. After the last day of the month, the contractor shall terminate coverage with a termination effective date retroactive to the paid-through date. DMDC sends written notification to the beneficiary of the termination and the reason for the termination. Until the termination action is processed, the contractor may pend any claims received for health care

furnished to the young adult dependent during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The young adult dependent will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pending, the contractor shall initiate recoupment of health care costs following the procedures in [Chapter 11, Section 4](#).

4.4.2. Failure to provide information to establish or maintain a recurring monthly EFT/RCC for monthly premium payment will result in coverage being terminated for failure to comply with [paragraph 5.2](#). and subordinate paragraphs.

4.4.3. A contractor shall apply a TYA purchase lockout to the young adult dependent for failure to make premium payments absent approval of a waiver. The lockout shall be for a period of 12 months from the effective date of termination. The DMDC CoCC (see [paragraph 4.1.1](#).) includes notice of the 12 month lockout period.

4.5. Requests For Voluntary Termination

The contractor shall accept written requests for termination of coverage from young adult dependents at any time. The effective date of termination is either (a) the last day of the month in which the request was received by the contractor, (b) the last day of a future month as specified in the request given that the request was received by the contractor in the month preceding the requested month of termination, or (c) as directed by the waiver approval authority for waiver cases. The contractor shall apply a TYA purchase lockout to young adult dependents covered by the TYA plan for a period of 12 months from the effective date of terminations initiated by the young adult dependent unless the young adult dependent is eligible for an employer-sponsored health plan. The DMDC written notification of termination (see [paragraph 4.1.1](#).) includes notice of the 12 month lockout period.

4.6. Cancelled Eligibility And Enrollment

When the contractor receives a PNT for a cancelled enrollment, the contractor will generate a letter notifying the young adult dependent of the cancellation and refund any unused portion of the premium payment. The contractor shall update DEERS with any premium amount refunded within 30 calendar days. No lockout shall be applied for a cancelled enrollment. The contractor shall recoup claims for the cancelled enrollment period.

4.7. Waiver Requests Of A Young Adult Dependent's Actions

The contractor shall advise young adult dependents that all waiver requests for (a) a refusal by the contractor to start coverage as requested by the young adult dependent or (b) lockouts shall be submitted by the young adult dependent to the appropriate contractor who will process and forward to the appropriate waiver approval authority. The waiver approval authority will issue decisions within 10 calendar days of receipt for all waiver requests. If changes are to be made to a young adult dependent's coverage as a result of a waiver determination, the waiver approval authority will send instructions to the contractor. The contractor shall carry out such instructions NLT 10 calendar days after receipt from the waiver approval authority, and notify the young adult dependent of the final decision. The waiver approval authority may authorize an override of information shown on DEERS,

pending a system update, based on appropriate documentation regarding qualification under the law, regulation, and policy.

5.0. PREMIUM COLLECTION

The contractor shall perform all premium functions required for TYA. Young adult dependents are responsible for all premium payments for the individual coverage being purchased. At least an initial payment (see [paragraph 4.1.](#)) is required, then only recurring monthly premium payments are permitted. Premium-related transactions shall be reported through the enrollment fee payment interface or Catastrophic Cap and Deductible (CC&D) Fee Web (see the TSM, [Chapter 3, Section 1.5.](#))

5.1. Jurisdiction For Premium Collection

5.1.1. The particular contractor servicing the residential address for the young adult dependent shall perform premium functions for the young adult dependent.

5.1.2. Any time the servicing contractor notices that a new residential address is in the servicing area of another contractor, the losing contractor will notify the young adult dependent within 10 calendar days that they need to contact a servicing contractor in their new area to transfer their coverage to the new area. A young adult dependent may elect to provide an alternate mailing address, but the servicing contractor is based on the residential, not alternate mailing, address. A young adult dependent may transfer regions at any time. There is no maximum number of transfers from one region to another allowed each year. The gaining contractor shall perform the premium collections for future payments.

5.1.3. All unsolicited PNTs for young adult dependents will be evaluated to determine if residential address changes require a notification to the young adult dependent (see [paragraph 5.1.2.](#)).

5.2. Premium Collection Processes

5.2.1. The contractor shall credit the young adult dependent for premium payments received. Premium payments are due for receipt by the contractor NLT the last calendar day of the current month for the following month of coverage. In the case of a start date of coverage at anytime other than the first of a month (see [paragraph 4.1.1.](#) or as directed by the waiver approval authority), the first payment collected by the contractor shall include the prorated amount on a daily basis necessary to synchronize the paid-through date to the last day of the month. The daily prorated amount shall be equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month.

5.2.2. The contractor shall collect monthly premium payments from TYA purchasers as appropriate and shall report the premium amount paid for those payments, including for any overpayments that are not refunded to the purchaser, to DEERS. (See the TSM, [Chapter 3.](#)) In the event that there are insufficient funds to process a premium payment, the contractor may assess the account holder a fee of up to 20 U.S. dollars (\$20.00). The contractor shall provide commercial payment methods for TYA premiums that best meet the needs of beneficiaries while conforming to [paragraphs 5.2.3.](#) through [5.2.8.](#)

5.2.3. Monthly premiums must be paid-through an automated, recurring electronic payment through an EFT or a RCC from a designated financial institution. These are the only acceptable payment methods for the recurring monthly premiums. An EFT/RCC payment shall be processed on the first business day of the month of coverage.

5.2.4. Purchasers must pay at least the first initial payment as specified in [paragraph 4.1.](#) at the time the TYA application is submitted to allow time for the EFT/RCC to be established. The contractor shall accept payment of at least the first installment by personal check, cashier's check, traveler's check, money order, or credit card (e.g., Visa/MasterCard).

5.2.5. The contractor shall initiate recurring monthly EFTs/RCCs and is responsible for obtaining and verifying the information necessary to do so.

5.2.6. The contractor shall initiate action to modify EFT/RCC payment amounts to support premium changes.

5.2.7. The contractor shall direct bill the young adult dependent only when a problem occurs in setting up or maintaining the EFT or RCC. Bills may be sent to the residential or mailing address designated by the young adult dependent.

5.2.8. When an administrative issue arises that stops or prevents an automated monthly payment from being received by the contractor (e.g., incorrect or transposed number provided by the beneficiary, credit card expired, bank account closed, etc.), the contractor shall grant the TYA purchaser 30 days after the paid-through date to provide information for a new automated monthly payment method. The contractor may accept payment in accordance with [paragraph 5.2.4.](#) during this 30 day period in order to preserve the beneficiary's TYA enrollment status.

5.3. Annual Premium Adjustment

Contractors shall notify current purchasers in writing of any annual premium adjustments NLT 30 days after the contractors receive notification of the updated premiums. The notification shall include the new amount for TYA coverage and will include the following statement:

“Young adult dependents eligible for medical coverage from their eligible employer-sponsored health plan as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986 or who are married do not qualify for TYA coverage. A request to terminate TYA coverage must be submitted to preclude recoupment actions and to request a refund of any overpaid premiums, as applicable.”

6.0. CLAIMS PROCESSING

6.1. The contractor shall process TYA claims using established TRICARE cost-sharing rules and guidance based on the sponsor's status and the TYA plan purchased. Normal claims jurisdiction rules apply (see [Chapter 8, Section 2](#)). Normal TRICARE Other Health Insurance (OHI) processing rules apply to TYA except for claims from eligible employer-sponsored health plans. See [paragraph 6.6.](#)