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TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 147  
6010.51-M  
SEPTEMBER 21, 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:** TRICARE PRIME FEE REFUNDS, CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP), AND FEE SYSTEM

**CONREQ:** 16097

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change requires refunding Prime enrollment fees to enrollees under age 65, who become eligible for Medicare Part A and purchase Part B, clarifies CHCBP eligibility, updates the TRICARE Systems Manual (TSM) based on implementation of the Fee Premium Interface, adds the Fiscal Year (FY) 2013 Prime Enrollment Fee amounts, and adds a Health Care Plan Coverage Code to the list of valid codes.

**EFFECTIVE DATE:** October 1, 2012, except for the CHCBP change which has an effective date of October 16, 2011.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 167, Aug 2002 TRM, Change No. 155, and Aug 2002 TSM, Change No. 100.

  
Reta M. Michak  
Director, Operations Division

**ATTACHMENT(S):** 20 PAGES  
**DISTRIBUTION:** 6010.51-M

**CHANGE 147**  
**6010.51-M**  
**SEPTEMBER 21, 2012**

**REMOVE PAGE(S)**

**CHAPTER 6**

Section 1, pages 11 through 18

**CHAPTER 24**

Section 1, pages 3 and 4

**CHAPTER 26**

Section 1, pages 1 through 8

**INSERT PAGE(S)**

Section 1, pages 11 through 19

Section 1, pages 3 and 4

Section 1, pages 1 through 9

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 include an explanation to the beneficiary for the fee refund.* 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. *The contractor shall include an explanation to the beneficiary for the fee refund.* 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 include an explanation to the beneficiary for the fee refund.* 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. *The contractor shall issue refunds to these beneficiaries upon receiving (1) a written request from the beneficiary (that includes a copy of their Medicare card) and either confirming their Part B enrollment in DEERS or in a previous Policy Notification Transaction (PNT), or (2) upon*

*receipt of a PNT noting a beneficiary's fee waiver update based on the Part B enrollment. DEERS generates a PNT when the Centers for Medicare and Medicaid Services (CMS) sends DEERS data indicating a Part B enrollment or disenrollment. Refunds are required for all payments that extend beyond the date the enrollee has Medicare Part B coverage, as calculated by DEERS. The contractor shall update DEERS with any amount refunded within 30 calendar days. The contractor shall include an explanation to the beneficiary for the fee refund. Effective October 1, 2012, if the fee waiver is a 100% waiver of the Prime enrollment fee, the contractor shall send a refund to the beneficiary. If the fee waiver is a 50% waiver of the Prime enrollment fee, DEERS will automatically calculate the overpayment and extend the paid through date for the policy, as appropriate; therefore, a refund may not be required unless a credit remains when the policy is paid in full.*

**11.4.2.** For Prime enrollees who become Medicare eligible 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 *DEERS or a previous PNT indicating a fee waiver based on Medicare* to substantiate any claim *for a refund*.

**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 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 MTF's 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

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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.



### **3.2. Survivor Coverage Under TRS**

If a member of the Selected Reserves dies while in a period of TRS coverage, the family member(s) may purchase new or continue existing TRS coverage for up to six months beyond the date of the member's death. If a member of the Selected Reserve is not covered by TRS on the date of his or her death, his or her surviving dependents do not qualify for TRS survivor coverage at anytime. For survivor qualification, there is no exclusionary criterion involving a health benefits plan under 5 USC Chapter 89, the FEHBP.

### **4.0. COVERAGE-RELATED PROCEDURES**

The contractor shall process coverage-related transactions through the Defense Online Enrollment System (DOES) (TRICARE Systems Manual (TSM) [Chapter 3, Section 1.5, paragraph 1.2.2.](#)). 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.](#)). The contractor shall perform all premium and billing functions in accordance with [paragraph 5.0.](#) and its subordinate paragraphs. The TRICARE Overseas Program (TOP) contractor shall perform these services for TRS members/survivors residing outside of the 50 United States or the District of Columbia. See the TSM, [Chapter 2, Addendum M](#) for a full list of TRS Health Care Delivery Plan (HCDP) Coverage Code Values. The TRICARE South Region contractor shall perform these services for TRS members or survivors residing outside the 50 United States or the District of Columbia until such time specified in the transition schedule to the new overseas contractor.

#### **4.1. Purchasing Coverage**

To purchase TRS coverage, qualified RC members and qualified survivors must complete the prescribed form using the appropriate online web application and submit it, along with an initial payment of the appropriate one month premium within deadlines specified in the paragraphs below. The initial payment may be made with a personal check, cashier's check, money order, or credit/debit card (i.e., Visa/MasterCard). (For enrollments effective on or after October 1, 2012, the initial payment required is two months of premium.) No handwritten TRS requests are to be accepted by the contractor. The contractor shall collect completed TRS requests submitted at TRICARE Service Centers (TSCs), by mail, and by other means determined by the contractor. If a lockout is in place, the contractor may accept and process requests up to 45 days before the end of the 12 month lockout period for new coverage to begin after the 12 month lockout period ends. The contractor shall not process new coverage transactions into DOES unless the initial payment received is the correct amount for the type of coverage. The procedures for determining the effective date of coverage are specified in the paragraphs below.

##### **4.1.1. Continuation Coverage**

A qualified member or qualified survivor may purchase TRS coverage with an effective date immediately following the termination of coverage under another TRICARE program. The TRS request required by [paragraph 4.1.](#) must be either received in the TSC or postmarked no later than 30 days after the termination of other TRICARE coverage.

#### 4.1.2. Qualifying Life Events

A qualified member may purchase TRS coverage in connection with a Qualifying Life Event (QLE) that results in a change of family composition. First, qualified members are responsible to report all changes in family composition to military personnel officials with Real-Time Automated Personnel Identification System (RAPIDS) access to appropriately update DEERS. Second, the TRS request form identifying the QLEs required by [paragraph 4.1.](#) must be either received in the TSC or postmarked no later than 60 days after the date of the QLE. The following QLEs are processed through DEERS and are recognized by TRS. The effective date of coverage is the date the QLE occurred (i.e., date of marriage, Date of Birth (DOB), etc.).

- Marriage;
- Birth or adoption of child;
- Placement of a child in the legal custody of the member by an order of the court;
- Divorce or annulment;
- Death of a spouse or family member, survivors; or
- Last family member/survivor becomes ineligible (e.g., child ages out).

#### 4.1.3. Open Enrollment

A qualified member or qualified survivor may purchase TRS coverage throughout the year. If the request and premium payment required by [paragraph 4.1.](#) are received in the TSC or postmarked by the last day of the month, the effective date of TRS coverage shall either be the first day of the next month or the first day of the second following month as indicated on the TRS request. Requests for next month that are postmarked in that month will be processed with an effective date of the first day of the month following the postmark date.

#### 4.1.4. Survivor Coverage Under TRS

If a Reserve sponsor dies while in a period of TRS coverage, the surviving eligible family members may purchase (or continue) TRS coverage for up to six months beyond the date of the member's death. Except for automatic transfers specified in [paragraph 4.1.4.1.](#), effective dates and deadlines specified in [paragraph 4.1.1.](#), [4.1.2.](#), and [4.1.3.](#) apply. The effective date of TRS survivor coverage is the day after the date of death. Applicable premium rates are specified in [paragraph 2.0.](#)

**4.1.4.1.** If TRS member and family coverage was in effect on the date of the member's death, DEERS will automatically transfer covered family members to TRS survivor coverage with an effective date of the day after the date of death and establish an end eligibility date in DEERS six months from the date of the member's death. Defense Manpower Data Center (DMDC) will issue letters to survivors advising them of their continued coverage and their option to terminate coverage, if so desired, by completing a TRS request form via the appropriate online web application or in a written letter to the appropriate Managed Care Support Contractor (MCSC). The DMDC generated survivor letter will include instructions on how to obtain a DoD Self-Service Logon (DS Logon) to access the TRS Web Portal or the option to terminate coverage via a written letter.

## CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP), ELIGIBILITY AND COVERAGE

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### 1.0. CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP)

1.1. The CHCBP is a health care program that allows certain groups of former Military Health System (MHS) beneficiaries to continue receiving health care coverage when they lose eligibility for military health care under the TRICARE programs. This temporary health program is supported by premium revenue collected from the participants in the program. The CHCBP contractor (herein referred to as the “contractor” unless otherwise specified) shall provide all services necessary to support the CHCBP as outlined in [32 CFR 199.20](#). Other references describing the CHCBP that are to be used by the contractor in fulfilling its responsibilities are applicable sections of the TRICARE Policy Manual (TPM), TRICARE Operations Manual (TOM), TRICARE Reimbursement Manual (TRM), TRICARE Systems Manual (TSM), and the **Federal Register** dated September 30, 1994 (pg. 49817ff), February 11, 1997 (pg. 6225ff), February 24, 1997 (pg. 8312), and September 16, 2011 (pg. 57637ff). The contractor shall perform these functions for CHCBP beneficiaries on a worldwide basis, irrespective of the geographic area in which the beneficiary resides or the area in which health care services are received.

1.2. The legislative basis for the program is Section 4408 of the National Defense Authorization Act (NDAA) of 1993 (Public Law 102-484) which added Section 1078a to Chapter 55 of 10 United States Code (USC). Beneficiaries *who may be* eligible to purchase the continued health program *after eligibility for coverage ends under a health benefits plan under 10 USC Chapter 55 or 10 USC § 1145(a)* are described in 10 USC § 1078a. *For those covered under premium-based TRICARE health benefits plans such as TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA), etc., such coverage must have been purchased and in place the day before the loss of eligibility.*

1.3. CHCBP is not part of the TRICARE Program; therefore, the contractor shall adhere to the following requirements for those areas in which the CHCBP instructions and processing requirements are different than TRICARE.

### 2.0. VALIDATE ELIGIBILITY FOR CHCBP

2.1. Upon receipt of a Department of Defense (DoD) (DD) Form 2837, CHCBP Application, from a prospective beneficiary, the contractor shall validate eligibility on the Defense Enrollment and Eligibility Reporting System (DEERS) and request information necessary to validate eligibility. The supporting documentation that the contractor shall

request from the applicant differs depending on the category of individual who is applying for enrollment as shown below:

**2.1.1.** Individual Uniformed Service sponsor (herein referred to as “sponsor”) and his/her family: a copy of the DD Form 214, Certificate of Release or Discharge from Active Duty, or a copy of the sponsor’s active duty orders.

**2.1.2.** Unremarried former spouse and stepchildren of the sponsor: a copy of the final divorce decree.

**2.1.3.** Child who loses TRICARE coverage due to marriage: a copy of marriage certificate.

**2.1.4.** Child who loses TRICARE coverage on his/her 21st birthday (age 23 if enrolled in a full-time course of study at an approved institution of higher learning and dependent on the uniformed service sponsor for more than half of their financial support): a copy of the front and back of the Uniformed Services identification (ID) card.

**2.1.5.** Child who loses TRICARE coverage due to college graduation: a copy of college transcript.

**2.1.6.** Child who loses TRICARE coverage when the child over the age of 21 and before the age of 23 ceases to be enrolled in a full-time course of study at an approved institution of higher learning or ceases to be dependent on the uniformed services sponsor for more than half of their financial support: a letter from the institution of higher learning stating the student’s status or a written statement from the dependent that he/she is no longer dependent on the uniformed services sponsor for more than half of their financial support.

**2.1.7.** Child that was previously placed in sponsor’s legal custody and then loses TRICARE coverage: a copy of the court order.

**NOTE:** Children who lose TRICARE coverage under paragraphs 2.1.4. through 2.1.7. may qualify to purchase TYA coverage until reaching the age of 26 (see Chapter 25). If qualified to purchase TYA coverage, the child cannot purchase CHCBP as an individual.

**2.1.8.** Child who loses eligibility for TYA coverage. However, if the TYA coverage was terminated due to eligibility for employer-sponsored health care coverage based on their own employment or failure to pay TYA premiums, then the child is not eligible to purchase CHCBP coverage (see Chapter 25).

**2.1.9.** For any other situations in which an individual loses TRICARE coverage and may potentially be eligible for CHCBP, the contractor shall request information needed to verify eligibility.

## **2.2. Family Members Not Identified on DEERS**

**2.2.1.** When a contractor receives a CHCBP claim which includes a family member not identified on DEERS as enrolled, but the sponsor indicates CHCBP family coverage, the contractor is to take the following action: If the claim includes a copy of an appropriately

marked CHCBP coverage card for the beneficiary, the claim is to be processed. If the claim is for a beneficiary who is less than 60 days old, the claim is to be processed, even if no copy of an CHCBP coverage card is attached as long as at least one member of the sponsor's family is currently enrolled in CHCBP. In all other cases, the claim is to be denied.

**2.2.2.** In order to be enrolled in the CHCBP, the beneficiary will be disenrolled from any TRICARE programs in which enrolled. This will require no action on the beneficiary's part.

### **2.3. Disputes Regarding Enrollment**

**2.3.1.** Confirmation of a person's eligibility as a CHCBP beneficiary is the responsibility of the CHCBP contractor. Disputed questions of fact concerning a beneficiary's eligibility will not be considered an appealable issue, but must be resolved with the appropriate Uniformed Service.

**2.3.2.** If the contractor determines the applicant does not appear eligible due to an ineligible response from DEERS (i.e., no history segments or record of previous DoD entitlement) or failure of the applicant to provide the documentation requested to verify eligibility the contractor shall deny the application in writing within 10 business days of the reason for the denial.

## **3.0. APPLICATION PERIOD AND PREMIUMS**

### **3.1. CHCBP Application Period**

There is a 60-day application period for CHCBP, beginning the day following the end date of the beneficiary's eligibility for TRICARE coverage. The contractor shall deny any applications received after the 60-day period. The contractor shall apply the following business rules when determining the start of the 60-day application period.

#### **3.1.1. Members and Former Members, Their Families, and Other Individuals Losing TRICARE Coverage**

The government routinely notifies beneficiaries prior to their loss of TRICARE coverage (active duty members are notified of the CHCBP during outprocessing; other beneficiaries who lose TRICARE coverage are notified by the Defense Manpower Data Center (DMDC) in writing of the availability of the CHCBP). However, if an eligible beneficiary advises the contractor that he/she was not notified of this program and submits documentation to support their position, the contractor shall establish the start-date of the 60-day application period as the date that the applicant received notification of the program.

#### **3.1.2. Unremarried Former Spouses**

There is no formal mechanism established to promptly identify unremarried former spouses that may qualify for this program, therefore the contractor shall process all applications from unremarried former spouses upon receipt.

**3.2. Coverage Categories**

CHCBP offers two coverage categories. Individual coverage is available to the member or former member, an unremarried former spouse, an adult child, a surviving spouse, or other qualified individuals. Family coverage is only available to the member or former member and his/her dependents. Dependents cannot be covered under family coverage unless the member or former member is also covered by family coverage.

**3.3. CHCBP Application**

DD Form 2837, CHCBP Application, shall be accepted as the application form for CHCBP coverage. No later than six months prior to the start work date of the contract, the contractor shall provide the Contracting Officer’s Representative (COR) with the contractor’s mailing address and toll-free telephone number. Should DD Form 2837 be revised or renumbered in the future, the contractor shall use the latest version.

**3.4. Dates of Coverage & Premiums**

**3.4.1.** Coverage will begin the day following the beneficiary's loss of TRICARE coverage and will end the last day of premium coverage.

**3.4.2.** Due to the documentation requirements for purchasing coverage, most coverage will be retroactive; however, there may be some coverage that will be prospective. Prospective coverage must be accompanied by a premium payment for one quarter. Retroactive coverage must be accompanied by full premium payment retroactive to the effective date of coverage through the end coverage date in the quarter in which the individual is applying.

**3.4.3.** Premiums are as stated in [paragraph 3.5.](#) of these instructions.

Examples of the premiums required for retroactive and prospective coverage:

	Military Benefits End	Application Received	Quarters of Premium Due	CHCBP Coverage Begins
Example 1:	10/01/2010	11/15/2010	1 quarter	10/02/2010
Example 2:	09/15/2010	02/10/2011	2 quarters	09/16/2010
Example 3:	11/05/2010	10/01/2010	1 quarter	11/06/2010
Example 4:	03/01/2011	11/01/2010	1 quarter	03/02/2011

**3.5. Premium Rates**

**3.5.1.** The amount of the CHCBP premiums shall be established by the government and may be adjusted each fiscal year. *Adjusted premium amounts will be provided in writing to the contractor by the Contracting Officer (CO).*

**3.5.2.** The contractor shall begin charging the adjusted quarterly premiums on the date *directed by the CO.*

**3.5.3.** Upon receipt of adjusted rates from the government, the contractor shall issue a written notice to the beneficiary of the changes in premium amounts, to include the effective date of the change. This notification should be done at least 30 days prior to the effective date *directed by the CO.*

**3.5.4.** When qualifying events occur that change the sponsor from individual to family coverage or vice versa, coverage and premiums shall be changed effective with the date of the qualifying event. The contractor, within 10 business days of receiving such information, shall issue a written notice to the beneficiary of the changes in the coverage category and premium amount, including the effective date of the changes.

### **3.6. Form of Payment**

**3.6.1.** Checks, money orders, or credit cards are allowable forms of payment for CHCBP beneficiaries to use in paying their premiums. The contractor may propose additional payment mechanisms, to include electronic processes for premium payments. Proposed electronic processes shall maintain the integrity and security of the application processes which includes important documentation required to validate eligibility for CHCBP.

**3.6.2.** As a minimum, the contractor shall accept VISA and MasterCard® for credit card payments, and may, but is not required to, accept additional nationally recognized major credit cards as a form of premium payment.

**3.6.3.** The contractor shall not accept premiums submitted by, or on behalf, of a health care provider for any beneficiary other than (a) the provider him/herself and (b) a member of the provider's immediate family. Should a provider submitted payment be received, the contractor shall return the payment to the provider with a written notice advising the provider that submission of premium payments by health care providers is prohibited. A copy of the letter should also be sent to the beneficiary. The contractor shall submit documentation to the TRICARE Management Activity (TMA) Program Integrity Office to include the following: a copy of contractor's notification to the provider, copy of front and back of premium (money order or check), originals of all documentation submitted by the provider (to include mailing envelope), documentation of all conversations and communications the contractor had with the provider on the subject of paying premiums, and any other information that the contractor has in its files or records concerning the provider that might be of assistance in Government follow-up action on this issue.

### **3.7. Insufficient Funds**

In the case of insufficient funds, the contractor shall, within three business days, issue a written notice to the applicant (for initial applications) or beneficiary (in the case of renewal premiums), advising the applicant or beneficiary of the insufficient funds, the amount of the premium due, and the date by which a valid premium must be received by the contractor. For initial application requests, the notice shall also advise the beneficiary that if premium payment is not received in full by the due date (the last day of the 60-day application period), the applicant will not be covered in CHCBP. For renewals, the notice

shall advise the beneficiary that if the contractor does not receive valid payment in full within 30 days of the date of the contractor's letter, that coverage will be terminated. That notice shall also provide the effective date of termination if payment is not received. If the premium payment has not been received by the contractor within the specified time frame, the contractor shall terminate the CHCBP coverage and issue a written notice to the beneficiary confirming the termination of coverage.

### **3.8. Refunds**

Premiums shall be refunded if the applicant is no longer eligible for CHCBP coverage, i.e., beneficiary regains TRICARE eligibility; ex-spouse remarries; death of beneficiary; prospective member who has prepaid premium but fails to provide required eligibility documentation; and sponsor change in coverage from family to individual. Voluntary termination because the beneficiary obtained Other Health Insurance (OHI) does not constitute grounds for a refund of unused premiums. When refunds are appropriate, the contractor shall prorate the refund from the date of loss of eligibility for program benefits through the last coverage date for which the premium was paid.

### **3.9. Limits of CHCBP Coverage**

The length of a beneficiary's CHCBP coverage varies according to the category of individual. Coverage lengths and categories are listed in the TPM, [Chapter 10, Section 4.1, Figure 10-4.1-1](#), CHCBP Eligibility Table.

### **3.10. Processing Applications**

**3.10.1.** Once the contractor has verified eligibility and approved the application request, the contractor shall enter the CHCBP enrollment into DEERS through the applicable on-line interface. As DEERS does not allow individuals to be added to a sponsor's record after the sponsor's TRICARE coverage ends, there will be a small number of CHCBP beneficiaries that the contractor cannot complete the CHCBP enrollment in DEERS. The majority will be newborns whose birth occurred after the sponsor's TRICARE coverage ends, but there will occasionally be other beneficiaries as well. The contractor should not rely on DEERS as being the sole determinant of whether or not an individual is eligible for CHCBP coverage as these individuals would not be reflected on DEERS (see [paragraph 2.0.](#)). The contractor's systems shall accommodate these unique cases in which the beneficiary is covered under CHCBP but not reflected on DEERS to ensure these beneficiaries are provided with all required CHCBP benefits and accurate processes, i.e., claims processing, issuing authorizations, accessing services, etc.

**3.10.2.** DEERS will not allow a CHCBP enrollment to be entered if the sponsor and/or dependents are still showing as eligible for TRICARE coverage. In these cases, the contractor shall pend the application and advise the applicant in writing for the sponsor to contact the nearest Uniformed Services ID card issuing office to rectify the situation. The contractor shall complete the processing of the application when DEERS has been updated to reflect that the sponsor and/or dependents are no longer eligible for services under TRICARE.

**3.10.3.** Once the application has been fully processed, the contractor shall issue the beneficiaries a CHCBP coverage ID card within 10 business days. The card provides the

beneficiaries with (a) confirmation that the individual is covered and the effective dates; and (b) documentation that the beneficiary can use to access health care services. The card shall contain sufficient information to facilitate access to health care. Coverage dates on the card shall be limited to those dates for which a valid quarterly premium has been received by the contractor. Cards shall be issued each quarter for all subsequent quarterly payments received by the contractor. The card shall reflect that coverage is for the CHCBP and at a minimum provides the contractor's name, address, toll-free telephone number, and claims center mailing address.

**3.10.4.** Once an application has been fully processed, the contractor shall issue a letter to the applicant confirming CHCBP coverage (including the dates of coverage) within 10 business days. The letter shall advise the beneficiary of the requirements that must be met for continued coverage in the program, including information regarding future contractor billings and premium payments that the beneficiary will be required to make. The contractor shall also issue either a CHCBP coverage policy or such other sufficient written information regarding the CHCBP for beneficiaries' reference should they have any questions regarding benefits and program requirements.

### **3.11. Coverage and Renewals**

**3.11.1.** The contractor shall mail initial premium renewal notices to beneficiaries no later than 30 days before the expiration of the coverage. The beneficiary's coverage in CHCBP is based on the documentation that the applicant submits to verify eligibility, therefore, the contractor shall not routinely query DEERS for renewal coverages and quarterly billings. Absent information or evidence to the contrary, the contractor shall assume that the individual continues to meet the requirements for CHCBP. Renewal notices shall clearly specify the premium amount due, the date by which the premium must be received, and the mailing address to which the premium payment must be sent. Renewal notices shall specify that failure to submit the premium due will result in denial of continued coverage and termination from the program.

**3.11.2.** The contractor shall provide a 30 calendar day grace period following the premium due date in which the beneficiary may submit his/her premium and continue benefits with no break in coverage. If the premium is not received following the initial renewal notice to the beneficiary requesting premium for the next quarter, the contractor shall issue a second renewal notice to the beneficiary within 10 business days of the start of the grace period. The second renewal notice shall indicate that this is the second and final billing notice and that if payment is not received by the due date specified in the notice, that CHCBP coverage will be terminated as of that date. The notice shall also advise the beneficiary that if coverage is terminated due to nonpayment of premium, that he/she will be permanently locked-out of CHCBP.

**3.11.3.** If the premium is not received by the end of the grace period, the contractor shall terminate the beneficiary's coverage in CHCBP and mail a letter to the beneficiary confirming the termination within 10 business days, to include the effective date and basis for the termination. The contractor shall enter all CHCBP terminations into DEERS.

**3.11.4.** Beneficiaries who desire to voluntarily withdraw from the CHCBP prior to the end of their paid up period shall send a written request to the contractor. Beneficiaries who

voluntarily disenroll from the CHCBP are not permitted to re-enroll until they gain and then once again lose TRICARE *coverage*. Refund of unused premiums is only allowed for items covered in [paragraph 3.8](#).

**3.11.5.** Following a beneficiary's termination from the CHCBP, except for those who have re-established TRICARE coverage, the contractor shall issue a Certificate of Creditable Coverage (CoCC) to the beneficiary within 10 business days from the termination date and upon request up to 24 months after the termination date. No later than four months prior to the start work date of the contract, the government will furnish the contractor with a sample of the format for the CoCCs.

**3.11.6.** In preparing and mailing all written notices and correspondence to applicants and beneficiaries, the contractor shall use the most current address on file or available.

### **3.12. CHCBP Coverage Data and Report**

The contractor shall maintain systems and databases to collect, track and process applications and to report monthly coverage information to the government as well as any ad hoc reports that may be requested regarding CHCBP coverage. The contractor shall have the capability to retroactively retrieve pertinent coverage information on any individual who has been accepted or denied coverage in the program, to include the basis for such denials.

## **4.0. PROGRAM MATERIALS**

All informational materials, booklets, brochures, and other public material are subject to review and approval by the TMA Beneficiary Education and Support (BE&SD) prior to finalizing the material, and all must contain the contractor's name, mailing address, toll-free telephone number and web site.

## **5.0. INQUIRIES AND CUSTOMER SERVICE FUNCTIONS**

The contractor shall respond to CHCBP inquiries from any geographic area, to include locations outside the 50 United States and the District of Columbia. The contractor shall provide timely, accurate and thorough responses to the inquiries it receives from any source, e.g., prospective applicants, beneficiaries, providers, other contractors, government officials, etc. in accordance with [Chapter 1, Section 3, paragraph 3.0](#).

## **6.0. FIDUCIARY RESPONSIBILITIES**

**6.1.** The contractor shall act as a fiduciary for all funds acquired from CHCBP premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of CHCBP premiums to the government. The contractor shall follow the requirements in [Chapter 3](#).

**6.2.** The contractor shall maintain a system for tracking and reporting premiums and beneficiaries/policy holders. The system is subject to government review and approval.

**6.3.** By the 10th calendar day of the month following the activity, the contractor shall submit the following reports: CHCBP Workload Report, CHCBP Monthly Enrollee

Premiums Report, CHCBP Adjusted Premiums Report, CHCBP Enrollment Data Report, and CHCBP Premiums Summary Report.

**7.0. DEERS**

Refer to the DEERS instructions in the TSM for additional DEERS requirements related to CHCBP.

**8.0. REPORTING RESPONSIBILITIES**

In addition to the written monthly reports, the CHCBP contractor may be required to produce CHCBP ad hoc reports as requested by the government. The data elements or information for such reports would be limited to that information that the CHCBP contractor has collected or should reasonably have collected in the performance of CHCBP work. Some manipulation and formatting of the data and information may be required to meet the requirements of the ad hoc reports. The government estimates that the CHCBP contractor would not receive more than three such requests per contract year and that the level of effort for the CHCBP contractor to produce the ad hoc reports is not expected to be significant.

