



TRICARE  
MANAGEMENT ACTIVITY

**OD**

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS**

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**CHANGE 148  
6010.51-M  
DECEMBER 17, 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: REMOVAL OF MAIL DELIVERY QUALITY CODE (MDQC)**

**CONREQ: 15805**

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

**SUMMARY OF CHANGE(S): This change removes all references to the MDQC.**

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

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

**This change is made in conjunction with Aug 2002 TPM, Change No. 172, and Aug 2002 TSM, Change No. 101.**

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**John L. Arendale  
Director, Operations Division**

**ATTACHMENT(S): 30 PAGES  
DISTRIBUTION: 6010.51-M**

**CHANGE 148**  
**6010.51-M**  
**DECEMBER 17, 2012**

**REMOVE PAGE(S)**

**CHAPTER 6**

Section 1, pages 3 - 6

**CHAPTER 8**

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**CHAPTER 24**

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**CHAPTER 25**

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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. 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).

**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 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 *calendar* 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.

##### **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.

#### **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 calendar 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.

#### **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

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 retired 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 TRR 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 TRR purchase lockout to the Retired Reserve member, family members, and/or survivors. 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**

##### **4.4.4.1. Termination of Existing Plan(s)**

The contractor shall accept requests for termination of coverage from TRR members/survivors 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 TRR purchase lockout to all beneficiaries covered by the TRR plan for a period of 12 months from the effective date of terminations initiated by the TRR 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 or survivors from TRR members/survivors 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 month preceding the requested month of termination, or (c) as otherwise specified. The contractor shall apply a TRR purchase lockout to individual family members or survivors whose TRR coverage was terminated upon request for a period of 12 months from the effective date of terminations initiated by the TRR 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/survivor 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. TRR Survivor Coverage Termination**

If TRR 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](#). for receipt by the contractor NLT 60 days after the date of death in order to terminate coverage retroactive to the day after the member's death and no lockout is applied. Alternatively, the survivor may request to terminate coverage in accordance with [paragraph 4.4.4](#). Otherwise, DEERS will terminate TRR survivor coverage on the date on which the deceased member of the Retired Reserve would have attained age 60. Refunds of premiums will be handled as specified in [paragraph 4.4](#).

#### **4.5. Exceptions**

##### **4.5.1. Reconsiderations of Member's and Survivor's Actions**

The contractor shall advise TRR members/survivors that all reconsideration requests for a (a) refusal of a late submission of a TRR request or (b) lockouts shall be submitted to the appropriate TRICARE RD or their designee or TAO Director for determination. The TRICARE RD or their designee or the TAO Director will issue decisions within ten calendar days of receipt for 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 days after receipt from the TRICARE RD or their designee or TAO Director. The TRICARE RD or their 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 TAO Director will notify the contractor when the government determines that an administrative situation occurred that prevented a retired 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 TRR. Retired Reserve members or survivors are responsible for all premium payments for the type of coverage elected (i.e., TRR member-only or TRR member-and-family). All applicable 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 TRR member or survivor shall perform premium billing and collection functions for the TRR 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 TRR member/financially responsible survivor to submit a change of address to the servicing contractor. At any time the servicing contractor notices that a new residential address is in the servicing area of another TRICARE contractor, 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 TRR member's or financially responsible survivor's reported new address. Any TRR member/financially responsible survivor may transfer regions at any time. The gaining contractor shall perform the premium collections for overdue and future payments.

**5.1.3.** All unsolicited PNTs for TRR 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 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. Bills shall reflect all payments received through no less than the fifth day of the month. The following statement will appear on all bills: Retired Reserve members (but not survivors) eligible for a health plan under 5 USC 89, the FEHBP, do not qualify for TRR and must submit a request to terminate TRR coverage.

## **5.3. Premium Collection**

The contractor shall credit the TRR member or 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 the 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 on the first five business days of the month of coverage. The contractor shall not generate monthly bills on or after January 1, 2013, when EFT or RCC payment is required, except when having to correct a problem establishing or maintaining the EFT or RCC payment. The contractor shall advise member/survivors at the time of EFT/RCC election that an insufficient-funds fee of up to \$20 U.S. may 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, to do so by the TRR member/survivor.

**5.3.3.** The contractor shall directly bill the TRR 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 TRR member's/survivor's account for any reason after an EFT or RCC payment is established, the TRR member/survivor 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 or survivor's coverage as specified in [paragraph 5.1](#).

#### **5.4. Annual Premium Adjustment**

**5.4.1.** Contractors shall include advance notification of any 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 payments until all of the overpayment is exhausted.

## **5.6. Terminations**

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 TRR 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 TRR claims under established TRICARE Standard and TRICARE Extra retiree cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRR.

**6.2.** The contractor shall pend all claims for health care provided to a newborn/new child of a TRR member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRR member has an unregistered newborn/new child, the contractor shall notify the TRR member of the requirement to register the 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 4.2.3.1](#), the contractor shall process any claims associated with the child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.1](#), the contractor shall deny any claims associated with the child's health care.

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

**6.4.** Non-Availability Statement (NAS) requirements shall apply to TRR members, family members, and survivors in the same manner as for retirees under TRICARE Standard/Extra.

**6.5.** If a Retired Reserve member purchases TRR during the same calendar year that the member had a TRICARE Reserve Select plan in effect, the catastrophic cap, deductibles and cost shares shall not be recalculated.

**6.6.** 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 22, Section 3](#). The MCSCs shall follow procedures established in the TRICARE Reimbursement Manual (TRM), ([Chapter 4, Section 4](#)) regarding dual-eligibles' claims processing.

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

**6.8.** If at anytime the contractor discovers that the Retired 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 TRR 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. BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)**

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

### **7.1. Customer Education**

**7.1.1.** Materials (i.e., public notices, flyers, informational brochures, web site etc.) will be developed and distributed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of BE&SD. The contractor shall distribute all informational materials associated with the TRR program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRR handbook and other information materials may be obtained through the usual TMA BE&SD process.

**7.1.2.** Upon start of coverage under TRR each contractor shall mail one copy of the TRR handbook to each TRR member/survivor with TRR member-only coverage and one copy to the household of each TRR member/survivor with TRR member-and-family coverage. The member/survivor's servicing contractor shall send additional handbooks upon request, such as when covered family members live in different locations (split locations).

### **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 TRR eligibility or qualifications, the contractor shall refer the individual to the appropriate RC.

## **8.0. ANALYSIS AND REPORTING**

TRR 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 TRR program claims according to [Chapter 3](#). The contractor shall process payments on a non-financially underwritten basis for the health care costs incurred for each TRR 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 TRR 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 TRR premiums or the account used for TRICARE Reserve Select (TRS) premium collections shall be used for TRR 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, net of refund payments, monthly to a specified government account as directed by the 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. TRR premiums). Premiums for TRS and TRR 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 e-mail 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).



**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. 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 pended, 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.](#)