



DEFENSE
HEALTH AGENCY

HPOS

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**CHANGE 142
6010.56-M
MARCH 11, 2015**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

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

CHANGE TITLE: CONSOLIDATED CHANGE 14-007

CONREQ: 17176

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: April 13, 2015.

IMPLEMENTATION DATE: April 13, 2015.

This change is made in conjunction with Feb 2008 TPM, Change No. 131.

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**ATTACHMENT(S): 28 PAGES
DISTRIBUTION: 6010.56-M**

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

CHANGE 142
6010.56-M
MARCH 11, 2015

REMOVE PAGE(S)

CHAPTER 6

Section 1, pages 5 - 16, and 19 - 21

CHAPTER 16

Section 6, pages 1 - 7

CHAPTER 25

Section 1, pages 9 - 15

INSERT PAGE(S)

Section 1, pages 5 - 16, 19, and 20

Section 6, pages 1 - 7

Section 1, pages 9 - 15

SUMMARY OF CHANGES

CHAPTER 6

1. Section 1.
 - a. Deletes obsolete language, since this information is no longer needed or used.
 - b. This change adds language to allow “telephonic” disenrollment.

CHAPTER 16

2. Section 6. This change clarifies that Active Duty Family Members (ADFM)s cannot be enrolled in TRICARE Prime Remote for Active Duty Family Members (TPRADFM) if they live within a Prime Service Area (PSA).

CHAPTER 25

3. Section 1. This change adds language to allow “telephonic” disenrollment.

3.7 PCM change requests submitted via any means other than BWE application by beneficiaries enrolled to the civilian network must be processed by the MCSC within three working days of receipt, with an effective date no later than (NLT) the third working day.

3.8 PCM change requests submitted to the MCSC via the BWE application by beneficiaries will be processed within six calendar days of receiving the requests, and the effective date will be the sixth calendar day after the request was submitted or the date requested by the beneficiary if over six days but less than 91 days.

4.0 ENROLLMENT PERIOD

4.1 Effective Date of Enrollment

The contractor shall support continuous open enrollment for all beneficiaries. Enrollment may occur any time during the contract period; however, all new enrollment periods shall coincide with the fiscal year. The contractor shall align any enrollment established based on an enrollment year period to the fiscal year upon the first renewal of the enrollment period.

4.1.1 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.

4.1.2 All other enrollment periods shall begin on the first day of the month following the month in which the enrollment application and any required 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. (This recurring principle is referred to as the 20th of the month rule.)

4.1.3 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](#).

4.2 Enrollment Expiration

4.2.1 NLT 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 all available payment options and methods. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date of the enrollment.

4.2.2 The contractor shall automatically renew enrollments, including those for ADSMs, upon expiration unless the enrollee declines renewal, is no longer eligible for Prime enrollment, or fails to

pay any required enrollment fee on a timely basis, including a 30 calendar day grace period beginning the first day following the last day of the enrollment period.

4.2.3 If the enrollee requests disenrollment during this grace period, the contractor shall disenroll the beneficiary effective retroactive to the enrollment period expiration date.

4.2.4 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.

4.2.5 ADSMs may not decline reenrollment nor may they request disenrollment.

4.2.6 DMDC sends written notification to the beneficiary of the disenrollment and the reason for the disenrollment within five business days of the disenrollment transaction.

4.3 Disenrollment

4.3.1 Disenrollment requests must be initiated by the sponsor, spouse, other legal guardian of the beneficiary, or an eligible beneficiary 18 or older. An official disenrollment request includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal consent provided via telephone and documented in the contractor's call notes, or (4) a self-attestation by the beneficiary when using the BWE system. (A sponsor cannot be disenrolled per paragraph 4.2.5.)

4.3.2 The contractor shall automatically disenroll beneficiaries when the appropriate enrollment fee payment is not received by the 30th calendar day following the enrollment period expiration date or the due date for the installment payment. The contractor shall set the disenrollment effective date retroactive to the annual renewal date or the payment due date, whichever applies. An appropriate enrollment fee payment includes the appropriate form of payment for the period the fee is intended to cover (i.e., monthly, quarterly, or annually).

4.3.3 Prior to processing a disenrollment for "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 contractor confirms that the payment amounts match, the disenrollment may be entered in DOES.

4.3.4 The disenrolled beneficiary will be responsible for the deductible and cost-shares applicable under TRICARE Extra or Standard 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.

4.3.5 The contractor may suspend claims processing during the grace period to avoid the need to recoup overpayments.

4.3.6 See the TPM, [Chapter 10, Sections 2.1 and 3.1](#) for additional information on disenrollment.

4.4 Enrollment Lockout

4.4.1 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 TPM, [Chapter 10, Sections 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.

4.4.2 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 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.)

4.4.3 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.

5.0 ENROLLMENT FEES

5.1 General

The contractor shall collect enrollment fee payments from TRICARE Prime enrollees as appropriate and shall report those fees, including any overpayments that are not refunded to the enrollee, to DEERS. (See the TSM, [Chapter 3](#).) The Prime enrollee may select one of the following three payment fee options (i.e., annual, quarterly, or monthly). 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 Prime enrollment fees that best meet the needs of beneficiaries while conforming to the following ([paragraphs 5.1.1 through 5.1.3.7](#)):

5.1.1 Annual Payment Fee Option

An annual installment is collected in one lump sum. For initial enrollments, the contractor shall prorate the fee from the enrollment date to September 30. The contractor shall accept payment of the annual enrollment fee only by credit card (e.g., Visa/MasterCard). See [paragraph 4.3.2](#) for disenrollment information if the appropriate enrollment fee payment is not received.

5.1.2 Quarterly Payment Fee Option

Quarterly installments are equal to one-fourth (1/4) of the total annual fee amount. For initial enrollments, the contractor shall prorate the quarterly fee to cover the period until the next fiscal year quarter. (Fiscal quarters begin on January 1, April 1, July 1, and October 1.) The contractor shall collect quarterly fees thereafter. The contractor shall accept payment of the quarterly enrollment fee only by credit card (e.g., Visa/MasterCard). See [paragraph 4.3.2](#) for disenrollment information if the appropriate enrollment fee payment is not received.

5.1.3 Monthly Payment Fee Option

Monthly installments are equal to one-twelfth (1/12) of the total annual fee amount. Monthly enrollment fees must be paid-through an automated, recurring electronic payment either in the form of an allotment from retirement pay or through Electronic Funds Transfer (EFTs) from the enrollee's designated financial institution (which may include a recurring credit or debit card charge). These are the only acceptable payment methods for the monthly payment option.

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

5.1.3.2 The contractor shall initiate monthly allotments and EFTs and is responsible for obtaining and verifying the information necessary to do so.

5.1.3.3 The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT.

5.1.3.4 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 enrollee 30 days to provide information for a new automated monthly payment method or the option to pay quarterly or annually. The contractor may accept payment by check during this 30 day period in order to preserve the beneficiary's Prime enrollment status.

5.1.3.5 Allotments from retired pay will be coordinated through the contractor with the Defense Finance and Accounting Service (DFAS), U.S. Coast Guard (USCG), or Public Health Service (PHS), as appropriate (see the TSM, [Chapter 1, Section 1.1, paragraph 11.10](#) for Payroll Allotment Interface Requirements). The contractor shall process all allotment requests submitted by beneficiaries.

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

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

5.2 Member Category

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

5.3 Unremarried Former Spouses (URFSs) and Children Residing with Them

5.3.1 URFSs became sponsors in their own right as of October 1, 2003. As such, they are enrolled under their own SSNs and pay an individual enrollment fee. URFS may not "sponsor" other family members and their fees may not be factored into any family fees associated with the former spouse/sponsor.

5.3.2 Children residing with the URFS and whose eligibility for benefits is based on the ex-spouse/former sponsor are identified under the ex-spouse/former sponsor's SSN on DEERS. Likewise, they are enrolled under the ex-spouse/former sponsor and fees for these children shall be combined with other fees paid under the ex-spouse/former sponsor.

Example: A contractor would collect the individual enrollment fee for an URFS's enrollment under the URFS's own SSN. The contractor would also collect a family enrollment fee for any two or more eligible family members enrolled under the SSN of the ex-spouse/former sponsor. These enrollees might include the sponsor, any current spouse, and all eligible children, including those living with the URFS.

5.4 TRICARE Prime Fee Waiver

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

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

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

5.6 Mid-Month Enrollees

The contractor shall collect any applicable enrollment fee from mid-month enrollees at the time of enrollment. However, there will be no enrollment fee collected for the days between the effective enrollment date and the determined enrollment date.

5.6.1 The effective enrollment date shall be the actual start date of the enrollment.

5.6.2 The determined enrollment date shall be established using the 20th of the month rule, as it is for initial enrollments.

Example: If the retirement date is May 27, the effective enrollment date will be May 27 and the determined enrollment date will be July 1. Fees will be charged for the period from July 1 forward; no fees will be assessed for the period from May 27 through June 30. Effective with enrollment fees that are to be applied to periods on or after October 1, 2012, DEERS will calculate the paid-through dates based on DEERS data and the enrollment fee amount collected and entered into DEERS by the contractor. Reference the TPM, [Chapter 10, Section 3.1](#).

5.7 Overpayment Of Enrollment Fees

5.7.1 Prior To October 1, 2012

If enrollment fees are overpaid at any point during an enrollment year, the contractor may credit the overpayment to any outstanding payments due. Such credits shall be reported on DEERS. If the overpayment of enrollment fees is not applied to outstanding payments due, the contractor shall refund any overpayments of \$1 or more to the enrollee. When TRICARE Prime enrollment changes from a family to an individual prior to annual renewal, the unused portion of the enrollment fee shall be prorated on a monthly basis and shall be applied toward a new enrollment period.

5.7.2 On Or After October 1, 2012

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

5.8 The following reports will be provided to the contractor by DEERS to assist with identifying and correcting enrollment fee discrepancies. The contractor shall correct all accounts identified as

discrepant. The contractor who is responsible for a beneficiary's current enrollment is responsible for resolving any over/under payments. For split enrollments, the reports will use the billing hierarchy to determine the responsible contractor.

5.8.1 Monthly Under Report (Prior To October 1, 2012)

Enrollment fees are considered delinquent and will show up on the Monthly Under Report when the paid-through date associated with a policy is greater than 60 days in the past. The Under Report will be provided on the first of each month. The contractor is required to analyze and correct all reported delinquencies within 30 days of the report's availability. The corrections may include synchronizing the fee data between the contractor's system and DEERS, correcting data discrepancies, and potentially terminating enrollments for failure to pay fees.

5.8.2 Monthly Over Report (Prior To October 1, 2012)

The Monthly Over Report will identify those policies where the paid amount is over the amount owed. Amount owed is based on the enrollment begin date, the paid-through date, any existing fee waivers, and DEERS data used to determine payment tiers (if applicable) and/or freezes of enrollment fees (premium override periods). The Over Report will be provided before the 10th business day of each month. The contractor is required to analyze and correct all reported accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary.

5.8.3 Quarterly Under Report (Prior To October 1, 2012)

The Quarterly Under Report will identify all terminated policies since the inception of the contract that have an associated paid-through date prior to the termination date. The Quarterly Report will be provided on the first day of the first month of the fiscal quarter (i.e., October 1, January 1, April 1, and July 1). The contractor shall correct all data discrepancies within 60 days of the report's availability.

5.8.4 Monthly Reports (On or After October 1, 2012)

5.8.4.1 DEERS will provide the following reports on a monthly basis:

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

5.8.4.2 These reports will be provided before the 10th business day of each month. The contractor is required to analyze and correct all report accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment

fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary. For enrollment fee payments effective on or after October 1, 2012, the contractor shall update DEERS with any fee amount refunded within 30 calendar days.

6.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

6.1 When family members of E-1 through E-4 reside in a Prime Service Area (PSA) of an MTF offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a PCM located in the MTF. Such family members may, however, specifically decline such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently disenroll may re-enroll at any time. The completion of an enrollment application is a prerequisite for enrollment of such family members.

6.2 Enrollment processing and allowance of civilian PCM assignments will be in accordance with the Memorandum of Understanding between the contractor and the MTF.

6.3 The primary means of identification and subsequent referral for enrollment will occur during in-processing. Non-enrolled E-4 and below families may also be referred to the MCSC's call center, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers, and others. Beneficiaries at overseas locations may also be referred to their local TSC.

6.4 MCSC representatives at their call center and those giving beneficiary education briefings 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 education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment, including guaranteed access, the support of a PCM, etc. The contractor shall reinforce that enrollment is at no cost for family members of E-1 through E-4 and will give them the opportunity to select or be assigned an MTF PCM, to select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime.

6.5 The contractor shall also 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). The effective date of enrollment shall be determined by the date the enrollment application is received by the MCSC. These enrollments and enrollment refusals should not be tracked, nor the enrollees identified differently than enrollments initiated through any other process, such as the MCSC's own marketing efforts.

6.6 Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures. Beneficiaries in this group may re-enroll at any time without restriction or penalty. However, such re-enrollments are subject to the 20th of the month rule.

6.7 Contractors are not required to screen TRICARE claims 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.

7.0 TRICARE ELIGIBILITY CHANGES/REFUNDS OF FEES

7.1 Refer to the TPM, [Chapter 10, Section 3.1](#), for information on changes in eligibility.

7.2 The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining 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). If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility. For enrollment fee payments effective on or after October 1, 2012, DEERS will calculate the paid-through date based on the enrollment fee amount collected and entered into 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.

7.3 Contractors shall refund the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees and their families who have been recalled to active duty. The contractor shall include an explanation to the beneficiary for the fee refund. Contractors shall calculate the refund using monthly prorating, and shall report such refunds to DEERS within 30 calendar days. 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.

7.4 The contractor shall refund enrollment fees for deceased enrollees upon receiving a written request from the remaining enrollee or the executor of the decedent's estate. The contractor shall include an explanation to the beneficiary for the fee refund. The enrollee's request must include a copy of the death certificate. Refunds shall be prorated on a monthly basis and apply both to individual plans where the sole enrollee is deceased and to the conversion of a family enrollment to an individual plan upon the death of one or more family members. For individual enrollments, the contractor shall refund remaining enrollment fees to the executor of the estate. For family enrollments that convert to individual plans, the contractor shall either credit the excess fees to the individual plan or refund them either to the remaining enrollee or to the executor of the decedent's estate, as appropriate. Enrollment fees for family enrollments of three or more members are not affected by the death of only one enrollee and no refunds shall be issued. The contractor shall update DEERS with any amount refunded within 30 calendar days.

7.5 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 upon disability, End Stage Renal Disease (ESRD) or upon attaining age 65, provided the beneficiary has Medicare Part B coverage.

7.5.1 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 an unsolicited 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.

7.5.2 For Prime enrollees who become Medicare eligible and who maintain Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts. The contractor shall utilize the PNTs received indicating a fee waiver based on Medicare to substantiate any claim of overpayment.

7.5.3 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.)

7.5.4 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.

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

8.0 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 TOP Prime Remote. 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".

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

8.1.1 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, or TOP Prime Remote are not eligible to enroll in the WII 415.

8.1.2 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 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.)

8.1.3 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. The TOP contractor will enter WII 415 enrollments through DOES for outside the 50 United States and the District of Columbia.

8.1.4 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
- Contractors can request unsolicited PNTs resend
- Modify begin date
- Modify end date

8.1.5 Service WII entities will provide contractors with 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 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.

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

8.2.1 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, TOP Prime, or TOP Prime Remote 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, TOP Prime, or TOP Prime Remote 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.

8.2.2 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 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](#).

Note: Non-active duty TRICARE Prime applicants who reside more than 30 minutes travel time from an MTF must be afforded the opportunity to enroll with a civilian PCM if they live in a PSA.

9.5.2.2 Zip codes and/or distances for which the MTF Commander is willing to accept enrollment. This can include both areas within a 30 minute or less drive-time and over a 30 minute drive but within 100 miles. Any enrollment for a beneficiary with a drive of more than 30 minutes requires a signed waiver of access standards. If an enrollee applicant resides within a zip code previously determined to lie entirely within 30 minutes travel time from the MTF, the contractor need not compute the travel time for that applicant.

9.5.2.3 Whether or not the MTF Commander will consider a request for enrollment for 100 miles or greater. In determining whether or not the MTF Commander will consider a request for enrollment beyond 100 miles, the MTF Commander may use zip codes to designate those areas the MTF Commander will consider requests or will not consider requests.

9.5.3 The contractor shall notify the MTF Commander (or 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 contractor shall make this notification by any mutually agreeable method specified in the MOU. The contractor shall not make the MTF enrollment effective unless notified by the MTF to do so.

9.5.3.1 The MTF Commander will notify the TRO Director of their desire to enroll a beneficiary who resides 100 miles or greater 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 request and notify the MTF Commander of their decision by a mutually agreeable method. The MTF Commander is responsible for notifying the contractor of all approved enrollment requests for beneficiaries who reside 100 miles or greater from the MTF. The contractor shall notify the beneficiary of the final decision.

9.5.3.2 Approved waivers for beneficiaries residing 100 miles or more from the MTF shall remain in effect until the beneficiary changes residence or unless the MTF Commander determines that they will no longer allow these enrollments. Even if a beneficiary has previously waived travel time standards, any MTF Commander may revise the MOU (following the MOU revision process) to state that enrollment of some or all current enrollees who reside 100 or more miles from the MTF are not to be renewed at the end of the enrollment period. The contractor shall inform such beneficiaries no later than two months prior to expiration of the current enrollment period that they are no longer qualified for renewal of enrollment to the MTF. Prior to notification, the contractor shall obtain the rationale for the change from the MTF to include in the notice to the beneficiary. The proposed notice shall be reviewed and concurred on by the TRO prior to being sent to the impacted beneficiaries. (The TRO will coordinate notices with the **Defense Health Agency (DHA)** Beneficiary Education and Support Division (BE&SD) prior to approval.)

9.5.4 At any time during the enrollment period, if the contractor 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 contractor shall, at the next annual TRICARE Prime renewal point, require the beneficiary to waive the primary and specialty care ATC standards before the enrollment will be renewed. (This includes monitoring address changes received by the contractor from all sources.) The contractor

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shall notify the beneficiary of this waiver requirement no later than two months before expiration of the annual enrollment period. The language for all beneficiary notices shall be reviewed and concurred on by the TRO prior to being sent to beneficiaries. (The TRO will coordinate notices with DHA BE&SD prior to approval.)

- Any notice to a beneficiary that is requesting they sign a waiver of access standards, denying their enrollment, or advising them they are not eligible for re-enrollment to an MTF, shall include information on any alternative options for enrollment. The notice must also advise the beneficiary of the option to participate in TRICARE Standard, Extra, or the USFHP where available.

9.5.5 For each approved enrollment to an MTF where the beneficiary has waived access standards, the contractor shall retain the enrollment request in a searchable electronic file until 24 months after the beneficiary is no longer enrolled to the MTF. The contractor shall provide the retained file to a successor contractor at the end of the final option period.

9.5.6 When an enrollment request requires MTF Commander or TRO Director approval, any contractual requirements relating to processing timeliness for enrollment requests will begin when the contractor has obtained direction from the MTF Commander or TRO Director regarding waiver approval or disapproval.

9.6 Civilian Enrollees

9.6.1 Within a PSA, the civilian network must have the capability and capacity to allow beneficiaries who reside in the PSA to enroll to a PCM within access standards. If a beneficiary who resides in the PSA requests enrollment to a specific PCM who is located more than a 30 minute drive from the beneficiary's residence, the contractor may allow the enrollment so long as the beneficiary waives travel time access standards. (Also, see [Chapter 5, Section 1](#).)

9.6.2 For new enrollments (including portability transfers), the contractor is not required to establish a network with the capability and capacity to grant enrollment to beneficiaries who reside outside a PSA. Requests for new enrollments to the civilian network from beneficiaries residing outside a PSA will be granted provided there is sufficient unused network capacity and capability to accommodate the enrollment and that the PSA civilian network PCM to be assigned is located less than 100 miles from the beneficiary's residence. Beneficiaries who reside outside the PSA and enroll in TRICARE Prime must waive their primary and specialty care travel time access standards. (The network shall have the capability and capacity to allow beneficiaries enrolled in TRICARE Prime, residing outside of PSAs, with a civilian network PCM prior to the beginning of Option Period One of the applicable regional Managed Care Support (MCS) contract to enroll to a PSA PCM provided the beneficiary resides less than 100 miles from an available network PCM in the PSA and waives both primary and specialty care travel time standards.)

9.6.3 Beneficiaries who reside outside the PSA and are 100 miles or greater from an available civilian network PCM in the PSA shall not be allowed to enroll in TRICARE Prime.

- END -

TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program

1.0 INTRODUCTION

TRICARE Prime Remote for Active Duty Family Member (TPRADFM) provides TRICARE Prime like benefits to certain Active Duty Family Members (ADFM) who reside with the TRICARE Prime Remote (TPR) enrolled sponsor in remote locations in the United States and the District of Columbia. It also provides continued TPRADFM eligibility for family members residing at remote locations after the departure of the sponsor for an unaccompanied assignment, and eligibility for family members of Reserve Component (RC) members ordered to active duty. It covers family members of Service members (on active duty for more than 30 days) of all seven Uniformed Services in the United States and the District of Columbia. TPRADFM benefits are comparable to TRICARE Prime, including access standards, benefit coverage, and cost-shares. TPRADFM does not apply to ADFM enrollees in areas outside the 50 United States. Such care and claims shall be processed in accordance with the TRICARE Overseas Program (TOP), [Chapter 24](#) and TRICARE Policy Manual (TPM), Chapter 12. The Defense Health Agency-Great Lakes (DHA-GL) and the Specified Authorization Staff (SAS) are not involved in any part of TPRADFM.

2.0 ELIGIBILITY

To be eligible for enrollment under TPRADFM, family members of Service members must meet the following eligibility requirements:

2.1 The Service member sponsor is eligible for, and enrolled in TPR and the ADFM resides with the Service member in a TPR area, or

2.2 The Service member is enrolled to a small government clinic, troop medical clinic, or other facility not capable of primary care management functions. These clinics have been designated by the Services and are located in certain TPR zip codes. These clinics allow active duty enrollment only, and are identified by Defense Medical Information System Identification Codes (DMIS-IDs). A list of applicable DMIS-IDs for the region will be provided to the Managed Care Support Contractor (MCSC) by the Regional Director (RD). The ADFM must reside with the Service member who is enrolled in a DMIS-ID Clinic in a TPR area.

2.3 ADFMs who reside within a Prime Service Area (PSA) are not eligible for enrollment in TPRADFM even if the Service member is enrolled in TPR. The ADFMs shall be enrolled within the PSA of residence.

2.4 National Guard/Reserve members who are ordered to active duty for a period of more than 30 days are not required to be eligible for, or enrolled, in TPR for their family members to be eligible for TPRADFM. Their family members are eligible for TPRADFM if they meet the criteria of [paragraph](#)

2.7.

2.5 If an Service member receives a subsequent unaccompanied assignment after the TPR assignment and the family members are not authorized to accompany the member to the next duty assignment, and they continue to reside in the same TPR location, the family members may remain in TPRADFM for the duration of the subsequent assignment.

2.5.1 ADFMs currently enrolled in TPRADFM, who transition to Transitional Survivor status, may remain enrolled in TPRADFM. See TPM, [Chapter 10, Section 7.1](#) for further information.

2.5.2 All Transitional Survivors may enroll in TPRADFM. At the request of the Transitional Survivor the contractor shall accept and process a new and continued enrollment request (enrollment form, Beneficiary Web Enrollment (BWE) transaction, or telephonic request documented in the contractor's call center notes) submitted by any Transitional Survivor living in, or moving to a TPR area. Enrollment in TPRADFM may continue for Transitional Survivors for the entire Transitional Survivor period. TPRADFM is not available to Survivors as they then become eligible for retiree family member benefits and cost-sharing. For example, after three years the surviving spouse is considered a survivor and, while still eligible for TRICARE, eligibility is at retiree payment rates and rules. Consequently, they are ineligible for TPRADFM which is an active duty program.

2.5.3 Transitional Survivor/Survivor status does not impact eligibility rules. Loss of eligibility as a result of any condition which routinely results in loss of TRICARE eligibility such as reaching age limits, marriage, remarriage, etc. also results in loss of Transitional Survivor/Survivor status.

2.6 "Resides with" is defined as the TPR residence address at which the family resides/resided with the sponsor while the sponsor was enrolled in TPR. Transitional Survivors only have to have a residence address in a TPR area to be eligible to enroll in TPRADFM.

2.7 To be eligible for enrollment under TPRADFM, family members of federalized National Guard/ Reserve members ordered to active duty for a period of more than 30 days must meet the following eligibility requirements:

- The family members reside with the member at the time of activation, and
- The residence address is located in a TPR zip code,
- "Resides with" is defined as the TPR residence address at which the family resides with the activated reservist upon activation.
- The federalized National Guard/Reserve member does not have to be TPR eligible or enrolled. However, for their family members to be eligible for TPRADFM the member must be ordered to active duty for a period of more than 30 days.
- Once enrolled in TPRADFM the family members of the federalized National Guard/ Reserve member, continuing to reside at the TPR residence address, may remain in TPRADFM for the period of active duty of the member, regardless of the subsequent assignment, enrollment location, or residence of the member.

- Family members of the federalized National Guard/Reserve member, continuing to reside at the TPR residence address, may enroll even after the sponsor has deployed/left for a subsequent assignment.

3.0 BENEFITS

ADFM enrolled in TPRADFM are eligible for the Uniform Health Maintenance Organization (HMO) Benefit, even in areas without contractor networks.

4.0 NETWORK DEVELOPMENT

TPRADFM has no network development requirements, except where contractually required. ADFMs enrolled in TPRADFM shall be assigned, or be allowed to select, a Primary Care Manager (PCM) when available through the TRICARE civilian provider network. If a network provider is not available to serve as a primary care provider, the TPRADFM enrollee may utilize any local TRICARE participating or authorized provider for primary care services. Enrolled ADFMs are required to use network providers where available within contractual access standards. If a network provider cannot be identified within the access standards, the enrolled family member shall use a TRICARE authorized provider. Contractors shall assist ADFMs in finding a TRICARE network or authorized provider for specialty care. The beneficiary may be eligible for the Prime travel benefit when referred more than 100 miles for specialty care. If the contractor has not established a network of PCMs in a remote area, a TPR designated ADFM will be enrolled without a PCM assigned. A generic PCM code will be used for TPRADFM enrollees without assigned PCMs. The ADFM without an assigned PCM will be able to use a local TRICARE participating or authorized provider for primary health care services without preauthorization. If a TPRADFM questions whether a service is covered as primary care, they may contact the contractor for assistance.

5.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

If a USFHP is available to ADFMs in a TPR area, the ADFMs have the choice of enrolling in the USFHP, enrolling in TPRADFM, or to remaining in TRICARE Standard. ADFMs choosing to enroll in USFHP will be unable to access care through Military Treatment Facilities (MTFs) or the TRICARE system.

6.0 REFERRALS

6.1 Specialty care requires a referral through the contractor. If the ADFM has a PCM, the PCM shall follow the contractor's referral and authorization procedures. In cases where the ADFM is not enrolled to a PCM, the ADFM, or the ADFM's parent or guardian is responsible for directly contacting the contractor to obtain referrals and authorizations if required. The ADFM should obtain a referral request from their primary care provider which the ADFM would forward to the contractor.

6.2 TPRADFM enrollees are required to obtain a referral and use TRICARE network providers for specialty care where available within TRICARE access standards or pay the POS deductible and cost-share unless an appropriate out-of-network referral is obtained as required under TRICARE Prime.

7.0 PROVIDER EDUCATION

Contractors shall familiarize network providers and, when appropriate, other providers with TPRADFM. The contractor shall propose an educational plan to the RD outlining how providers will become familiar with TPRADFM. The contractor shall provide separate and distinct information to PCMs about the requirements and the special procedures for handling care for TPRADFM (e.g., specialty care referral requirements, balance billing limitations, etc.). On an ongoing basis, contractors shall include information on TPRADFM specialty care procedures, benefits, or requirements in routine information and educational programs.

8.0 BENEFICIARY EDUCATION

8.1 Beneficiary education will be a joint effort with the Government providing all beneficiary educational materials for the TPR program.

8.2 The MCSC shall distribute the supplied educational materials, and is responsible for postage, envelopes, and mailing costs for distributing educational materials. The contractor shall give ADFMs the option of participating in health promotion and wellness programs offered in the MTF and Prime program locations. The contractor shall design and conduct, with RD approval, TPRADFM briefings. The contractor shall include TPRADFM information and updates as part of all TRICARE briefings. Ongoing briefings will be on an "as needed" basis and will be coordinated with the RD.

8.3 Enrollment in TPRADFM is optional for ADFMs who qualify for the program; therefore, a contractor shall limit educational activities for TPRADFM enrollees to distributing the materials provided or approved by the Government.

9.0 ENROLLMENT

9.1 When the contractor receives an enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) from an ADFM for TPRADFM, the contractor shall ensure the Service member sponsor is eligible for, and enrolled in the TPR program or a DMIS-ID clinic located in TPR designated zip codes. If an ADFM enrollment request is received and the Service member sponsor is either not eligible for TPR, or not enrolled in TPR or a TPR DMIS-ID clinic, the request shall be returned to the sender with a notice that the ADFM is not eligible for TPRADFM and the reason(s) why enrollment was denied. See [paragraph 9.5](#) when a TPRADFM enrollment request is received for a family member of a Reserve Component (RC) member called or ordered to active service for more than 30 days.

9.2 Enrollment in TPRADFM is optional for ADFMs. However, ADFMs must enroll in TPRADFM to receive the TPRADFM benefit. ADFMs who elect not to enroll in TPRADFM may use the TRICARE Standard benefit, or enroll in TRICARE Prime where available, with access standards waived. TPRADFM beneficiaries who elect not to enroll in TPRADFM, and instead receive benefits under the TRICARE Standard and Extra programs must pay the associated TRICARE Standard and Extra cost-shares and deductibles.

9.3 An enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) must be submitted to the contractor by either the ADFM or the Service member sponsor for each family member enrolling in TPRADFM. The effective

date for TPRADFM enrollment is the first day of the following month, if the request is received by the 20th of the month, or the first day of the second month, if the request is received after the 20th of the month.

- An official enrollment request includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal consent provided via telephone and documented in the contractor's call notes, or (4) a self attestation by the beneficiary when using the BWE system. A written signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

9.4 The residence address zip code of the TPR eligible or enrolled Service members must match with the ADFMs. If the zip codes match, the contractor shall deem the ADFM as eligible for TPRADFM and enroll the ADFM in the program. If the residence address zip codes of the TPR Service members and their ADFMs do not match, the ADFMs shall be advised by letter that they are not eligible for enrollment in TPRADFM but they remain eligible for TRICARE Standard, Extra, or Prime as appropriate.

9.5 When the contractor receives an enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) for TPRADFM from a family member of a RC member called or ordered to active service for more than 30 days, the contractor shall ensure the family members are registered as eligible on DEERS.

9.6 The contractor shall match the TPR residence addresses from the enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) of the activated federalized National Guard/Reservist member and the family members. If the residence addresses match, to include zip code only match, the contractor shall deem the family members as eligible for TPRADFM and enroll the family member in the program.

9.7 If the TPR residence addresses from the enrollment request (enrollment form, BWE transaction, or telephonic requests documented in the contractor's call center notes) of the activated federalized National Guard/Reserve member and the family members do not match, the family members shall be advised by letter they are not eligible for enrollment in TPRADFM and they shall remain eligible for TRICARE Standard, Extra, or Prime as appropriate.

9.8 Enrollments or disenrollments will occur upon change of duty location out of the remote area, transfer into a MTF/clinic PSA, retirement, or separation from the Service. The ADFM or Service member is responsible for notifying the contractor when an enrollment transfer is needed. The contractor shall follow enrollment portability and transfer procedures in [Chapter 6, Section 2](#).

9.9 The contractor shall enroll the ADFM in the DEERS Online Enrollment System (DOES) and enter the TPRADFM's enrollment status into DOES. The contractor shall use the DMIS-ID code(s) designated by the RD for that region to enroll ADFMs into TPRADFM (see the TRICARE Systems Manual (TSM)). If the contractor has not established a network of PCMs in a remote area, a TPR designated ADFM will be enrolled without a PCM assigned. A generic PCM code shall be used for TPRADFM enrollees without assigned PCMs. The ADFM without an assigned PCM will be able to use a local TRICARE participating or authorized provider for primary health care services without preauthorization.

9.10 The contractor shall provide TPRADFM enrollment information in the formats indicated in the contract requirements.

10.0 PCM ASSIGNMENT

At the time of enrollment, an ADFM will select (or will be assigned) a PCM within the access standard. The MCSC shall advise the ADFM of the availability of PCMs. If a PCM is not available, the ADFM shall be enrolled to TPRADFM without an identified PCM. An ADFM without an assigned PCM may use any TRICARE-authorized provider for primary care.

11.0 SUPPORT SERVICES

11.1 Inquiries

The contractor shall designate a point of contact for Government (RD, [Defense Health Agency \(DHA\)](#), and Military Service) inquiries related to TPRADFM. The contractor may establish a dedicated unit for responding to inquiries about TPRADFM, or may augment existing TPR service units already serving the Service members enrolled in TPR. The correspondence requirements and standards in [Chapter 1, Section 3](#), apply to TPRADFM written inquiries.

11.2 Toll-Free Telephone Service

The contractor shall provide toll-free telephone access for TPRADFM beneficiary inquiries.

12.0 CLAIMS PROCESSING

The regional contractor where the TPRADFM is enrolled shall process all claims for that enrollee, except for care provided overseas (i.e., care outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary is enrolled. POS claims processing provisions do apply. The contractor shall provide TPRADFM claims information in the format for the Monthly Workload Reports and the Monthly Cycle Time Aging reports.

13.0 CLAIM REIMBURSEMENT

13.1 The payment provisions applicable under TPR for Service members which allow for additional payment in excess of otherwise allowable amounts to providers who are not TRICARE-authorized or certified do not apply to TPRADFM. Such payments shall not be made unless such payments are otherwise allowed under the payment provisions for unauthorized providers contained in the TPM.

13.2 For network providers, the contractor shall pay TPRADFM claims at the negotiated rate. For participating providers the contractor shall pay up to the CHAMPUS Maximum Allowable Charge (CMAC), or billed charges, whichever is less. Contractors shall follow the requirements in [Chapter 8, Section 5](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 5, Section 1](#), for claims for TPRADFM enrollees receiving care from non-participating providers.

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13.3 If a non-participating provider requires a TPRADFM enrollee to make an “up front” payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances.

13.4 If the contractor becomes aware that a civilian provider is “balance billing” a TPRADFM enrollee or has initiated collection action for emergency or authorized care, the contractor shall notify the provider that balance billing is prohibited.

13.5 If CMAC rates have been waived for TPR Service member enrollees under [Section 4, paragraph 3.5](#), the TPRADFM enrollee shall not be extended the same waived CMAC rates. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate within 100% of the CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. By law the contractor shall not negotiate a rate higher than 115% of CMAC for TPRADFM care rendered by a non-participating provider. The contractor shall ensure that the approved payment is annotated in the authorization/claims processing system.

14.0 APPEALS PROCESS

TPRADFM enrollees may appeal denials of authorization or reimbursement through the contractor in accordance with [Chapter 12](#). If the contractor denies authorization or reimbursement for a TPRADFM enrollee’s health care services, the contractor shall, on the Explanation of Benefits (EOB) or other appropriate document, furnish the enrollee with clear guidance for requesting a reconsideration from, or filing an appeal with, the contractor.

15.0 TRICARE ENCOUNTER DATA (TED) SUBMITTAL

The contractor shall report TPRADFM claims under the financially underwritten provisions of the MCS contract.

- END -

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 10, Section 4](#).

4.4.2 Failure to provide information to establish or maintain a recurring 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 TN includes notice of the 12 month lockout period.

4.5 Requests For Voluntary Termination

The contractor shall accept requests for termination of coverage from young adult dependents at any time. **Termination of coverage requests includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal consent provided via telephone and documented in the contractor's call notes, or (4) a self-attestation by the beneficiary when using the BWE system.** 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 notification of termination (see [paragraph 4.1.2](#)) 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 notify 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, for determination. 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](#)) of premiums are required, then only monthly premium payments are permitted. Premium-related transactions shall be reported through the enrollment fee payment interface or CC&D Fee Web (see the TSM, [Chapter 3, Section 1.4](#)).

5.1 Jurisdiction For Premium Billing And 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 4.1.2](#) 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 is 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 EFTs 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 within the first five business days 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 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](#).

6.2 Non-Availability Statement (NAS) requirements shall apply to young adult dependents in the same manner as under the corresponding TRICARE plan.

6.3 If a young adult dependent purchases TYA coverage during the same fiscal year that he or she had another TRICARE health plan in effect, the individual cost-shares, contributions to the individual and family deductibles, and contributions to the family catastrophic cap from the other TRICARE health plan still apply in that fiscal year and shall not be recalculated. If retroactive TYA coverage is purchased and replaces previously purchased CHCBP coverage, cost-shares, contributions to deductibles, or contributions to the catastrophic cap amounts previously paid under CHCBP shall be carried over to a TYA plan. Otherwise, any cost-shares, contributions to deductibles, or contributions to the catastrophic cap amounts previously paid under CHCBP shall not be carried over to a TYA plan.

6.4 Medicare is the primary payer for TRICARE beneficiaries who are eligible for Medicare. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#). The contractors shall follow procedures established in [Chapter 8, Section 2](#) regarding claims jurisdiction for dual eligibles. Payment of Medicare Part B premiums do not provide a basis to waive TYA premiums.

6.5 If the contractor receives a PNT notifying them of a retroactive TYA disenrollment the contractor shall initiate recoupment of claims paid if appropriate as specified in [Chapter 10](#).

6.6 If at any time the contractor discovers that the young adult dependent may be eligible or is enrolled in an eligible employer-sponsored health plan from their employer, the contractor shall report the discovery to the appropriate waiver approval authority NLT one business day after discovery. Claims may be pended or held until a final decision is reached. As applicable, the contractor shall follow [paragraph 4.3](#) and its subordinate paragraphs for loss of TYA eligibility.

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 other TRICARE plans.

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), [Defense Health Agency \(DHA\)](#), Office of BE&SD. The contractor shall distribute all informational materials associated with

the TYA program to the same extent and through the same means as other TRICARE materials are distributed. Copies of TYA informational materials may be obtained through the usual DHA BE&SD process.

7.1.2 Upon start of coverage under TYA, the DMDC-generated enrollment notification will include information on how purchasers can obtain TYA and other TRICARE plan materials over the Internet or how to request fulfillment materials from the contractor. The servicing contractor shall send fulfillment materials only upon request.

7.2 Customer Service

The contractor shall provide all customer service support to young adult dependents in a manner equivalent to that provided to other TRICARE beneficiaries.

8.0 ANALYSIS AND REPORTING

TYA 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 TYA 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 TYA 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 TYA 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 Premiums shall be deposited into a non-interest bearing account to collect and disburse TYA premiums. The contractor shall deposit TYA premium collections to the established account within one business day of receipt. A separate bank account is not required; however, individual line item reporting for the TYA program is required.

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 DHA 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 DHA 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., TYA premiums).

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 as described in the Contract Data Requirements List (CDRL) DD Form 1423.

10.0 CHCBP TO TYA PROCEDURES

Young adult dependents who qualify for TYA coverage and were previously or are currently enrolled in the CHCBP may elect to purchase TYA.

10.1 Enrollment Procedures

Enrollment actions must be coordinated between the CHCBP contractor and the TYA enrolling contractor. The CHCBP contractor will provide contact information to the enrolling contractors to coordinate CHCBP to TYA enrollments.

10.1.1 CHCBP Coverage Was Terminated More Than 30 Days Before Receipt of TYA Application and Young Adult Dependent Is Not Eligible for Continuation or Retroactive TYA Coverage

The enrolling contractor will validate in DEERS that the CHCBP enrollment was terminated more than 30 days from the date of the TYA application. The TYA enrolling contractor will process the TYA application according to [paragraph 4.1.2](#).

10.1.2 Currently Enrolled in CHCBP or TYA Application Received Within 30 Days of Termination of CHCBP Coverage

Upon receipt of a TYA application for someone currently enrolled in or within 30 days of termination of CHCBP coverage, the enrolling contractor will request the CHCBP contractor to disenroll the young adult dependent from CHCBP with an effective date one day prior to the requested start date. The CHCBP contractor will terminate the CHCBP coverage based on the TYA effective date or the CHCBP paid-through date, whichever is earlier. The CHCBP contractor will recalculate the amount of premiums required for the remaining CHCBP coverage, and refund any overpayment of CHCBP premiums. The refund shall include an explanation that the refund amount represents a refund of CHCBP premiums as a result of the TYA enrollment and how the refund amount was calculated.

10.2 CHCBP Premium Refund Procedures

CHCBP premium refunds do not need to be approved by the **DHA** CRM F&AO prior to making a payment to the beneficiary. The refunds should be reduced from the CHCBP premiums collected during a given month and the net amount sent to the **DHA** CRM F&AO as required by TPM, [Chapter 10, Section 4.1](#).

10.3 Refunds for Overpayment of Family Deductible and/or Catastrophic Caps

10.3.1 Upon termination of CHCBP coverage with retroactive TYA coverage for the same period, the CHCBP contractor will review CHCBP claims history for the retroactive period, and post any CHCBP cost-shares and deductibles to the TRICARE family deductible and catastrophic cap as a TYA

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claim, ensuring the amounts posted do not exceed the applicable catastrophic cap and deductible limits. Cost-shares over the catastrophic cap and deductible limit will be refunded.

10.3.2 Refunds for overpayments of family deductible and/or catastrophic cap must be approved by the **DHA** CRM F&AO before being released/mailed. Payments will be processed under manual payment procedures as required by contract requirements. Supporting documentation for these payments will be provided no more often than weekly and no less than monthly to the **DHA** CRM F&AO by the CHCBP contractor and will include the name, DoD Benefits Number, the calculation of the refund, and the amount being refunded. Upon approval from the **DHA** CRM F&AO, the CHCBP contractor will release payments for refunds of the overpaid amounts.

10.4 TRICARE Encounter Data (TED) Records For Claims Previously Processed As CHCBP and Affected by a Retroactive TYA Enrollment

Prior TED records processed as CHCBP and affected by a TYA retroactive enrollment should be reprocessed as follows:

10.4.1 Upon notification from the CHCBP contractor, appropriate Pharmacy TED records shall be adjusted by the Pharmacy contractor to indicate the appropriate TYA HCDP Plan Coverage Code and Enrollment/Health Plan Code. These records are to be submitted on a TED Header Type Indicator 6. Administrative claim payments for these adjustments will be manually billed to **DHA**.

10.4.2 TED records, other than pharmacy, where the claim jurisdiction indicates South Region will be cancelled and replaced by the CHCBP contractor. The new TED record will retain all the original claim data except the appropriate TYA HCDP Plan Coverage Code and Enrollment/Health Plan Code will replace the CHCBP enrollment codes. These records are to be submitted on a TED Header Type Indicator 6.

10.4.3 TED records, other than pharmacy, with a claim jurisdiction other than the South Region will be adjusted by the CHCBP Contractor to indicate the appropriate TYA HCDP Plan Coverage Code and Enrollment/Health Plan Code. These records are to be submitted on a TED Header Type Indicator 6. Administrative claim payments for these adjustments will be manually billed to **DHA**.

11.0 CODING OF TED RECORDS

When the secondary HCDP Coverage Code is 400 (Extended Care Health Option (ECHO)) and the TYA beneficiary is receiving care considered an ECHO benefit, the contractor shall submit the primary TYA HCDP Plan Coverage Code and Special Processing Codes 'PF' or 'AU' as appropriate on the TED record.

- END -

