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

**CHANGE 162**  
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**REMOVE PAGE(S)**

**CHAPTER 6**

Section 1, pages 3 - 20

**CHAPTER 16**

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**CHAPTER 22**

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## **SUMMARY OF CHANGES**

### **CHAPTER 6**

1. Section 1. This change clarifies the TRICARE Prime disenrollment policy for enrollees identified as being ineligible for enrollment, allows collection of less than a three month deposit to enroll in TRICARE Prime, and establishes cross-region enrollment.

### **CHAPTER 16**

2. Section 1. This change clarifies the enrollment jurisdiction for Active Duty Family Members (ADFM).
3. Section 3. This change adds the disenrollment policy if a service member is identified as being ineligible for TRICARE Prime Remote (TPR) enrollment.
4. Section 6. This change clarifies the enrollment of ADFMs living in a Prime Service Area, but without a Primary Care Manager being within the 30-minute drive time. The change also adds the disenrollment policy if an active duty family member is identified as being ineligible for TPRADFM enrollment.

### **CHAPTER 22**

5. Section 1. This change adds the newborn policy for the TRICARE Regional Director, the TAO Director, or their designee to extend the TRICARE Reserve Select enrollment period for a newborn/adopted child up to 120-days, on a case-by-case or regional basis, as well as minor language changes.



## **2.0 DUAL ELIGIBLES (ENTITLEMENT UNDER BOTH MEDICARE AND TRICARE)**

**2.1** Dual eligibles, retired, and under age 65 are eligible to enroll in TRICARE Prime provided they maintain Medicare Part A and Part B. Dual eligible **Active Duty Family Members (ADFM)s**, regardless of age, are eligible to enroll in Prime. Dual eligible retirees and family members age 65 and over are not eligible to enroll in Prime (unless they are not eligible for premium-free Medicare Part A on their own record or the record of their current, former, or deceased spouse). Medicare is primary payor for all dual eligibles regardless of their sponsor's status. (See the TPM, [Chapter 10, Section 6.1](#) for additional dual eligible information.)

**2.2** Prime-enrolled dual eligibles, to the extent practicable, should follow all TRICARE Prime requirements for PCM assignment, referrals and authorizations. However, they are not subject to POS cost-sharing. Enrollment fees are waived for dual eligibles as described below.

## **3.0 ASSIGNMENT OF PCM**

The contractor shall assign all enrollees a PCM by name (PCMBN) on DOES at the time of enrollment. This applies to beneficiaries assigned to Direct Care (DC) and civilian network PCMs.

**3.1** All DC TRICARE Prime enrollees shall be enrolled to a Department of Defense (DoD) MTF Primary Care Location by the MCSCs. The contractor shall comply with the MTF Commander's specifications in the MTF MOU for which enrollees or categories of enrollees shall be assigned a DC PCM or offered a choice of civilian network PCMs.

**3.1.1** The contractor shall enroll TRICARE Prime beneficiaries to the MTF until the capacity is optimized in accordance with the MTF Commander's determinations; TRICARE Prime beneficiaries who cannot be enrolled to the MTF will be enrolled to the contractor's network.

**3.1.2** All active duty personnel not meeting the requirements for TRICARE Prime Remote (TPR) shall be enrolled to an MTF, not the contractor's network, regardless of capacities.

**3.1.3** When a family member of a sponsor E-1 through E-4 requests a PCM in an MTF that offers TRICARE Prime for any beneficiary category other than active duty, that beneficiary must be assigned an MTF PCM unless capacity has been reached. If overall MTF capacity has not been reached, the MCSC shall request the MTF to shift capacity in DOES to the ADFM beneficiary category from another category if necessary to accommodate an E-1 - E-4 ADFM beneficiary's PCM assignment request.

**3.2** MTFs will provide the MCSC a current listing of all Primary Care Locations with associated groups or a current listings of DC PCMs. The list(s) will be made available for the beneficiary's use for the initial selection or change of a PCM. The MCSC will provide guidance to the enrollee in selecting a Primary Care Location or PCM, as appropriate given MTF guidance in the MOU. Upon receipt of an inquiry from a DC enrollee in regards to the person's assigned PCM, the MCSC shall refer the beneficiary to the MTF to which the beneficiary is enrolled.

**3.3** At the time of enrollment, the contractor is responsible for determining the appropriate enrollment Defense Medical Information System Identification (DMIS-ID) based on the regional and MTF MOUs, access standards and/or other specific Government guidance. The contractor shall

assign each enrollee a PCMBN at the time of enrollment based on those PCMs available within DOES.

**3.3.1** The contractor will attempt to assign the beneficiary to the PCM requested by the beneficiary (see paragraph 1.1.2) if capacity is available. If the preferred PCM is not available, the contractor will use the default PCM for that DMIS.

**3.3.2** If the enrollment request (see paragraph 1.1.2) identifies a gender or specialty preference, the MCSC will try to assign an appropriate PCM. If the gender or specialty is not available, the beneficiary will be enrolled to the default PCM for that DMIS.

**3.3.3** If there is no PCM preference stated on the enrollment request (see paragraph 1.1.2), the contractor will use the default PCM for that DMIS.

**3.3.4** If there is no DC PCM available in the appropriate DMIS/MTF, nonactive duty beneficiaries may be enrolled to a civilian PCM, by following the procedures specified for such situations in the local MTF MOU.

**3.3.5** If there is no PCM capacity in the MTF for an ADSM, then the MCSC will contact the MTF for instructions.

**3.4** DOES reflects only those DC PCMs that the MTF has loaded onto the DEERS PCM Repository. Further, DOES will only display PCMs with available capacity for the specific beneficiary's category and age. The contractors cannot add, delete, or modify DC PCMs on the repository.

**3.5** The contractor shall complete all panel PCM reassignments (batch) using a Government-provided systems application, PCM Reassignment System (PCMRS). Panel reassignments may be specified by the appropriate MTF Commander for a variety of reasons, including the rotation or deployment of DC PCMs. MCSCs should expect at least one-half of DC PCM assignments to change each year. These moves may be based on various factors of either the enrollment or the individual beneficiary, including:

- 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

**3.6** MTFs may request PCM reassignment, including panel reassignments, in several ways, including telephone, e-mail or other electronic submissions. The most common method to request individual PCM reassignments is the telephone. The preferred method for panel reassignments is the batch staging application within PCMRS. Regardless of the submission method, the MTF must provide sufficient information identifying both the PCMs and beneficiaries involved in a move to allow the contractor to reasonably accomplish the move. Thereafter, the contractor shall complete each DC PCM reassignment, both individual and panel reassignment, within three working days of receiving all necessary information from the MTF.

**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. See paragraph 9.5, for actions required if a beneficiary is identified as being ineligible for continued Prime, TPR or TPRADFM enrollment.

**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. (An ADSM 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) or Electronic Funds Transfer (EFTs) from the enrollee's designated financial institution. Payments may be made on a recurring basis. 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 **one to three months of fees**, at the time the enrollment **request** is submitted to allow time for the allotment or EFT to be established. The contractor shall **explain the deposit amount required and** accept payment by personal check, cashier's check, traveler's check, money order, or **debit/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 9.10](#) 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

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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, 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.)

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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](#).

**8.2.3** WII 416 enrollments can be in conjunction with an MTF, TPR, TOP Prime, or TOP Prime Remote enrollment. DEERS will end WII 416 enrollments upon loss of member's active duty eligibility. WII 416 program enrollments will not be portable across programs or regions.

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

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

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

## **9.0 TRICARE POLICY FOR ACCESS TO CARE (ATC) AND PRIME SERVICE AREA (PSA) STANDARDS**

**9.1** Non-active duty beneficiaries in the Continental United States (CONUS) and Hawaii who reside more than 30 minutes travel time from their desired PCM must waive primary and specialty drive-time ATC standards. (Due to the unique health care delivery challenges in Alaska, the requirement to request a waiver for the drive-time access standard does not apply to beneficiaries in Alaska.) Before effecting an enrollment or portability transfer request, contractors shall ensure that a beneficiary has waived travel time ATC standards either by signing Section V of the DD Form 2876 enrollment application (this includes an electronic signature offered by and collected by the contractor), by providing verbal consent via telephone communication (which is documented in the contractor call notes), or by requesting enrollment through the BWE service (for both civilian and MTF PCMs). An approved waiver for a beneficiary residing less than 100 miles from their PCM will remain in effect until the beneficiary changes residence.

**9.2** Contractors must estimate the travel time or distance between a beneficiary's residence to a PCM (either a civilian PCM or an MTF) using at least one web-based mapping program. The choice of the mapping program(s) is at the discretion of the contractor, but the contractor must use a consistent process to determine the driving distance for each enrollee applicant who may reside more than 30 minutes travel time from their PCM. The time or distance shall be computed between the enrollee's residence and the physical location of the PCM (including MTFs). It is not acceptable to use a geographic substitute, such as a geographic centroid.

**9.3** Contractors (in conjunction with MTFs for MTF enrollees) are responsible for beneficiary drive-time waiver education and must ensure that beneficiaries who choose to waive these standards have a complete understanding of the rules associated with their enrollment and the travel time standards they are forfeiting. This includes educating beneficiaries who waive their ATC travel standards of the following:

- They should expect to travel more than 30 minutes for access to primary care (including urgent care) and possibly more than one hour for access to specialty care services.
- They will be held responsible for POS charges for care they seek that has not been referred by their PCM (or for MTF enrollees, by another MTF provider).
- They should consider whether any delay in accessing their enrollment site might aggravate their health status or delay receiving timely medical treatment.

#### **9.4 Cross-Region Enrollment**

Beneficiaries shall enroll to the Region where the desired PCM is located; however, all TRICARE Prime enrollment policies still apply, i.e., PCM selection and utilization, referrals, drive times and distance standards to the desired PCM. A signed access to care drive-time waiver is required (see paragraph 9.1). All claims are processed by the Region of enrollment. Cross-region enrollment must be requested by either submitting an enrollment form (DD Form 2876) or by calling the regional contractor servicing the desired PCM. The enrolling contractor shall ensure a beneficiary is not approved for cross-region enrollment if they live within 30-minutes of an MTF, unless the MTF's servicing contractor approves the enrollment. The beneficiary shall be enrolled to the MTF if a PCM is available.

**9.5** If at any point during the enrollment period the contractor determines or is advised that a beneficiary is no longer eligible for continued TRICARE Prime enrollment, the contractor shall inform the beneficiary of the discrepant address situation. For example, their residential address is 100 miles or more from the PCM or MTF (with no 100 mile waiver) to which they are enrolled or their residential address is 100 miles or more from their assigned network PCM. This notification (letter, telephone call, or e-mail) shall occur when the discrepant information is first known by the contractor. If the beneficiary confirms the DEERS-recorded address is incorrect, and the beneficiary updates DEERS with correct information (contractor to assist as appropriate), the beneficiary will remain enrolled in TRICARE Prime if all enrollment requirements are met. If the contractor confirms the beneficiary is ineligible for enrollment, the contractor shall advise the beneficiary they are being disenrolled. Their disenrollment from TRICARE Prime will be effective the first of the month following 30 days from the initial notification date. The contractor shall provide the beneficiary information about TRICARE Standard and Extra. A 12-month lock out does not apply and any excess enrollment fees will be refunded.

#### **9.6 MTF Enrollees**

**9.6.1** Non-active duty beneficiaries must reside within 30 minutes travel time from an MTF to which they desire to enroll. If a beneficiary desiring enrollment resides more than 30 minutes (but less than 100 miles) from the MTF, they may be enrolled so long as they waive primary and specialty ATC standards and the MTF Commander (or designee) approves the enrollment. (If the MOU includes zip codes or drive-time distances for which the MTF is willing to accept enrollments that

are beyond a 30 minute drive, this constitutes approval. If not addressed in the MOU, the contractor shall submit each request to the MTF Commander (or designee) in a method that is outlined in the MOU.) The TRICARE Regional Office (TRO) Director may approve waiver requests from beneficiaries who desire to enroll to an MTF and who reside 100 miles or more from the MTF. In these cases, the MTF Commander must also be agreeable to the enrollment and have sufficient capacity and capability.

**9.6.2** The contractor shall process all requests for enrollment to an MTF in accordance with the MOU between the MTF and the contractor. See paragraph 9.4 regarding cross-region enrollments. Enrollment guidelines in MOUs may include:

**9.6.2.1** Zip codes and/or distances for which the MTF Commander is mandating enrollment to the MTF. These mandatory MTF enrollment areas must be within access standards (i.e., a 30 minute drive-time of the MTF) and can apply to all eligible beneficiaries or can be based on beneficiary category priorities for MTF access.

**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.

**9.6.2.2** 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.

**9.6.2.3** 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.

**9.6.3** 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.

**9.6.3.1** 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.

**9.6.3.2** 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.)

**9.6.4** 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 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.

**9.6.5** 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.

**9.6.6** 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.

## **9.7 Civilian Enrollees**

**9.7.1** 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.](#))

**9.7.2** 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

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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.)

**9.7.3** 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 -



**6.4** The contractor shall forward all written inquiries and correspondence related to SAS denials of authorization, or authorization for reimbursement to the appropriate SAS. The contractor shall refer telephonic inquiries related to SAS denials to the appropriate SAS.

## **7.0 ACTIVE DUTY FAMILY MEMBERS (ADFM)s AND OTHERS**

TRICARE-eligible family members accompanying Service members who are either eligible for or enrolled in the TPR program may enroll in the TRICARE Prime Remote for Active Duty Family Member (TPRADFM) Program in accordance with [Section 6. Enrollment jurisdiction for the ADFMs may be based on the enrollment jurisdiction of the TPR enrolled Service member per paragraph 8.6.](#)

## **8.0 TPR PROGRAM DIFFERENCES**

In addition to the SHCP differences specified in [Chapter 17, Section 1, paragraph 4.0](#), the following differences apply to the TPR program.

**8.1** If the contractor has not established a network of PCMs in a remote area, a TPR designated Service member will still be enrolled without a PCM assigned. The Service member without an assigned PCM will be able to use a local TRICARE-authorized provider for primary health care services without SAS review.

**8.2** Point of Service (POS) cost-sharing and deductible amounts do not apply to Service members. If a TPR enrolled Service member receives primary care without a referral or authorization, the enrolling contractor shall process the claim and make payment if the care meets all other TRICARE requirements (i.e., the care is medically necessary, a covered benefit of TRICARE an approved waiver is provided, etc.).

**8.3** Annual Service member re-enrollment is not required.

**8.4** If the Uniformed Services determine that an active duty member is eligible for the TPR program, enrollment of the member is mandatory, unless there are service-specific issues that merit assignment to a military PCM, or if the Service member elects to waive access standards and enrolls to an MTF (subject to unit commander/supervisor approval).

**8.5** If Third Party Liability (TPL) is involved in a claim, Service member claim payment will not be delayed during the development of TPL information from the Service member.

**8.6** Enrollment jurisdiction may be based on the location of the military work unit instead of the Service member's residence. This is determined by the Services.

- END -



## Enrollment, Beneficiary Education, And Support Services

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### 1.0 ENROLLMENT

**1.1** The Regional Director (RD) will, on an as needed basis, but at least semi-annually, provide the contractor with an update to the TRICARE Prime Remote (TPR) directory of units whose members are eligible for enrollment in the program according to [Section 1, paragraph 3.0](#).

**1.2** An enrollment request, as described above, must be submitted by either the Service member or the Service member's unit commander for each Service member enrolling in the TPR Program. The effective date for TPR Program enrollment is the date the Service member or the Service member's unit commander submitted the enrollment request.

**1.3** Service member enrollment in the TPR Program will be for the tour of duty. Enrollment transfers or disenrollments will occur upon change of duty location out of the region, transfer into an Military Treatment Facility (MTF)/clinic Prime Service Area (PSA), retirement, or separation from the service. The Service member will be 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](#).

**1.3.1** If at any point during the enrollment period the contractor determines or is advised that a Service member is no longer eligible for TPR, the contractor shall notify (letter, telephone call, or e-mail) the Service member of the discrepant enrollment immediately. If the discrepant enrollment is not corrected within 30-days of the notification date, the contractor shall disenroll the Service member from TPR effective the first of the month after the 30-day notification period. The contractor shall use the address in Defense Enrollment Eligibility Reporting System (DEERS) to reassign the Service member to TRICARE Prime at an MTF utilizing the MTF/Enhanced Multi-Service Market (eMSM) enrollment guidelines.

**1.3.2** 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 Beneficiary Web Enrollment (BWE) system. A Service member signature is not required to make enrollment changes using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#). A signature is not required to complete the enrollment as enrollment in TPR is mandatory per [paragraph 1.0](#).

**1.4** The contractor shall record the Service member's TPR enrollment in the DEERS via DEERS Online Enrollment System (DOES). The TPR enrollment card is provided by Defense Manpower Data Center (DMDC). When processing TPR enrollment requests from Service member astronauts, the contractor shall not assign the astronauts to a network or other TRICARE authorized Primary Care Manager (PCM). The National Aeronautics and Space Administration (NASA) providers shall provide primary care for the Service member astronauts and the contractor shall use the PCM (unassigned)

procedure when enrolling Service member astronauts into the TPR program. The contractor shall coordinate referrals and authorizations from the NASA providers for TPR enrolled Service member astronauts in accordance with [Section 2, paragraph 5.2](#) and its subordinate paragraphs.

## **2.0 PRIMARY CARE MANAGER (PCM) ASSIGNMENT**

At the time of enrollment, a Service member will select (or will be assigned) a PCM in the local community, if available. A Service member without an assigned PCM may use a local TRICARE-authorized provider for primary care.

## **3.0 BENEFICIARY EDUCATION**

**3.1** Enrollment in the TPR Program is mandatory for Service members who qualify for the program (see [Section 1, paragraph 2.0](#)); therefore, the Managed Care Support Contractor (MCSC) shall limit educational activities for TPR-enrollees to distributing the informational materials provided by the Government. The RD will determine the initial supply of materials required and the MCSC shall forward materials to the TPR Program Units. The contractor shall include enrollment request options (enrollment forms, BWE transactions, and telephonic requests documented in the contractor's call center notes), for the TPR Program in the Service member informational materials.

**3.2** Educational issues include the PCM concept (and what procedures to follow when a network PCM is not assigned), how to access care in and out of the area using the contractor, how to access specialty care through the contractor and Specified Authorization Staff (SAS), and information on filing medical claims.

**3.3** The Government will provide all TPR enrollees with information about how to obtain self-care manuals. The contractor shall give TPR-enrolled Service members and their family members the option of participating in health promotion and wellness programs offered by the contractor in MTF PSAs.

**3.4** Educational activities in the TPR Program areas shall involve the joint efforts of the service unit of the Service member, the SASs, the Service Medical Departments, the RD, and the contractor. The contractor shall distribute **Defense Health Agency (DHA)**-supplied educational materials unique to the TPR Program. The contractor is responsible for postage, envelopes, and mailing costs for distributing educational material.

**4.0** The contractor shall include TPR Program information and updates as part of all TRICARE briefings. The contractor may propose alternative methods for supplying educational information to Service members eligible to enroll in the TPR Program.

## **5.0 SUPPORT SERVICES**

### **5.1 General**

The requirements and standards in [Chapters 1](#) and [11](#), apply to the TPR Program unless otherwise stated in this chapter.

## **5.2 Inquiries**

The contractor shall designate a point of contact for Government (RD, **DHA**), and Uniformed Service) inquiries related to the TPR Program. The contractor may establish a dedicated unit for responding to inquiries about the TPR Program and the Supplemental Health Care Program (SHCP). The contractor shall respond to all inquiries--written, telephone, walk-in (overseas only), etc.-- that are not related to dental care or to SAS reviews of medical care. The contractor shall forward all inquiries that specifically address dental care or SAS review of medical care to the active duty dental claims processor or the TPR enrollee's SAS for response. The requirements and standards in [Chapter 1, Section 3](#), apply to TPR inquiries.

## **5.3 Toll-Free Telephone Service**

The contractor shall provide toll-free telephone access for TPR Program beneficiary inquiries. This toll-free access may also serve the SHCP beneficiaries. See [Chapter 1, Section 3](#) for telephone standards. The contractor shall handle provider inquiries through the contractor's provider inquiry system.

- END -



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](#).

- If at any point during the enrollment period the contractor determines or is advised that a family member is no longer eligible for TPRADFM, the contractor shall notify (letter, telephone call, or e-mail) the Service member of the discrepant enrollment immediately. If the discrepant enrollment is not corrected within 30 days of the notification date, the contractor shall disenroll the family member(s) from TPRADFM effective the first of the month after 30 days from the initial notification date and provide information on TRICARE Standard and TRICARE Extra.

**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.

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**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.

**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 -



## TRICARE Reserve Select (TRS)

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### 1.0 GENERAL

TRICARE Reserve Select (TRS) is a premium-based TRICARE health plan available for purchase by qualified members of the Reserve Components (RCs) and qualified survivors that offers health coverage for RC members and their eligible family members. The RCs will validate members' and survivors' qualifications to purchase TRS coverage and will identify qualified members/survivors in the Defense Enrollment Eligibility Reporting System (DEERS).

### 1.1 Benefits/Scope Of Care

The TRS health plan delivers the TRICARE Standard benefit to all covered individuals. TRICARE Standard and TRICARE Extra cost-shares, deductibles and catastrophic caps applicable to Active Duty Family Members (ADFMs) shall apply to all individuals (including RC members themselves) covered under TRS. TRS members, their covered family members, and TRS survivors are eligible for Direct Care (DC) in a Military Treatment Facility (MTF), including MTF pharmacies with the same access priority as ADFMs not enrolled in TRICARE Prime. The contractor shall review and modify MTF Memoranda of Understanding (MOU) as necessary to reflect MTF requirements for accommodating and ensuring that TRS members, family members and survivors are provided the same level of service as ADFMs under TRICARE Standard/Extra.

### 1.2 Specific Programs Not Available Under TRS

Specific programs not available under TRS include those listed below:

- TRICARE Reserve and National Guard Family Member Benefits program that established the authority to waive the annual TRICARE Standard (or Extra) deductible for RC family members who became eligible for TRICARE as a result of their sponsor's activation in support of a contingency operation as specified in TRICARE Policy Manual (TPM), [Chapter 10, Section 8.1](#).
- Extended Care Health Option (ECHO)
- TRICARE Prime Programs including the Uniformed Services Family Health Plan (USFHP)
- Supplemental Health Care Program (SHCP) funds, except for civilian care referred by Military Health System (MHS) Facilities as specified in [Chapter 17](#) to the same extent that SHCP covers civilian care for MHS beneficiaries who are not Active Duty Service Members (ADSMs).
- Special Supplemental Food Program

## 2.0 TRS PREMIUMS

TRS offers two types of coverage: TRS member-only coverage and TRS member and family coverage. Each year the government will determine premium rates payable monthly by the member/survivor for each type of coverage. The government will provide the premium rates to the contractor No Later Than (NLT) 60 calendar days prior to the effective date. TRS premium rates are specified in [Addendum A, Figure 22.A-2](#). Unless otherwise specified, the premium rates will be in effect for a full calendar year. A surviving family member who qualifies to purchase (or continue) TRS coverage as described in [paragraph 3.2](#) shall pay the member-only rate if there is only one covered survivor and the member and family rate if there are two or more survivors to be covered.

## 3.0 QUALIFYING TO PURCHASE TRS COVERAGE

The RCs will validate member's and survivor's qualifications to purchase TRS coverage and will identify qualified members/survivors in DEERS. The contractor shall rely solely upon DEERS to identify members who have been qualified to purchase TRS coverage. The contractor shall refer RC members/survivors to their respective RC for issues concerning qualifying to purchase TRS coverage. To qualify for TRS a RC member must be in the Selected Reserve throughout the period of coverage. The qualifications unique to TRS are listed below for contractor information purposes only.

### 3.1 Member Purchase

A member of the RC of the Armed Forces qualifies to purchase TRS coverage if the member meets both the following conditions:

- Member of the Selected Reserve of the Ready Reserve;
- Not enrolled in, or eligible to enroll in, a health benefits plan under 5 United States Code (USC) Chapter 89, the Federal Employees Health Benefit Program (FEHBP).

### 3.2 Survivor Coverage Under TRS

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

## 4.0 COVERAGE-RELATED PROCEDURES

The contractor shall process coverage-related transactions through the Defense Online Enrollment System (DOES) (TRICARE Systems Manual (TSM), [Chapter 3, Section 1.4, paragraph 1.2.2](#)). Premium-related transactions shall be reported through the enrollment fee payment interface (see the TSM, [Chapter 3, Section 1.4, paragraph 1.2.8.1](#)). The contractor shall perform all premium and billing functions in accordance with [paragraph 5.0](#) and subordinate paragraphs. The TRICARE Overseas Program (TOP) contractor shall perform these services for TRS members, **which include TRS-covered survivors**, residing outside of the 50 United States or the District of Columbia.

See the TSM, [Chapter 2, Addendum L](#) for a full list of TRS Health Care Delivery Plan (HCDP) Coverage Code Values. The TRICARE South Region contractor shall perform these services for TRS members or survivors residing outside the 50 United States or the District of Columbia until such time specified in the transition schedule to the new overseas contractor.

#### 4.1 Purchasing Coverage

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

##### 4.1.1 Continuation Coverage

A qualified member or qualified survivor may purchase TRS coverage with an effective date immediately following the termination of coverage under another TRICARE program. The TRS request required by [paragraph 4.1](#) must be either received by the MCSC/TOP contractor or postmarked NLT 30 days after the termination of other TRICARE coverage.

##### 4.1.2 Qualifying Life Events

A qualified member may purchase TRS coverage in connection with a Qualifying Life Event (QLE) that results in a change of family composition. First, qualified members are responsible to report all changes in family composition to military personnel officials with Real-Time Automated Personnel Identification System (RAPIDS) access to appropriately update DEERS. Second, the TRS request form identifying the QLE, required by [paragraph 4.1](#) must be either received by the MCSC/TOP contractor or postmarked NLT 60 days after the date of the QLE. The following QLEs are processed through DEERS and are recognized by TRS. The effective date of coverage is the date the QLE occurred (i.e., date of marriage, Date of Birth (DOB), etc.).

- Marriage;
- Birth or adoption of child;
- Placement of a child in the legal custody of the member by an order of the court for a period of at least 12 months;
- Divorce or annulment;
- Death of a spouse or family member, survivor; or
- Last family member/survivor becomes ineligible (e.g., child ages out).

### 4.1.3 Open Enrollment

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

### 4.1.4 Survivor Coverage Under TRS

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

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

**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 by the MCSC/TOP contractor or postmarked NLT 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 5.4](#) 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 by the MCSC/TOP contractor 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 by the MCSC/TOP contractor 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 6.2](#).

**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 TRS member may submit a request for reconsideration to the appropriate TRICARE Regional Director the TRICARE Area Office (TAO) Director, **or their designee** 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 (see [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 payment, 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 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 Suspension 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 suspension or after receipt of a Policy Notification Transaction (PNT) notifying the contractor of a suspension, 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 suspension for a member covered under TRS shall be the effective date of the loss of their qualification for TRS coverage. The contractor shall place the TRS member,

their family members, and/or survivors in a suspended status from the last paid-through date by “applying a lockout” in DOES. While DOES will apply a “lockout” status, the TRS member, family members, and/or survivors are considered to be in a “suspended” status, subject to reinstatement in certain circumstances, for the period of 12 months from the last paid-through date and will not incur a lockout when coverage is terminated due to a loss of TRS eligibility (i.e., member no longer qualifies to purchase TRS due to status change of Active Duty or FEHBP).

#### **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 suspended 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 suspended coverage. The contractor shall suspend coverage for the sponsor as appropriate (see [paragraph 4.4.1](#)).

#### **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 suspend 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 suspended coverage. The contractor shall suspend coverage for the family member(s) or survivor(s) as appropriate (see [paragraph 4.4.1](#)).

#### **4.4.1.3 Sponsor Involuntarily Removed**

When a Selected Reserve member’s service has recorded in DEERS that the member is being involuntarily removed from the Selected Reserve under other than adverse conditions, and the member was covered by TRS on the last day of his or her Selected Reserve membership, DEERS will terminate TRS coverage 180 days after the date on which the member is removed from the Selected Reserve. DEERS will send the contractor an unsolicited PNT advising the contractor of the adjusted anticipated end date. The contractor shall continue to collect monthly premiums until the adjusted anticipated end date (see [paragraph 5.2](#)) unless the coverage is otherwise suspended/terminated earlier. This extended TRS coverage provision expires December 31, 2018.

#### **4.4.2 Member or Survivor Gains Other TRICARE Coverage**

No lockout shall be applied for suspension 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 suspend TRS coverage in accordance with [paragraph 4.4.1.1](#). The contractor must be aware of the fact that DEERS may reflect ADSM and 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 suspend 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 suspension of coverage. The effective date of suspension is the first day following the paid-through date. The contractor shall automatically suspend 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 of coverage. After the last day of the month, the contractor shall suspend coverage up to 12 months from the last paid-through date. DMDC will provide written notification to the TRS member or survivor of the suspension along with the reason, noting the suspension may become a retroactive termination and 12 month lockout from the last paid-through date. During a suspension, 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 3](#).

**4.4.3.2** Upon failure of a TRS member or survivor to pay monthly premiums in accordance with [paragraph 4.4.3](#), a contractor shall place the TRS member, family members, and/or survivors in a suspended status for a period of 12 months from the last paid-through date by “applying a lockout” in DOES. The DMDC written notification of suspension (see [paragraph 4.4.3.1](#)) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

### **4.4.4 Member/Survivor Request for Voluntary Suspension**

A contractor shall place the TRS member, family members, and/or survivors in a suspended status for a period of 12 months from the last paid-through date by “applying a lockout” in DOES. While DOES will apply a “lockout” status, the TRS member, family members, and/or survivors are considered to be in a “suspended” status, subject to reinstatement in certain circumstances, for the period of 12 months from the last paid-through date. When the 12 month suspension expires, the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

#### **4.4.4.1 Suspension of Existing Plan(s)**

The contractor shall accept requests for suspension of coverage from TRS members or survivors at any time. The effective date of suspension is either (a) the last day of the month in which the request was postmarked or received by the MCSC/TOP contractor or (b) the last day of a future month as specified in the request given that the request was postmarked or received by the MCSC/TOP contractor in the month preceding the requested month of suspension. The contractor shall place the TRS member, family members and/or survivors in a suspended status for a period of 12 months from the terminations last paid-through-date by “applying a lockout” in DOES. The DMDC written notification of the suspension (see [paragraph 4.4.3.1](#)) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

#### 4.4.4.2 Suspension of an Individual's Coverage

The contractor shall accept requests for suspension of coverage from individual family members of TRS members or survivors at any time. The effective date of suspension is either (a) the last day of the month in which the request was postmarked or received by the MCSC/TOP contractor or (b) the last day of a future month as specified in the request, if the request was postmarked or received by the MCSC/TOP contractor in the month preceding the requested month of suspension. The contractor shall apply a suspension to individual family members or survivors whose TRS coverage was suspended upon request for a period of 12 months from the effective date of suspension initiated by the TRS member or survivor. The DMDC written notification of the suspension (see [paragraph 4.4.3.1](#)) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

#### 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. The contractor shall include an explanation for the premium refund.

#### 4.4.5 TRS Survivor Coverage Suspension

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 NLT 60 days after the date of death in order to suspend coverage retroactive to the day after the member's death. Alternatively, the survivor may request to suspend 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 and Survivor's Request to Enroll

The contractor shall advise TRS members/survivors that all reconsideration requests for a refusal of a late submission of a request to enroll shall be submitted to the appropriate TRICARE **Regional Director**, the TAO Director, or their designee for determination. The TRICARE **Regional Director**, the TAO Director, or their designee will issue decisions 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 **Regional Director**, the TAO Director, or their designee will send instructions to the contractor. The contractor shall carry out such instructions NLT 10 calendar days after receipt from the TRICARE **Regional Director**, the TAO Director, or their designee. **Additionally, the TRICARE Regional Director, the TAO Director, or their designee may extend the TRS enrollment period for a newborn/adopted child up to 120 days, on a case-by-case or regional basis.**

#### **4.5.2 Administrative Issues Regarding Requests to Enroll**

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

#### **4.5.3 Lifting Suspension of TRS Coverage**

The contractor shall lift suspension of TRS coverage before 12 months has elapsed from the paid-through date as specified below. If a suspension is not lifted by 12 months from the paid-through date, the termination and lock out become final for the time period ending 12 months from the paid-through date.

##### **4.5.3.1 Reinstatement of Suspended TRS Coverage (Retroactive Coverage)**

**4.5.3.1.1** While a 12 month suspension is in force, a TRS member/survivor may submit a request to the contractor to retroactively reinstate TRS coverage with no justification needed. The contractor shall lift the suspension and process the appropriate transaction to reinstate coverage effective the first day after the last paid-through date if the request meets all of the following conditions:

- The request is received by the contractor or postmarked NLT the first business day of the fourth month after the paid-through date;
- Payment of all premiums from the last paid-through date through the current month, plus the amount for the following two months is included (to include any administrative fees); and
- Information is provided to establish recurring electronic premium payments as specified in [paragraph 5.2.2](#).

**4.5.3.1.2** The contractor shall reject the request to reinstate coverage retroactively if any of the conditions above are not met, and inform the member/survivor of their option to purchase new coverage specified under [paragraph 4.5.3.2](#). The contractor shall issue a response to the member/survivor within 10 calendar days of receipt for all reinstatement requests. The response is either a rejection of the request with reason specified or notification that the TRS coverage has been reinstated retroactively.

##### **4.5.3.2 Reinstatement of Suspended TRS Coverage (No Retroactive Coverage)**

**4.5.3.2.1** While a 12 month suspension is in force, a TRS member/survivor may submit a request to the contractor for new TRS coverage with no justification needed. The contractor shall lift the suspension and process the appropriate transaction for new TRS coverage effective the first day of the following month the request is received, with no new application (DD Form 2896-1) required if the request meets all of the following conditions:

- The request is received by the contractor or postmarked after the first business day of the fourth month (but less than one year) after the paid-through date;

- Payment of two months of the appropriate premium payment in full is included (to include any administrative fees); and
- Information is provided to establish recurring electronic premium payments as specified in [paragraph 5.2.2](#).

**4.5.3.2.2** The contractor shall reject the request for new coverage if any of the conditions above are not met. The contractor shall issue a response to the member/survivor within 10 calendar days of receipt for all new coverage requests. The response is either a rejection of the request with reason specified or notification that new TRS coverage has been established.

## **5.0 PREMIUM COLLECTION**

The contractor shall perform all premium collection functions required for TRS. Service members or survivors are responsible for all premium payments for the type of coverage elected (i.e., TRS member-only or TRS member and family). After enrollment, only 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 1.4](#)).

### **5.1 Jurisdiction for Premium Collection**

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

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

**5.1.2** Any time the servicing contractor notices that a new residential address is in the servicing area of another TRICARE contractor, the losing contractor shall notify the TRS member or survivor within 10 calendar days that they need to contact the servicing contractor in their new area to transfer their coverage to the new area. A TRS member or survivor may elect to provide an alternate mailing address, but the servicing contractor shall be based on the TRS member's or financially responsible survivor's residential, not alternate mailing address. Any TRS member/financially responsible survivor may transfer regions at any time. The gaining contractor shall perform the premium collections for future payments.

**5.1.3** All unsolicited PNTs for TRS members or survivors will be evaluated to determine if residential address changes require a notification to the TRS member or survivor (see [paragraph 5.1.2](#)).

### **5.2 Premium Collection Processes**

**5.2.1** The contractor shall credit the TRS member or survivor for premium payments received. In the case of a start date of coverage at any time other than the first of a month, the first payment collected by the contractor shall include the prorated amount on a daily basis necessary to synchronize billing 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. DEERS will automatically 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.

**5.2.2** The contractor shall collect monthly premium payments from TRS members or survivors as appropriate and shall report the premium amount paid for those payments to DEERS (see the TSM, [Chapter 3](#)), including any overpayments that are not refunded to the TRS member or survivor. 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 United States (U.S.) dollars (\$20.00). The contractor shall provide commercial payment methods for TRS 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 Electronic Funds Transfer (EFT) or Recurring Credit/Debit Card (RCC) (i.e., Visa/MasterCard) from a designated financial institution. These are the only acceptable payment methods for the recurring monthly premiums. An EFT payment or a RCC payment shall be processed within the first five business days of the month of coverage. The contractor shall advise TRS members or 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.

**5.2.4** TRS members or survivors must make the required initial payment (as specified in [paragraph 4.1](#)) at the time the TRS application is submitted to allow time for the EFT/RCC to be established for subsequent monthly premium payments.

**5.2.5** The contractor shall establish 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** 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 TRS member or survivor 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 4.1](#) during this 30 day period in order to preserve the TRS member's or survivor's enrollment status.

**5.2.8** The contractor shall directly bill the TRS member or survivor only when a problem occurs in setting up or maintaining the EFT or RCC payment; to include a fee of up to \$20 U.S. due to insufficient funds. Bills may be sent to the residential or alternate mailing address designated by the TRS member or survivor. All bills shall specify that the premium payment is due for receipt by the contractor no later than the last business day of the month. Premium payments shall be made payable to the contractor servicing the member's or survivor's coverage as specified in [paragraph 5.1](#). The contractor shall terminate billing once the problem with EFT/RCC payment is resolved.

### **5.3 Annual Premium Adjustment**

**5.3.1** Contractors shall notify current TRS members or survivors in writing of any annual premium adjustments NLT 30 days after the contractors receive notification of the updated premiums.

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

### **5.4 Premium Adjustments from Changes Associated with QLEs**

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

**5.4.2** If the change from a QLE results in an increase in the premium, the contractor shall notify the TRS member or survivor of the increase and adjust the next premium amount due, to include any underpaid amount (prorated to the day as specified in [paragraph 5.2](#)), to the effective date of the change.

**5.4.3** 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 electronic payments until all of the overpayment is exhausted.

### **5.5 Suspensions/Terminations**

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

### **5.6 Online Transactions**

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

## **6.0 CLAIMS PROCESSING**

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

**6.2** The contractor shall pend all claims for health care provided to a newborn/new child of a TRS member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRS member has an unregistered newborn/new child, the contractor shall notify the TRS member of the requirement to register the newborn/new child in DEERS and submit a TRS 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 newborn/new 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 newborn/

new child's health care.

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

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

**6.5** Medicare is the primary payer for TRICARE beneficiaries who 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 Managed Care Support Contractors (MCSCs) shall follow procedures established in [Chapter 8, Section 2](#), regarding claims jurisdiction for dual eligibles.

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

**6.7** If at any time the contractor discovers that the Selected Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE [Regional Director, the TAO Director, or their designee](#) NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRS qualification.

## **7.0 BENEFICIARY EDUCATION AND SUPPORT (BE&S)**

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

### **7.1 Customer Education**

**7.1.1** Information materials (i.e., public notices, flyers, informational brochures, etc.) will be developed and printed centrally by Department of Defense (DoD), Defense Health Agency (DHA), [Communications](#). The contractor shall distribute all documents associated with the TRS Program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRICARE handbook and other information materials may be ordered through the usual DHA [Communications](#) ordering process.

**7.1.2** Upon start of coverage under TRS the contractor shall mail one copy of the TRICARE handbook to each first time TRS member's or survivor's household. The TRS member's or survivor's servicing contractor shall send additional handbooks upon request.

### **7.2 Customer Service**

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

## **8.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED**

### **8.1 Claims Reporting**

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

### **8.2 Fiduciary Responsibilities**

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

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

**8.2.3** The contractor shall wire-transfer the premium collections and 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., TRS premiums). Premiums for TRS and TRR, when established, may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to [DHA](#) Office of General Counsel - Appeals, Hearings & Claims Collection Division (OGC-AC) shall be wire-transferred separately. The contractor shall notify [DHA](#) CRM F&AO and [DHA](#) 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 [DHA](#) OGC-AC and the date and amount of the deposit.

**8.2.4** 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.

## **9.0 DELINQUENT PREMIUMS**

**9.1** The contractor shall no longer collect delinquent premiums with two exceptions:

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