



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066

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The Defense Health Agency has authorized the following addition(s)/revision(s).

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SUMMARY OF CHANGE(S): See page 3.

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This change is made in conjunction with Feb 2008 TPM, Change No. 159.

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Digitally signed by ARENDALE JOHN LOUIS II 1150775368
DN: cn=US, o=U.S. Government, ou=DoD, ou=PRK, ou=TMA,
c=ARENDALE JOHN LOUIS II 1150775368
Date: 2016.05.02 09:46:27 -0500

John L. Arendale
Section Chief, Health Plan
Operations Branch (HPOB)
Defense Health Agency (DHA)

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SUMMARY OF CHANGES

CHAPTER 6

1. Section 1. This change adds “debit” cards as a payment option when paying the TRICARE Prime annual or quarterly enrollment fee. EFFECTIVE DATE: June 6, 2016.

CHAPTER 22

2. Section 1. This change provides the eligibility actions to be taken by a contractor when a TRICARE Reserve Select (TRS) sponsor’s eligibility is restored within 90-days of loss of eligibility and describes the enrollment notification and information a beneficiary will receive at the start of TRS or TRICARE Retired Reserve (TRR) coverage. EFFECTIVE DATE: June 6, 2016.
3. Section 2. This change provides the eligibility actions to be taken by a contractor when a TRICARE Reserve Select (TRS) sponsor’s eligibility is restored within 90-days of loss of eligibility and describes the enrollment notification and information a beneficiary will receive at the start of TRS or TRICARE Retired Reserve (TRR) coverage. EFFECTIVE DATE: June 6, 2016.

CHAPTER 25

4. Section 1. This change clarifies the young adult’s coverage as up to the age of 26 for all beneficiaries, to include young adults of Survivors, TRS/TRR and Transitional Assistance Management Program, and the cost shares for those beneficiary categories. June 6, 2016.

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. **The contractor shall report refunds of any enrollment fees to DEERS if the refunded amounts were previously recorded in 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 or debit 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 or debit 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 7.10](#) 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. **The contractor shall update DEERS with any amount refunded within 30 calendar days and include an explanation to the beneficiary for the fee refund.**

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

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. **If a sponsor’s eligibility is restored within 90 days from loss of eligibility, DEERS will automatically reinstate the TRS coverage previously in effect and send an unsolicited PNT to the appropriate contractor notifying them of the reinstated TRS coverage. Upon notification of the reinstated TRS coverage, the contractor shall contact the sponsor within 10 business days from receipt of unsolicited PNT and collect all required premiums owed through the current month (see paragraphs 5.2.2 through 5.2.4).** 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 **at a date other than an anticipated end date**, 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 pending, 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 DMDC will generate an enrollment notification for the member or survivor upon start of coverage under TRS. The enrollment notification shall include information on how purchasers may obtain TRS-specific and other TRICARE information from their regional contractor or TRICARE web sites. The contractor shall provide of the TRICARE Handbook to beneficiaries via e-mail or direct them to <http://www.tricare.mil/publications>, to download. One printed (hardcopy) TRICARE Handbook per household shall be mailed only when specifically requested by the TRS member or survivor.

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

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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.

9.2 The contractor shall terminate collection of delinquent premiums for all other cases within 60 days through an adjustment to the account and issue written notification to the debtor that collection has been terminated. Language for a sample letter is included at [Addendum A, Figure 22.A-1](#). A summary report of all cases terminated shall be provided to the OGC within 30 days following termination of all cases. Such report shall include the sponsor's name, SSN, debt amount, and date closed.

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

- END -

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

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

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

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

6.6 Medicare is the primary payer for TRICARE beneficiaries who are entitled to 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 MCSCs shall follow procedures established in [Chapter 8, Section 2](#) regarding claims jurisdiction for dual-eligibles.

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

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

7.0 BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)

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

7.1 Customer Education

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

7.1.2 DMDC will generate an enrollment notification for the member or survivor upon start of coverage under TRR. The enrollment notification shall include information on how purchasers may obtain TRR-specific and other TRICARE information from their regional contractor or TRICARE web sites. The contractor shall provide the TRICARE Handbook to beneficiaries via e-mail or direct them to <http://www.tricare.mil/publications>, to download. One printed (hardcopy) TRICARE Handbook per household shall be mailed only when specifically requested by the TRR member or survivor.

7.2 Customer Service

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

8.0 ANALYSIS AND REPORTING

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

9.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED

9.1 Claims Reporting

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

9.2 Fiduciary Responsibilities

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

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

9.2.3 The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified government account as directed by the 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. TRR premiums). Premiums for TRS and TRR may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to 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

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amount, payment date, date case was transferred to DHA OGC-AC and the date and amount of the deposit.

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

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

- END -

- Is not otherwise eligible for care under Chapter 55, 10 USC or Chapter 58, 10 USC Section 1145(a), TAMP; and
- Is not a member of the uniformed services.

3.2 Eligibility Of Uniformed Service Sponsor

3.2.1 Eligibility for TYA is only determined by a proper eligibility response in DEERS. Based on the status of the uniformed service sponsor, the ability to purchase may be limited or not allowed based on the uniformed service sponsor's status and eligibility for medical care under Chapter 55, 10 USC or Chapter 58, 10 USC Section 1145(a). In addition, young adult dependents must meet all other qualifications shown in [paragraph 3.1](#).

3.2.2 Young adult dependents of active duty members (including those called to active duty for more than 30 days) may qualify to purchase TYA coverage until the active duty sponsor's date of separation or **until the young adult dependent reaches** the age of 26, whichever comes first. Upon the death of an active duty sponsor, **former young adult dependents already aged out of TRICARE are classified as Survivors and** may qualify to purchase TYA coverage up to the age of 26 **but with Survivor (retiree) cost-shares**.

3.2.3 Young adult dependents of retired uniformed service sponsors may qualify to purchase TYA coverage until they reach the age of 26.

3.2.4 Young adult dependents of uniformed service sponsors eligible to purchase TRS or TRICARE Retired Reserve (TRR) may qualify to purchase TYA coverage only if the sponsor is enrolled in TRS or TRR **and until the young adult dependent reaches age 26**. Failure of the uniformed service sponsor to enroll in and maintain enrollment in TRS or TRR or failure to pay TRS or TRR premiums will result in the young adult dependent not being eligible to purchase TYA coverage as of the date of the sponsor's loss of enrollment in TRS or TRR.

3.2.5 If the Selected Reserve sponsor dies while enrolled in TRS, the young adult dependent may qualify to purchase TYA coverage for **up to** six months after the date of death of the Selected Reserve sponsor, or until the young adult dependent reaches the age of 26, whichever comes first, **but with Survivor (retiree) cost-shares**.

3.2.6 Young adult dependents of a member of the Retired Reserve, who dies while in a period of TRR coverage, may qualify to purchase new or continue existing TYA coverage until the young adult dependent reaches the age of 26. If a member of the Retired Reserve is not covered by TRR on the date of his or her death, his or her surviving dependents do not qualify for TYA coverage until the date on which the deceased member of the Retired Reserve would have attained age 60, at which time they may **qualify to** purchase TYA coverage until reaching the age of 26.

3.2.7 Young adult dependents of a member eligible for TAMP coverage may qualify to purchase TYA coverage until the TAMP coverage ends or the young adult dependent reaches age 26, whichever comes first. If the member dies while covered under TAMP, the young adult dependent may qualify to purchase TYA coverage to the end of the TAMP coverage period or until the young adult dependent reaches age 26, whichever comes first, with Active Duty Family Member (ADFM) cost-shares.

4.0 COVERAGE-RELATED PROCEDURES

The contractor shall process coverage-related transactions through the Web Defense Online Enrollment System (Web DOES) (TSM, [Chapter 3, Section 1.4](#)). 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](#)). The contractor shall perform all premium functions in accordance with [paragraph 5.0](#) and its subordinate paragraphs. The TRICARE Overseas Program (TOP) contractor shall perform these services for young adult dependents residing outside of the 50 United States or the District of Columbia. See the TSM, [Chapter 2, Addendum L](#), for a full list of TYA Health Care Delivery Program (HCDP) Coverage Code Values.

4.1 Purchasing Coverage

To purchase TYA coverage, young adult dependents should submit an application request along with at least an initial payment of two months worth of premiums for either TYA Standard/Extra or TYA Prime coverage, within deadlines specified in the following paragraphs. The contractor (except for the TOP contractor) shall accept and process TYA enrollment applications from the BWE application effective January 1, 2014. Young adult dependents have the option of submitting the application and premiums online, or printing and mailing the completed application form with the premiums. An application request includes those with: (1) an original signature on a hard copy form, (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 which includes waiver of the Prime access to care standards for Prime coverage, or (4) a self-attestation when using the Beneficiary Web Enrollment (BWE) system (<http://www.dmdc.osd.mil/appj/bwe/>). The contractor shall collect written applications by mail and/or by other means determined by the contractor.

If a qualified young adult dependent would like to change coverage from TYA Standard/Extra to TYA Prime, a separate application must be submitted. TYA applications submitted before the CO directed effective start date for TYA Prime coverage will be processed as TYA Standard/Extra coverage. If TYA Prime coverage is still desired, the young adult dependent must submit another TYA application to request Prime coverage when available. If an enrollment lockout is in place (see [paragraph 4.3.2](#)), 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 Web DOES unless the initial payment received, if eligible, is the correct amount for the type of coverage purchased. The procedures for determining the effective date of coverage are specified in the following paragraphs.

4.1.1 Open Enrollment

A qualified young adult dependent may purchase TYA coverage throughout the year unless locked out from TYA coverage.

4.1.1.1 TYA Standard/Extra Plans

The effective date of TYA Standard/Extra coverage shall be the first day of the next month, or the first day of the month requested up to 90 days in the future, provided 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.

4.1.1.2 TYA Prime Plans

4.1.1.2.1 TYA Prime effective dates will be determined in accordance with [Chapter 6, Section 1, paragraph 4.1.2](#).

4.1.1.2.2 Young adult dependents may qualify to purchase TOP Prime or TOP Prime Remote plan coverage (see [Chapter 24, Section 5](#)).

4.1.1.2.3 Young adult dependents may cross-region enroll ([Chapter 6, Section 1, paragraph 9.4](#)) but apply using the TYA Application (DD Form 2947) following [paragraph 4.1.4](#).

4.1.1.2.4 When TYA Prime enrollees no longer meet TRICARE Prime enrollment requirements (see [Chapter 6, Section 1, paragraph 9.5](#)), the contractor will notify them that their TYA coverage will be terminated on the first of the month following 30 days from the initial notification date and the option of applying for TYA Standard coverage ([paragraphs 2.1 and 4.1.3](#)). No 12-month lockout applies.

4.1.2 Continuation Coverage

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

4.1.3 Changing Coverage Within Same Contractor

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

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

4.1.4 Transfer of Coverage to Another Contractor

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

contractor shall process transfer requests within 10 calendar days.

4.2 Processing

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

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

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

4.3 Termination Of TYA Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 calendar days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the young adult dependent's contractor of a termination, whichever is later. Premium refunds, to include an explanation of the premium refund, will be sent to young adult dependent's residential address unless an alternate mailing address has been provided. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days.

4.3.1 Loss Of TYA Qualification

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

4.3.1.1 Change in Sponsor Status

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

4.3.1.1.2 TYA Standard/Extra Coverage

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

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

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

4.3.1.1.3 TYA Prime Coverage

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

4.3.1.1.3.2 If TYA eligibility is re-established subsequent to a termination due to a sponsor status change, DMDC will send an unsolicited PNT with an updated enrollment end reason code and an enrollment extension end reason code. Upon receipt of an unsolicited PNT with an updated enrollment end reason code and an enrollment extension end reason code indicating a young adult dependent is again eligible for TYA coverage after termination due to a change in sponsor status, the contractor will contact the young adult dependent within 10 calendar days using best business practices to offer enrollment assistance if TYA coverage has not already been re-established.

4.3.1.2 Sponsor Loss Of Eligibility

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

4.3.1.3 Young Adult Dependent Loss Of Eligibility

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

4.3.2 Lockout

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

4.3.2.1 Reinstatement

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

If it is determined that the young adult dependent failed to pay premiums due to extraordinary circumstances and continuous coverage is warranted, upon beneficiary request, the contractor will notify the waiver approval authority. The waiver approval authority may direct the young adult dependent to be reinstated (contingent on payment of required premiums). No new application is necessary. A reinstatement request must be received by the contractor NLT 90 days after the end of the month during which the last full premium was paid. Upon direction of the waiver authority, continuous coverage may be reinstated upon payment of the appropriate premiums. Premium payments, including current requirements, must be received by the contractor within 30 days of the beneficiary notification of approval for reinstatement. However, if payment has not been made by the 30th day, then coverage will be deemed to be terminated as of the paid-through date and no claims may be paid for care rendered after the date of termination.

4.3.2.2 Young Adult Dependent Gains Other TRICARE Coverage

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

4.3.2.3 Young Adult Dependent Gains Own Eligible Employer-Sponsored Coverage

No lockout shall be applied for termination due to eligibility for medical coverage offered from an eligible employer-sponsored plan. The young adult dependent shall notify the contractor via written request, BWE, or telephone request (which is to be documented in the contractor's call notes) to terminate TYA coverage within 30 calendar days when he or she is eligible or enrolled in

an eligible employer-sponsored health plan offered by his or her employer.

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

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

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

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

4.4 Failure To Make Payment

4.4.1 Failure or refusal to pay monthly premiums and/or any outstanding insufficient fees in accordance with the procedures in this chapter shall result in termination of coverage absent approval of a waiver. The effective date of termination is the paid-through date. The contractor shall terminate coverage of the young adult dependent if the monthly premium payment is not received by the last day of the month following the due date for the monthly premium payment. After the last day of the month, the contractor shall terminate coverage with a termination effective date retroactive to the paid-through date. DMDC sends written notification to the beneficiary of the termination and the reason for the termination. Until the termination action is processed, the contractor may pend any claims received for health care furnished to the young adult dependent during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The young adult dependent will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pended, the contractor shall initiate recoupment of health care costs following the procedures in [Chapter 10, Section 4](#).

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

4.4.3 A contractor shall apply a TYA purchase lockout to the young adult dependent for failure to make premium payments absent approval of a waiver. The lockout shall be for a period of 12 months from the effective date of termination. The DMDC TN includes notice of the 12 month lockout period.

4.5 Requests For Voluntary Termination

The contractor shall accept requests for termination of coverage from young adult dependents at any time. Termination of coverage requests includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal

consent provided via telephone and documented in the contractor's call notes, or (4) a self-attestation by the beneficiary when using the BWE system. The effective date of termination is either (a) the last day of the month in which the request was received by the contractor, (b) the last day of a future month as specified in the request given that the request was received by the contractor in the month preceding the requested month of termination, or (c) as directed by the waiver approval authority for waiver cases. The contractor shall apply a TYA purchase lockout to young adult dependents covered by the TYA plan for a period of 12 months from the effective date of terminations initiated by the young adult dependent unless the young adult dependent is eligible for an employer-sponsored health plan. The DMDC notification of termination (see [paragraph 4.1.2](#)) includes notice of the 12 month lockout period.

4.6 Cancelled Eligibility And Enrollment

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

4.7 Waiver Requests of a Young Adult Dependent's Actions

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

5.0 PREMIUM COLLECTION

The contractor shall perform all premium functions required for TYA. Young adult dependents are responsible for all premium payments for the individual coverage being purchased. At least an initial payment (see [paragraph 4.1](#)) of premiums are required, then only monthly premium payments are permitted. Premium-related transactions shall be reported through the enrollment fee payment interface or CC&D Fee Web (see the TSM, [Chapter 3, Section 1.4](#)).

5.1 Jurisdiction For Premium Billing And Collection

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

5.1.2 Any time the servicing contractor notices that a new residential address is in the servicing area of another contractor, the losing contractor will notify the young adult dependent within 10

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

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

5.2 Premium Collection Processes

5.2.1 The contractor shall credit the young adult dependent for premium payments received. Premium payments are due for receipt by the contractor NLT the last calendar day of the current month for the following month of coverage. In the case of a start date of coverage at anytime other than the first of a month (see [paragraph 4.1.2](#) or as directed by the waiver approval authority), the first payment collected by the contractor shall include the prorated amount on a daily basis necessary to synchronize the paid-through date to the last day of the month. The daily prorated amount is equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month.

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

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

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

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

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

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

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

5.3 Annual Premium Adjustment

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

"You must notify us if you:

- Become eligible for employer-sponsored medical coverage based on your own employment as defined in section 5000A(f)(2) of the Internal Revenue Code of 1986;
- Marry;
- Are a uniformed services member on active duty greater than 30 days; or
- Are a uniformed services member of the Selected Reserves.

If any of the above occurs, you must notify us by submitting a request to terminate your TYA coverage to preclude recoupment actions and to request a refund of any overpaid premiums, as applicable."

6.0 CLAIMS PROCESSING

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

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

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

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

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

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

7.0 BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)

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

7.1 Customer Education

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

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

7.2 Customer Service

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

8.0 ANALYSIS AND REPORTING

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

9.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED

9.1 Claims Reporting

The contractor shall report TYA program claims according to [Chapter 3](#). The contractor shall

process payments on a non-financially underwritten basis for the health care costs incurred for each TYA claim processed to completion according to the provisions of [Chapter 3](#).

9.2 Fiduciary Responsibilities

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

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

9.2.3 The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified government account as directed by the DHA Contract Resource Management (CRM) Finance And Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the DHA CRM F&AO, by e-mail, within one business day of the deposit, specifying the date and amount of the deposit as well as its purpose (i.e., TYA premiums).

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

9.2.5 The contractor shall electronically submit monthly reports of premium activity supporting the wire transfer of dollars as described in the Contract Data Requirements List (CDRL) DD Form 1423.

10.0 CHCBP TO TYA PROCEDURES

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

10.1 Enrollment Procedures

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

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

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

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

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

10.2 CHCBP Premium Refund Procedures

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

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

10.3.1 Upon termination of CHCBP coverage with retroactive TYA coverage for the same period, the CHCBP contractor will review CHCBP claims history for the retroactive period, and post any CHCBP cost-shares and deductibles to the TRICARE family deductible and catastrophic cap as a TYA claim, ensuring the amounts posted do not exceed the applicable catastrophic cap and deductible limits. Cost-shares over the catastrophic cap and deductible limit will be refunded.

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

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

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

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

10.4.2 TED records, other than pharmacy, where the claim jurisdiction indicates South Region will be cancelled and replaced by the CHCBP contractor. The new TED record will retain all the

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original claim data except the appropriate TYA HCDP Plan Coverage Code and Enrollment/Health Plan Code will replace the CHCBP enrollment codes. These records are to be submitted on a TED Header Type Indicator 6.

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

11.0 CODING OF TED RECORDS

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

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