



DEFENSE  
HEALTH AGENCY

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**CHANGE 191  
6010.56-M  
AUGUST 15, 2016**

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

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

**CHANGE TITLE: CONSOLIDATED CHANGE 16-004**

**CONREQ: 18110**

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

**SUMMARY OF CHANGE(S): See page 3.**

**EFFECTIVE DATE: See page 3.**

**IMPLEMENTATION DATE: September 30, 2016.**

**This change is made in conjunction with Feb 2008 TSM, Change No. 90.**

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**CHANGE 191  
6010.56-M  
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**REMOVE PAGE(S)**

**CHAPTER 5**

Section 1, pages 1 and 2

**CHAPTER 6**

Section 1, pages 7 through 21

**CHAPTER 8**

Section 1, page 3

**CHAPTER 16**

Section 1, page 3

**CHAPTER 24**

Section 30, pages 1 and 2

**CHAPTER 25**

Section 1, pages 3 through 16

**INSERT PAGE(S)**

Section 1, pages 1 and 2

Section 1, pages 7 through 21

Section 1, pages 3 and 4

Section 1, page 3

Section 30, pages 1 and 2

Section 1, pages 3 through 16

## **SUMMARY OF CHANGES**

### **CHAPTER 5**

1. Section 1. This change allows the addition of zip codes enclosed entirely within a Prime Service Area's (PPAs) boundary to be included in the PSA. EFFECTIVE DATE: September 15, 2016.

### **CHAPTER 6**

2. Section 1. This change updates DEERS when Prime enrollment fees are refunded and/or forfeited. EFFECTIVE DATE: September 30, 2016.

### **CHAPTER 8**

3. Section 1. This change clarifies effective date of enrollment for newborns or adoptees deemed to be enrolled in Prime and deletes obsolete language. EFFECTIVE DATE: September 15, 2016.

### **CHAPTER 16**

4. Section 1. This change adds a cross reference and revises language on enrollment fees reporting in Defense Enrollment Eligibility Reporting System (DEERS). EFFECTIVE DATE: September 15, 2016.

### **CHAPTER 24**

5. Section 30. This change corrects a misspelling of the word TRICARE. EFFECTIVE DATE: September 15, 2016.

### **CHAPTER 25**

6. Section 1. This change adds language as to when TRICARE Young Adult (TYA) enrollment applications from the Beneficiary Web Enrollment (BWE) for the TRICARE Overseas Program (TOP) Contractor are effective. EFFECTIVE DATE: September 15, 2016.



## Network Development

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The contractor shall provide a plan for establishing a provider network throughout the region to support TRICARE Prime and TRICARE Extra and to complement Military Treatment Facility (MTF) capabilities. The network shall meet the standards in [paragraph 2.0](#).

### 1.0 GEOGRAPHIC AVAILABILITY

**1.1** The contractor shall establish and maintain provider networks, supporting TRICARE Prime and TRICARE Extra, in all Prime Service Areas (PSAs), throughout all health care delivery periods of the contract. (See [Chapter 16](#) for TRICARE Prime Remote (TPR) network requirements.) In each area where TRICARE Prime is offered (TRICARE PSA), the contractor shall permit enrollment by beneficiaries under the terms and conditions of [Chapters 6](#) and [11](#). The contractor shall enroll beneficiaries only to MTF Primary Care Managers (PCMs) or to PCMs in the PSA network.

**1.1.1** The contractor shall ensure the network has the capability and capacity to permit each beneficiary enrolled in Prime to a civilian PCM prior to the start of option period one and residing outside of PSAs under this contract to enroll to a PSA PCM, provided the beneficiary resides less than 100 miles from an available network PCM in the PSA and waives both primary and specialty care travel time standards. Beneficiaries enrolled in Prime to a civilian PCM prior to the beginning of option period one who reside outside of PSAs under this contract and are 100 miles or more from an available PCM in the PSA network, shall not be permitted to continue their enrollment.

**1.1.2** The contractor will not be required to establish a network with the capability and capacity to grant new enrollments to beneficiaries who reside outside a PSA. The contractor shall grant a request for a new enrollment to the network from a beneficiary residing outside a PSA provided there is sufficient unused network capability and capacity to accommodate the enrollment, the PSA network PCM to be assigned is located less than 100 miles from the beneficiary's residence, and the beneficiary waives both primary and specialty care travel time standards.

### 1.2 Areas Where Establishment Of TRICARE Prime And TRICARE Extra Is Required

The contractor shall make TRICARE Prime and TRICARE Extra available in all PSAs. PSAs are the entire area of all the zip codes lying within or intersected by the 40-mile radius around enrolling MTFs and Base Realignment and Closure (BRAC) sites. **Zip codes enclosed entirely within a PSA's boundary shall also be included.** The contract contains a list of mandatory PSA sites.

### 1.3 Areas Where Establishment Of An Originating Site For Telemental Health (TMH) Is Required

To the greatest extent practical, the contractor shall establish one civilian originating site within 40 miles of each MTF (defined by Section J of each Managed Care Support (MCS) contract),

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and one civilian originating site more than 40 miles from an MTF (defined by Section J of each MCS contract) with a high concentration of TPR and/or TRICARE Reserve Select (TRS) for each region.

## 2.0 NETWORK REQUIREMENTS AND STANDARDS

The contractor shall establish, in consonance with the RDs, provider networks through contractual arrangements. Network requirements and standards are listed below.

### 2.1 RDs And MTF Interface In Provider Network Development

Prior to the contractor finalizing the civilian network, MTF Commanders and the RDs shall be given an opportunity to provide input into the development of the network in their PSAs and the BRAC sites. The contractor shall meet with the RD and all MTF Commanders within 30 calendar days of the award to obtain their network size and specialty makeup input. The contractor shall follow the MTF Commander's directions regarding the priorities for the assignment of enrollees to PCMs.

### 2.2 Standards For Network Providers

Network and access to care standards are in [32 CFR 199.17](#). Each PSA established is considered to be a separate service area to which the standards apply. The contractor shall develop and implement a system for continuously monitoring and evaluating network adequacy.

### 2.3 Participation On Claims

All network provider **agreements** shall require the provider to participate on all claims and submit claims on behalf of all Military Health System (MHS) and Medicare beneficiaries. **On or after a date specified by the Contracting Officer (CO) any new or renewed non-institutional network provider agreements shall include the following provision:**

**2.3.1** The submission of a claim by a physician or supplier or their representative certifies that the services shown on the claim are medically indicated and necessary for the health of the patient and were personally furnished by the physician/supplier or furnished incident to his/her professional service by his/her employee under his/her immediate personal supervision, except as otherwise permitted by Medicare or TRICARE regulations. For services to be considered as "incident" to a physician's professional service:

- They must be rendered under the physician's immediate personal supervision by his/her employee;
- They must be an integral, although incidental part of a covered physician's service;
- They must be of kinds commonly furnished in physician's offices; and
- The services of non-physicians must be included on the physician's bills.

**2.3.2** The non-institutional network provider/supplier further certifies that he/she (or any employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the U.S. Government (refer to 5 United States Code (USC) 5536). Anyone who

**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 to DEERS: (1) all refunds of enrollment fees collected, and (2) fee amounts forfeited by enrollees who voluntarily disenroll and are not due a refund per [paragraph 7.0](#). The forfeited fee amounts, unless they can be credited to the enrollment of another family member(s), shall not be retained as a credit. For forfeited fees, the contractor shall adjust the fees paid on the enrollment policy to match with the voluntary termination date (“zero” the fees paid). (See the TSM, [Chapter 3](#).)

**Note:** The contractor shall update DEERS on September 30, 2016, to remove all historical forfeited enrollment fee amounts and then ongoing as voluntary disenrollments occur.

- 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.

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 6, Section 1

#### Enrollment Processing

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**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 will remain in an active duty status while receiving medical care or undergoing physical disability processing. WII programs vary in name according to Service. The Service shall determine member eligibility for enrollment into a WII program, as well as whether or not to utilize these enrollments.

To better manage this population, a secondary enrollment classification of HCDP Plan Coverage Codes, WII 415 and WII 416 were developed. The primary rules apply to the WII HCDP codes:

- ADSMs must be enrolled to a TRICARE Prime program prior to, or at the same time, as being enrolled into a WII 415 or WII 416 program.
- A member cannot be enrolled in WII 415 and WII 416 programs at the same time.
- WII 415 and WII 416 enrollments will terminate at the end of the member's active duty eligibility, when members transfer enrollment to another MTF, change of a plan code, or at the direction of the Service-specific WII entity.
- Any claims processed for WII 415/416 enrollees shall follow the rules associated with the primary HCDP Plan Coverage Code, such as TRICARE Prime, TPR, TRICARE Overseas Program (TOP) Prime, or TOP Prime Remote. All claims will process and pay under Supplemental Health Care Program (SHCP) rules. DEERS will not produce specific enrollment cards or letters for WII 415/416 enrollment.

WII 415/416 TRICARE Encounter Data (TED) records shall be coded with the WII 415/416 HCDP Plan Coverage Code; however, the Enrollment/Health Plan Code data element on the TED record shall reflect the appropriate value for the primary HCDP Plan Coverage Code. For example, a TED record for a WII 416 enrollee with primary enrollment to TPR would reflect the HCDP Plan Coverage Code of "416" but the Enrollment/Health Plan Code would be coded "W TPR Active Duty Service Member".

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

**8.1.1** Service defined eligible ADSMs assigned to a WII 415 Program such as a MEDHOLD or WTU shall be enrolled to TRICARE Prime or TOP Prime prior to, or at the same time, as being enrolled into the WII 415. Members cannot be enrolled to the WII 415 without a concurrent TRICARE Prime or TOP Prime enrollment. Service appointed WII case managers as determined by

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the Services, will coordinate with the MTF to facilitate TRICARE Prime PCM assignments for WII 415 members. The contractor shall then assign a PCM in accordance with the MTF MOU and in coordination with the WII case manager. WII 415 enrollment will not run in conjunction with TAMP and members enrolled in TPR, or TOP Prime Remote are not eligible to enroll in the WII 415.

**8.1.2** The Service-specific WII entity will stamp the front page of the DD Form 2876, enrollment application form, with WII 415 for new enrollments that begin after the DEERS implementation date. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

- WII 415 HCDP Plan Coverage Code
- WII 415 Enrollment Start Date (Contractors may change the DOES defaulted start date, which may or may not coincide with the Prime Enrollment Start Date. The start date can be changed up to 289 days in the past or 90 days into the future.)

**8.1.3** WII 415 enrollments will be in conjunction with an MTF enrollment only, not to civilian network PCMs under TPR enrollment rules. DEERS will end WII 415 enrollments upon loss of member's active duty eligibility. WII 415 program enrollments will not be portable across programs or regions. The TOP contractor will enter WII 415 enrollments through DOES for outside the 50 United States and the District of Columbia.

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

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

**8.1.5** Service WII entities will provide contractors with a list by name and SSN of those ADSMs currently assigned to their WII program at the time the program is implemented by DEERS. The contractors shall enter these ADSMs into DOES as enrolled in WII 415 with a start date of the date of implementation, unless another date, up to 289 days in the past, is provided by the WII entity.

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

**8.2.1** Service defined eligible ADSMs may be assigned to a WII 416 Program such as the Army's CBHCO and receive required medical care near the member's home. The service member shall be enrolled to TRICARE Prime, TPR, TOP Prime, or TOP Prime Remote prior to or at the same time as being enrolled into WII 416. Members cannot be enrolled to the WII 416 program without a concurrent Prime, TPR, TOP Prime, or TOP Prime Remote enrollment. Service appointed case managers will coordinate with the contractor or MTF to facilitate TRICARE Prime or TPR PCM assignments for eligible beneficiaries. The contractor shall then assign a PCM based on the MTF

MOU and in coordination with the WII entity (e.g., CBHCO). WII 416 enrollments will not run in conjunction with TAMP.

**8.2.2** The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

- WII 416 HCDP Plan Coverage Code
- WII 416 Enrollment Start Date (Date received by the contractor or the date indicated by the Service-specific WII Program which can be up to 289 days in the past, or 90 days in the future.)

An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

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

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

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

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

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

**9.1** Non-active duty beneficiaries in the Continental United States (CONUS) and Hawaii who reside more than 30 minutes travel time from their desired PCM must waive primary and specialty drive-time ATC standards. (Due to the unique health care delivery challenges in Alaska, the requirement to request a waiver for the drive-time access standard does not apply to beneficiaries

in Alaska.) Before effecting an enrollment or portability transfer request, contractors shall ensure that a beneficiary has waived travel time ATC standards either by signing Section V of the DD Form 2876 enrollment application (this includes an electronic signature offered by and collected by the contractor), by providing verbal consent via telephone communication (which is documented in the contractor call notes), or by requesting enrollment through the BWE service (for both civilian and MTF PCMs). An approved waiver for a beneficiary residing less than 100 miles from their PCM will remain in effect until the beneficiary changes residence.

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

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

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

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

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

**9.5** If at any point during the enrollment period the contractor determines or is advised that a beneficiary is no longer eligible for continued TRICARE Prime enrollment, the contractor shall inform the beneficiary of the discrepant address situation. For example, their residential address is 100 miles or more from the PCM or MTF (with no 100 mile waiver) to which they are enrolled or their residential address is 100 miles or more from their assigned network PCM. This notification (letter, telephone call, or e-mail) shall occur when the discrepant information is first known by the

contractor. If the beneficiary confirms the DEERS-recorded address is incorrect, and the beneficiary updates DEERS with correct information (contractor to assist as appropriate), the beneficiary will remain enrolled in TRICARE Prime if all enrollment requirements are met. If the contractor confirms the beneficiary is ineligible for enrollment, the contractor shall advise the beneficiary they are being disenrolled. Their disenrollment from TRICARE Prime will be effective the first of the month following 30 days from the initial notification date. The contractor shall provide the beneficiary information about TRICARE Standard and Extra. A 12-month lock out does not apply and any excess enrollment fees will be refunded.

## 9.6 MTF Enrollees

**9.6.1** Non-active duty beneficiaries must reside within 30 minutes travel time from an MTF to which they desire to enroll. If a beneficiary desiring enrollment resides more than 30 minutes (but less than 100 miles) from the MTF, they may be enrolled so long as they waive primary and specialty ATC standards and the MTF Commander (or designee) approves the enrollment. (If the MOU includes zip codes or drive-time distances for which the MTF is willing to accept enrollments that are beyond a 30 minute drive, this constitutes approval. If not addressed in the MOU, the contractor shall submit each request to the MTF Commander (or designee) in a method that is outlined in the MOU.) The TRICARE Regional Office (TRO) Director may approve waiver requests from beneficiaries who desire to enroll to an MTF and who reside 100 miles or more from the MTF. In these cases, the MTF Commander must also be agreeable to the enrollment and have sufficient capacity and capability.

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

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

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

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

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

**9.6.3** The contractor shall notify the MTF Commander (or designee) when a beneficiary residing 100 miles or more from the MTF, but in the same Region, requests a new enrollment or

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portability transfer to the MTF. Such notification is not necessary if the MOU has already established that the MTF Commander will not accept enrollment of beneficiaries who reside 100 miles or more from the MTF. The contractor shall make this notification by any mutually agreeable method specified in the MOU. The contractor shall not make the MTF enrollment effective unless notified by the MTF to do so.

**9.6.3.1** The MTF Commander will notify the TRO Director of their desire to enroll a beneficiary who resides 100 miles or greater from the MTF and request approval for the enrollment. The TRO Director will make a determination on whether or not to approve or deny the request and notify the MTF Commander of their decision by a mutually agreeable method. The MTF Commander is responsible for notifying the contractor of all approved enrollment requests for beneficiaries who reside 100 miles or greater from the MTF. The contractor shall notify the beneficiary of the final decision.

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

**9.6.4** At any time during the enrollment period, if the contractor determines there is no signed travel time waiver on file for a current MTF enrollee who resides more than 30 minutes from the MTF, the contractor shall, at the next annual TRICARE Prime renewal point, require the beneficiary to waive the primary and specialty care ATC standards before the enrollment will be renewed. (This includes monitoring address changes received by the contractor from all sources.) The contractor shall notify the beneficiary of this waiver requirement no later than two months before expiration of the annual enrollment period. The language for all beneficiary notices shall be reviewed and concurred on by the TRO prior to being sent to beneficiaries. (The TRO will coordinate notices with DHA BE&SD prior to approval.)

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

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

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

## **9.7 Civilian Enrollees**

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

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

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

- END -



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Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the CMS 1500 Claim Form or the CMS 1450 UB-04, whichever is appropriate. The form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the DHA Administrative Office to order the DD Form 2642.

#### 4.0 CLAIMS RECEIPT AND CONTROL

All claims shall be controlled and retrievable. The face of each hardcopy TRICARE claim shall be stamped with an individual Internal Control Number (ICN), which will be entered into the automated system within five workdays of actual receipt. For both hardcopy and Electronic Media Claim (EMC), the ICN shall contain the Julian date indicating the actual date of receipt. The Julian date of receipt shall remain the same even if additional ICNs are required to process the claim. If a claim is returned, the date of the receipt of the resubmission shall be entered as the new date of receipt. All claims not processed to completion and supporting documentation shall be retrievable by beneficiary name, sponsor's Social Security Number (SSN), Defense Enrollment Eligibility Reporting System (DEERS) family ID, or ICN within 15 calendar days following receipt.

#### 5.0 NEWBORN CLAIMS

5.1 Claims for newborns can be processed without eligibility on DEERS as long as:

- The newborn date of birth is within 365 days of the contractor's eligibility query; and
- The sponsor is/was eligible for TRICARE for the dates of care on the newborn claim.

5.2 A newborn or adoptee will be deemed to be enrolled in Prime as of the day of birth or adoption if one family member is already enrolled in Prime. A responsible representative has 60 days to officially enroll the child to the Prime option. If the newborn or adoptee is formally enrolled in Prime within the 60 day period, the effective date of enrollment will be the first of the month following the date of birth or adoption. (The 20th of the month enrollment rule is waived, if necessary.) If the newborn or adoptee is not formally enrolled during the 60 day calendar period, the newborn or adoptee will revert to a non-enrolled beneficiary effective the 61st day. If the decision is made to continue Prime coverage, an official enrollment request (enrollment form, Beneficiary Web Enrollment (BWE) transaction, or telephonic request) must be completed on behalf of the child. For retirees or their family members or survivors who decide to continue enrollment for the child, the unused portion (prorated on a monthly basis) of the single enrollment fee they paid will be applied toward a new family enrollment period. For newborns and newly adopted children enrolled under this provision, Point of Service (POS) cost-sharing does not apply through the 60th day or the effective date of enrollment, whichever is earlier. All services shall be processed with the Prime copayment even in the absence of referrals or authorizations. The TRICARE Regional Director (RD) may extend the deemed period up to 120 days, on a case-by-case or regional basis.

- Newborns/adoptees in overseas locations are deemed to be enrolled for 120 days following birth/adoption when one other family member, to include the sponsor, is enrolled in TRICARE Overseas Program (TOP) Prime or TOP Prime Remote

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- For additional information on newborns under the TRICARE Retired Reserve (TRR) and TRICARE Reserve Select (TRS) programs, see [Chapter 22, Sections 2 and 1](#) respectively.

- END -

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

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

TRICARE-eligible family members accompanying Service members who are either eligible for or enrolled in the TPR program may enroll in the TRICARE Prime Remote for Active Duty Family Member (TPRADFM) Program in accordance with [Section 6](#). Enrollment jurisdiction for the ADFMs may be based on the enrollment jurisdiction of the TPR enrolled Service member per [paragraph 8.6](#). This includes cross-region enrollment (see [Chapter 6, Section 1, paragraph 9.4](#)).

## **8.0 TPR PROGRAM DIFFERENCES**

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

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

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

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

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

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

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

- END -



## Figures

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### FIGURE 24.30-1 OVERSEAS PHARMACY PROVIDER NOTICE LETTER (SAMPLE)

**(Provider Name)**

**(Provider Street Address)**

**(Provider City, State and Zip Code)**

Dear **(Provider Name)**:

The Department of Defense, through **Defense Health Agency (DHA)**, is responsible for appropriate cost containment for services provided to TRICARE beneficiaries. One particular area of concern has been the costs billed for prescription drugs. In an effort to establish a Uniformed Military Services drug benefit and claim processing requirement for all TRICARE eligibles, the Deputy Director, **DHA**, has determined that pharmacy claims submitted for services outside the United States must be reimbursed in accordance with the reimbursement formulas for TRICARE United States (U.S.) claims as established under the Code of Federal Regulations.

This letter notifies you that effective sixty (60) days from date on this letter, **(Date)**, overseas pharmacy claims submitted will be processed in accordance with the reimbursement formulas for TRICARE claims in the United States which are from a schedule of allowable charges based on the Average Wholesale Price (AWP) rates plus \$3.00 administration fee. Should you have any questions regarding this requirement, please write me at **(Contractor Mailing Address)**.

Sincerely,

**(Contractor Name)**

**(Contractor Title)**

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**FIGURE 24.30-2 TOP CONTRACTOR PROVIDER CERTIFICATION REQUEST LETTER**



**OVERSEAS**

(Sample Philippine Contractor Provider Certification Request Letter)

Dear Provider:

(**TOP Contractor Name**), your TRICARE claims processor has received a claim for services provided by you.

You are not currently listed with us as a TRICARE authorized/credentialed provider. To complete processing of your claim, you must request to be an authorized/credentialed TRICARE provider. So that we may complete the processing of your claim, please complete the attached **TRICARE** Provider Application including copies of your current license(s). Unless we receive the requested license(s)/credentials the claim will be denied.

Please return the completed application with copies of your license(s)/credentials to:

**(Contractor's Name and Address)**

Sincerely,

**(Contractor's Name)**

- 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 shall accept and process TYA enrollment applications from the BWE application. **The contractor shall start processing TYA enrollment applications from the Beneficiary Web Enrollment (BWE) application on December 1, 2016.** 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 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.

- END -