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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 85
6010.56-M
SEPTEMBER 21, 2012

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

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

CHANGE TITLE: TRICARE PRIME FEE REFUNDS, CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP), AND FEE SYSTEM

CONREQ: 16098

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change requires refunding Prime enrollment fees to enrollees under age 65, who become eligible for Medicare Part A and purchase Part B, clarifies CHCBP eligibility, updates the TRICARE Systems Manual (TSM) based on implementation of the Fee Premium Interface, adds the Fiscal Year (FY) 2013 Prime Enrollment Fee amounts, and adds a Health Care Plan Coverage Code to the list of valid codes.

EFFECTIVE DATE: October 1, 2012, except for the CHCBP change which has an effective date of October 16, 2011.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 78, Feb 2008 TRM, Change No. 72, and Feb 2008 TSM, Change No. 44.


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Director, Operations Division

ATTACHMENT(S): 13 PAGES
DISTRIBUTION: 6010.56-M

CHANGE 85
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CHAPTER 6

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 6, Section 1

Enrollment Processing

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.

6.3 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.

6.4 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.

6.5 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.

6.5.1 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.**

6.5.2 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.

6.5.3 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.)

6.5.4 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.

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

7.0 WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION

The WII program provides a continuum of integrated care from the point of injury to the return to duty or transition to active citizenship for the Active Component (AC) or the Reserve Component (RC) service members who have been activated for more than 30 days. These AC/RC service members, referred to as ADSMs, have been injured or become ill while on active duty and will remain in an active duty status while receiving medical care or undergoing physical disability processing. WII programs vary in name according to Service. The Service shall determine member eligibility for enrollment into a WII program, as well as whether or not to utilize these enrollments.

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

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

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

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

7.1.1 Service defined eligible ADSMs assigned to a WII 415 Program such as a MEDHOLD or WTU shall be enrolled to TRICARE Prime or TOP Prime prior to, or at the same time, as being enrolled into the WII 415. Members cannot be enrolled to the WII 415 without a concurrent TRICARE Prime or TOP Prime enrollment. Service appointed WII case managers as determined by the Services, will coordinate with the MTF to facilitate TRICARE Prime PCM assignments for WII 415 members. The contractor shall then assign a PCM in accordance with the MTF MOU and in coordination with the WII case manager. WII 415 enrollment will not run in conjunction with TAMP and members enrolled in TPR, or TOP Prime Remote are not eligible to enroll in the WII 415.

7.1.2 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.)

7.1.3 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.

7.1.4 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

7.1.5 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.

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

7.2.1 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.

7.2.2 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](#).

7.2.3 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.

7.2.4 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

Continued Health Care Benefit Program (CHCBP), Eligibility And Coverage

1.0 CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP)

1.1 The CHCBP is a health care program that allows certain groups of former Military Health System (MHS) beneficiaries to continue receiving health care coverage when they lose eligibility for military health care under the TRICARE programs. This temporary health program is supported by premium revenue collected from the participants in the program. The CHCBP contractor (herein referred to as the “contractor” unless otherwise specified) shall provide all services necessary to support the CHCBP as outlined in [32 CFR 199.20](#). Other references describing the CHCBP that are to be used by the contractor in fulfilling its responsibilities are applicable sections of the TRICARE Policy Manual (TPM), TRICARE Operations Manual (TOM), TRICARE Reimbursement Manual (TRM), TRICARE Systems Manual (TSM), and the **Federal Register** dated September 30, 1994 (pg. 49817ff), February 11, 1997 (pg. 6225ff), February 24, 1997 (pg. 8312), and September 16, 2011 (pg. 57637ff). The contractor shall perform these functions for CHCBP beneficiaries on a worldwide basis, irrespective of the geographic area in which the beneficiary resides or the area in which health care services are received.

1.2 The legislative basis for the program is Section 4408 of the National Defense Authorization Act (NDAA) of 1993 (Public Law 102-484) which added Section 1078a to Chapter 55 of 10 United States Code (USC). Beneficiaries **who may be eligible to purchase the continued health program after eligibility for coverage ends under a health benefits plan under 10 USC Chapter 55 or 10 USC § 1145(a)** are described in 10 USC § 1078a. **For those covered under premium-based TRICARE health benefits plans such as TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA), etc., such coverage must have been purchased and in place the day before the loss of eligibility.**

1.3 CHCBP is not part of the TRICARE Program; therefore, the contractor shall adhere to the following requirements for those areas in which the CHCBP instructions and processing requirements are different than TRICARE.

2.0 VALIDATE ELIGIBILITY FOR CHCBP

2.1 Upon receipt of a Department of Defense (DoD) (DD) Form 2837, CHCBP Application, from a prospective beneficiary, the contractor shall validate eligibility on the Defense Enrollment and Eligibility Reporting System (DEERS) and request information necessary to validate eligibility. The

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supporting documentation that the contractor shall request from the applicant differs depending on the category of individual who is applying for enrollment as shown below:

2.1.1 Individual Uniformed Service sponsor (herein referred to as "sponsor") and his/her family: a copy of the DD Form 214, Certificate of Release or Discharge from Active Duty, or a copy of the sponsor's active duty orders.

2.1.2 Unremarried former spouse and stepchildren of the sponsor: a copy of the final divorce decree.

2.1.3 Child who loses TRICARE coverage due to marriage: a copy of marriage certificate.

2.1.4 Child who loses TRICARE coverage on his/her 21st birthday (age 23 if enrolled in a full-time course of study at an approved institution of higher learning and dependent on the uniformed service sponsor for more than half of their financial support): a copy of the front and back of the Uniformed Services identification (ID) card.

2.1.5 Child who loses TRICARE coverage due to college graduation: a copy of college transcript.

2.1.6 Child who loses TRICARE coverage when the child over the age of 21 and before the age of 23 ceases to be enrolled in a full-time course of study at an approved institution of higher learning or ceases to be dependent on the uniformed service sponsor for more than half of their financial support: a letter from the institution of higher learning stating the student's status or a written statement from the dependent that he/she is no longer dependent on the uniformed services sponsor for more than half of their financial support.

2.1.7 Child that was previously placed in sponsor's legal custody and then loses TRICARE coverage: a copy of the court order.

Note: Children who lose TRICARE coverage under [paragraphs 2.1.4 through 2.1.7](#) may qualify to purchase TYA coverage until reaching the age of 26 (see [Chapter 25](#)). If qualified to purchase TYA coverage, the child cannot purchase CHCBP as an individual.

2.1.8 Child who loses eligibility for TYA coverage. However, if the TYA coverage was terminated due to eligibility for employer-sponsored health care coverage based on their own employment or failure to pay TYA premiums, then the child is not eligible to purchase CHCBP coverage (see [Chapter 25](#)).

2.1.9 For any other situations in which an individual loses TRICARE coverage and may potentially be eligible for CHCBP, the contractor shall request information needed to verify eligibility.

2.2 Family Members Not Identified on DEERS

2.2.1 When a contractor receives a CHCBP claim which includes a family member not identified on DEERS as enrolled, but the sponsor indicates CHCBP family coverage, the contractor is to take the following action: If the claim includes a copy of an appropriately marked CHCBP coverage card for the beneficiary, the claim is to be processed. If the claim is for a beneficiary who is less than 60 days old, the claim is to be processed, even if no copy of an CHCBP coverage card is attached as

long as at least one member of the sponsor's family is currently enrolled in CHCBP. In all other cases, the claim is to be denied.

2.2.2 In order to be enrolled in the CHCBP, the beneficiary will be disenrolled from any TRICARE programs in which enrolled. This will require no action on the beneficiary's part.

2.3 Disputes Regarding Enrollment

2.3.1 Confirmation of a person's eligibility as a CHCBP beneficiary is the responsibility of the CHCBP contractor. Disputed questions of fact concerning a beneficiary's eligibility will not be considered an appealable issue, but must be resolved with the appropriate Uniformed Service.

2.3.2 If the contractor determines the applicant does not appear eligible due to an ineligible response from DEERS (i.e., no history segments or record of previous DoD entitlement) or failure of the applicant to provide the documentation requested to verify eligibility the contractor shall deny the application in writing within 10 business days of the reason for the denial.

3.0 APPLICATION PERIOD AND PREMIUMS

3.1 CHCBP Application Period

There is a 60-day application period for CHCBP, beginning the day following the end date of the beneficiary's eligibility for TRICARE coverage. The contractor shall deny any applications received after the 60-day period. The contractor shall apply the following business rules when determining the start of the 60-day application period.

3.1.1 Members and Former Members, Their Families, and Other Individuals Losing TRICARE Coverage

The government routinely notifies beneficiaries prior to their loss of TRICARE coverage (active duty members are notified of the CHCBP during outprocessing; other beneficiaries who lose TRICARE coverage are notified by the Defense Manpower Data Center (DMDC) in writing of the availability of the CHCBP). However, if an eligible beneficiary advises the contractor that he/she was not notified of this program and submits documentation to support their position, the contractor shall establish the start-date of the 60-day application period as the date that the applicant received notification of the program.

3.1.2 Unremarried Former Spouses

There is no formal mechanism established to promptly identify unremarried former spouses that may qualify for this program, therefore the contractor shall process all applications from unremarried former spouses upon receipt.

3.2 Coverage Categories

CHCBP offers two coverage categories. Individual coverage is available to the member or former member, an unremarried former spouse, an adult child, a surviving spouse, or other qualified individuals. Family coverage is only available to the member or former member and his/her dependents. Dependents cannot be covered under family coverage unless the member or

former member is also covered by family coverage.

3.3 CHCBP Application

DD Form 2837, CHCBP Application, shall be accepted as the application form for CHCBP coverage. No later than six months prior to the start work date of the contract, the contractor shall provide the Contracting Officer's Representative (COR) with the contractor's mailing address and toll-free telephone number. Should DD Form 2837 be revised or renumbered in the future, the contractor shall use the latest version.

3.4 Dates of Coverage & Premiums

3.4.1 Coverage will begin the day following the beneficiary's loss of TRICARE coverage and will end the last day of premium coverage.

3.4.2 Due to the documentation requirements for purchasing coverage, most coverage will be retroactive; however, there may be some coverage that will be prospective. Prospective coverage must be accompanied by a premium payment for one quarter. Retroactive coverage must be accompanied by full premium payment retroactive to the effective date of coverage through the end coverage date in the quarter in which the individual is applying.

3.4.3 Premiums are as stated in [paragraph 3.5](#) of these instructions.

Examples of the premiums required for retroactive and prospective coverage:

	Military Benefits End	Application Received	Quarters of Premium Due	CHCBP Coverage Begins
Example 1:	10/01/2010	11/15/2010	1 quarter	10/02/2010
Example 2:	09/15/2010	02/10/2011	2 quarters	09/16/2010
Example 3:	11/05/2010	10/01/2010	1 quarter	11/06/2010
Example 4:	03/01/2011	11/01/2010	1 quarter	03/02/2011

3.5 Premium Rates

3.5.1 The amount of the CHCBP premiums shall be established by the government and may be adjusted each fiscal year. **Adjusted premium amounts will be provided in writing to the contractor by the Contracting Officer (CO).**

3.5.2 The contractor shall begin charging the adjusted quarterly premiums on the date **directed by the CO.**

3.5.3 Upon receipt of adjusted rates from the government, the contractor shall issue a written notice to the beneficiary of the changes in premium amounts, to include the effective date of the change. This notification should be done at least 30 days prior to the effective date **directed by the CO.**

3.5.4 When qualifying events occur that change the sponsor from individual to family coverage or vice versa, coverage and premiums shall be changed effective with the date of the qualifying event. The contractor, within 10 business days of receiving such information, shall issue a

written notice to the beneficiary of the changes in the coverage category and premium amount, including the effective date of the changes.

3.6 Form of Payment

3.6.1 Checks, money orders, or credit cards are allowable forms of payment for CHCBP beneficiaries to use in paying their premiums. The contractor may propose additional payment mechanisms, to include electronic processes for premium payments. Proposed electronic processes shall maintain the integrity and security of the application processes which includes important documentation required to validate eligibility for CHCBP.

3.6.2 As a minimum, the contractor shall accept VISA and MasterCard® for credit card payments, and may, but is not required to, accept additional nationally recognized major credit cards as a form of premium payment.

3.6.3 The contractor shall not accept premiums submitted by, or on behalf, of a health care provider for any beneficiary other than (a) the provider him/herself and (b) a member of the provider's immediate family. Should a provider submitted payment be received, the contractor shall return the payment to the provider with a written notice advising the provider that submission of premium payments by health care providers is prohibited. A copy of the letter should also be sent to the beneficiary. The contractor shall submit documentation to the TRICARE Management Activity (TMA) Program Integrity Office to include the following: a copy of contractor's notification to the provider, copy of front and back of premium (money order or check), originals of all documentation submitted by the provider (to include mailing envelope), documentation of all conversations and communications the contractor had with the provider on the subject of paying premiums, and any other information that the contractor has in its files or records concerning the provider that might be of assistance in Government follow-up action on this issue.

3.7 Insufficient Funds

In the case of insufficient funds, the contractor shall, within three business days, issue a written notice to the applicant (for initial applications) or beneficiary (in the case of renewal premiums), advising the applicant or beneficiary of the insufficient funds, the amount of the premium due, and the date by which a valid premium must be received by the contractor. For initial application requests, the notice shall also advise the beneficiary that if premium payment is not received in full by the due date (the last day of the 60-day application period), the applicant will not be covered in CHCBP. For renewals, the notice shall advise the beneficiary that if the contractor does not receive valid payment in full within 30 days of the date of the contractor's letter, that coverage will be terminated. That notice shall also provide the effective date of termination if payment is not received. If the premium payment has not been received by the contractor within the specified time frame, the contractor shall terminate the CHCBP coverage and issue a written notice to the beneficiary confirming the termination of coverage.

3.8 Refunds

Premiums shall be refunded if the applicant is no longer eligible for CHCBP coverage, i.e., beneficiary regains TRICARE eligibility; ex-spouse remarries; death of beneficiary; prospective member who has prepaid premium but fails to provide required eligibility documentation; and

sponsor change in coverage from family to individual. Voluntary termination because the beneficiary obtained Other Health Insurance (OHI) does not constitute grounds for a refund of unused premiums. When refunds are appropriate, the contractor shall prorate the refund from the date of loss of eligibility for program benefits through the last coverage date for which the premium was paid.

3.9 Limits of CHCBP Coverage

The length of a beneficiary's CHCBP coverage varies according to the category of individual. Coverage lengths and categories are listed in the TPM, [Chapter 10, Section 4.1, Figure 10.4.1-1](#), CHCBP Eligibility Table.

3.10 Processing Applications

3.10.1 Once the contractor has verified eligibility and approved the application request, the contractor shall enter the CHCBP enrollment into DEERS through the applicable on-line interface. As DEERS does not allow individuals to be added to a sponsor's record after the sponsor's TRICARE coverage ends, there will be a small number of CHCBP beneficiaries that the contractor cannot complete the CHCBP enrollment in DEERS. The majority will be newborns whose birth occurred after the sponsor's TRICARE coverage ends, but there will occasionally be other beneficiaries as well. The contractor should not rely on DEERS as being the sole determinant of whether or not an individual is eligible for CHCBP coverage as these individuals would not be reflected on DEERS (see [paragraph 2.0](#)). The contractor's systems shall accommodate these unique cases in which the beneficiary is covered under CHCBP but not reflected on DEERS to ensure these beneficiaries are provided with all required CHCBP benefits and accurate processes, i.e., claims processing, issuing authorizations, accessing services, etc.

3.10.2 DEERS will not allow a CHCBP enrollment to be entered if the sponsor and/or dependents are still showing as eligible for TRICARE coverage. In these cases, the contractor shall pend the application and advise the applicant in writing for the sponsor to contact the nearest Uniformed Services ID card issuing office to rectify the situation. The contractor shall complete the processing of the application when DEERS has been updated to reflect that the sponsor and/or dependents are no longer eligible for services under TRICARE.

3.10.3 Once the application has been fully processed, the contractor shall issue the beneficiaries a CHCBP coverage ID card within 10 business days. The card provides the beneficiaries with (a) confirmation that the individual is covered and the effective dates; and (b) documentation that the beneficiary can use to access health care services. The card shall contain sufficient information to facilitate access to health care. Coverage dates on the card shall be limited to those dates for which a valid quarterly premium has been received by the contractor. Cards shall be issued each quarter for all subsequent quarterly payments received by the contractor. The card shall reflect that coverage is for the CHCBP and at a minimum provides the contractor's name, address, toll-free telephone number, and claims center mailing address.

3.10.4 Once an application has been fully processed, the contractor shall issue a letter to the applicant confirming CHCBP coverage (including the dates of coverage) within 10 business days. The letter shall advise the beneficiary of the requirements that must be met for continued coverage in the program, including information regarding future contractor billings and premium payments that the beneficiary will be required to make. The contractor shall also issue either a CHCBP

coverage policy or such other sufficient written information regarding the CHCBP for beneficiaries' reference should they have any questions regarding benefits and program requirements.

3.11 Coverage and Renewals

3.11.1 The contractor shall mail initial premium renewal notices to beneficiaries no later than 30 days before the expiration of the coverage. The beneficiary's coverage in CHCBP is based on the documentation that the applicant submits to verify eligibility, therefore, the contractor shall not routinely query DEERS for renewal coverages and quarterly billings. Absent information or evidence to the contrary, the contractor shall assume that the individual continues to meet the requirements for CHCBP. Renewal notices shall clearly specify the premium amount due, the date by which the premium must be received, and the mailing address to which the premium payment must be sent. Renewal notices shall specify that failure to submit the premium due will result in denial of continued coverage and termination from the program.

3.11.2 The contractor shall provide a 30 calendar day grace period following the premium due date in which the beneficiary may submit his/her premium and continue benefits with no break in coverage. If the premium is not received following the initial renewal notice to the beneficiary requesting premium for the next quarter, the contractor shall issue a second renewal notice to the beneficiary within 10 business days of the start of the grace period. The second renewal notice shall indicate that this is the second and final billing notice and that if payment is not received by the due date specified in the notice, that CHCBP coverage will be terminated as of that date. The notice shall also advise the beneficiary that if coverage is terminated due to nonpayment of premium, that he/she will be permanently locked-out of CHCBP.

3.11.3 If the premium is not received by the end of the grace period, the contractor shall terminate the beneficiary's coverage in CHCBP and mail a letter to the beneficiary confirming the termination within 10 business days, to include the effective date and basis for the termination. The contractor shall enter all CHCBP terminations into DEERS.

3.11.4 Beneficiaries who desire to voluntarily withdraw from the CHCBP prior to the end of their paid up period shall send a written request to the contractor. Beneficiaries who voluntarily disenroll from the CHCBP are not permitted to re-enroll until they gain and then once again lose TRICARE coverage. Refund of unused premiums is only allowed for items covered in [paragraph 3.8](#).

3.11.5 Following a beneficiary's termination from the CHCBP, except for those who have re-established TRICARE coverage, the contractor shall issue a Certificate of Creditable Coverage (CoCC) to the beneficiary within 10 business days from the termination date and upon request up to 24 months after the termination date. No later than four months prior to the start work date of the contract, the government will furnish the contractor with a sample of the format for the CoCCs.

3.11.6 In preparing and mailing all written notices and correspondence to applicants and beneficiaries, the contractor shall use the most current address on file or available.

3.12 CHCBP Coverage Data and Report

The contractor shall maintain systems and databases to collect, track and process applications and to report monthly coverage information to the government as well as any ad hoc reports that may be requested regarding CHCBP coverage. The contractor shall have the capability

to retroactively retrieve pertinent coverage information on any individual who has been accepted or denied coverage in the program, to include the basis for such denials.

4.0 PROGRAM MATERIALS

All informational materials, booklets, brochures, and other public material are subject to review and approval by the TMA Beneficiary Education and Support Division (BE&SD) prior to finalizing the material, and all must contain the contractor's name, mailing address, toll-free telephone number and web site.

5.0 INQUIRIES AND CUSTOMER SERVICE FUNCTIONS

The contractor shall respond to CHCBP inquiries from any geographic area, to include locations outside the 50 United States and the District of Columbia. The contractor shall provide timely, accurate and thorough responses to the inquiries it receives from any source, e.g., prospective applicants, beneficiaries, providers, other contractors, government officials, etc. in accordance with [Chapter 1, Section 3, paragraph 3.0](#).

6.0 FIDUCIARY RESPONSIBILITIES

6.1 The contractor shall act as a fiduciary for all funds acquired from CHCBP premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of CHCBP premiums to the government. The contractor shall follow the requirements in [Chapter 3](#).

6.2 The contractor shall maintain a system for tracking and reporting premiums and beneficiaries/policy holders. The system is subject to government review and approval.

6.3 By the 10th calendar day of the month following the activity, the contractor shall submit the following reports: CHCBP Workload Report, CHCBP Monthly Enrollee Premiums Report, CHCBP Adjusted Premiums Report, CHCBP Enrollment Data Report, and CHCBP Premiums Summary Report as described in the DD Form 1423, Contract Data Requirements List (CDRL), and submit per [Chapter 14, Section 2](#).

7.0 DEERS

Refer to the DEERS instructions in the TSM for additional DEERS requirements related to CHCBP.

8.0 REPORTING RESPONSIBILITIES

In addition to the written monthly reports, the CHCBP contractor may be required to produce CHCBP ad hoc reports as requested by the government. The data elements or information for such reports would be limited to that information that the CHCBP contractor has collected or should reasonably have collected in the performance of CHCBP work. Some manipulation and formatting of the data and information may be required to meet the requirements of the ad hoc reports. The government estimates that the CHCBP contractor would not receive more than three such requests per contract year and that the level of effort for the CHCBP contractor to produce the ad hoc

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reports is not expected to be significant.

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