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CHANGE 97
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REMOVE PAGE(S)

CHAPTER 9

Section 17.1, pages 1 and 2

CHAPTER 10

Table of Contents, page 1

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Section 4.1, pages 1 - 4, 7, 8

Section 6.1, page 1

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pages 5 and 6

SUMMARY OF CHANGES

CHAPTER 9

1. Section 17.1. Administrative change.

CHAPTER 10

2. Table of Contents. Adds additional language to the Subject Title of Section 6.1.
3. Section 2.1. Adds note stating enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of End Stage Renal Disease and who maintain enrollment in Part B of Medicare. Removes language referring to Senior Prime beneficiaries transferring to TRICARE Plus and enrollments of TFL beneficiaries into MTFs. Clarifies TRICARE Prime eligibility for dual eligibles. Removes language regarding Primary Care Manager referrals.
4. Section 4.1. Adds effective date of coverage for CHCBP. Adds notes and correction to table regarding CHCBP eligibility.
5. Section 6.1. Clarifies provisions regarding TRICARE for Life eligibles and TRICARE Prime eligibility for dual eligibles.
6. Section 8.1. Administrative change.

INDEX

7. Adds additional language to the index marker for Chapter 10, Section 6.1.

Chapter 9

Section 17.1

Providers

Issue Date: August 4, 1988

Authority: [32 CFR 199.6\(e\)](#)

1.0 POLICY

1.1 Services and items cost-shared through the Extended Care Health Option (ECHO) must be rendered by TRICARE authorized providers.

1.2 ECHO inpatient care providers: A provider of residential institutional care authorized under the ECHO must:

1.2.1 Be a not-for-profit organization which primarily provides services to the disabled, OR

1.2.2 Be a facility operated by the state or under state contract, AND

1.2.3 Meet all applicable licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider is located.

1.3 ECHO outpatient care providers. A provider of ECHO outpatient, ambulatory, or in-home services shall be:

1.3.1 An authorized provider of services as defined in [32 CFR 199.6](#), or

1.3.2 An individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as a ECHO benefit and not otherwise allowable as a benefit of [32 CFR 199.4](#), that meets all applicable licensing or other regulatory requirements that are extant in the state, county, municipality, or other political jurisdiction in which the ECHO service is rendered.

1.4 Individual professional providers authorized by [32 CFR 199.6](#) for the Basic Program are also authorized providers for the ECHO. Individual professional providers who can be authorized only under the ECHO must meet all applicable licensing and other regulatory requirements that are extant in that state, county, municipality, or other political jurisdiction in which the ECHO service is rendered, or, in the absence of such licensing or regulatory requirements, as determined by the Director, TRICARE Management Activity (TMA) or designee.

1.5 For the purpose of services rendered in conjunction with Applied Behavioral Analysis (ABA) **reinforcement** under the ECHO **Other Services** benefit (see [Section 9.1](#)), TRICARE-authorized providers are those that:

1.5.1 Have a current State license to provide ABA services; or

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1.5.2 Are currently State-certified as an Applied Behavioral Analyst; or

1.5.3 Where such State license or certification is not available, are certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst (BCBA); and

1.5.4 Otherwise meet all applicable requirements of TRICARE-authorized providers.

1.6 ECHO vendor. A provider of an allowable ECHO item, supply, equipment, orthotic, or device shall be deemed to be an authorized vendor for the provision of the specific item, supply, equipment, orthotic, or device when the vendor supplies such information as the Managed Care Support Contractor (MCSC) or Director, TRICARE Area Office (TAO) determines necessary to adjudicate a specific claim.

1.7 Provider requirements for the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration are indicated in the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#).

2.0 EFFECTIVE DATE

September 1, 2005.

- END -

Chapter 10

Eligibility And Enrollment

Section/Addendum	Subject/Addendum Title
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- | | |
|-----|--|
| 1.1 | Eligibility Requirements For TRICARE Beneficiaries |
| 2.1 | Prime Enrollment |
| 3.1 | Prime And Status Changes |
| 4.1 | Continued Health Care Benefit Program (CHCBP)
Figure 10.4.1-1 CHCBP Eligibility Table |
| 5.1 | Transitional Assistance Management Program (TAMP) |
| 6.1 | TRICARE For Life (TFL) And Other Medicare-Eligible Beneficiaries |
| 7.1 | Transitional Survivor Status And Survivor Status |
| 8.1 | TRICARE Reserve And National Guard (NG) Family Member Benefits |
| 9.1 | Early Eligibility Benefits For Reserve And National Guard (NG) |

Chapter 10

Section 2.1

Prime Enrollment

Issue Date: May 15, 1996
Authority: [32 CFR 199.17](#)

1.0 POLICY

1.1 In order to receive the expanded benefits and special cost-sharing of Prime, all beneficiaries must take specific action to enroll. For active duty members located in areas where the TRICARE program is implemented, enrollment in Prime is mandatory. An enrollment form must be completed to ensure Defense Enrollment Eligibility Reporting System (DEERS) enrollment data is current and claims are processed expeditiously.

1.1.1 Enrollment Procedures

1.1.1.1 No non-active duty beneficiary shall be enrolled unless he/she is shown as eligible on the DEERS. All enrollments and re-enrollments shall be recorded on the DEERS.

1.1.1.2 Enrollment may occur at any time; however, the enrollment period shall coincide with the fiscal year (i.e., the beneficiary's initial enrollment expires on October 1; all future enrollment periods will be October 1 to September 30). Enrollment may be on an individual or family basis.

1.1.1.3 The contractor is responsible for collecting enrollment fees from Prime enrollees, as appropriate, and retains all such fees.

1.1.1.4 Payment of enrollment fees may be made on an annual or quarterly basis by credit card and for monthly enrollment fee payments, by Electronic Fund Transfers (EFTs) or an allotment from retirement pay. No administrative fees are charged to enrollees who choose to pay monthly or quarterly.

Note: Effective March 26, 1998, the Prime enrollment fee is waived for those enrollees who have Medicare Part B, regardless of age. Dual eligibles age 65 and older, who have an Active Duty (AD) sponsor or who are not entitled to premium-free Medicare Part A on their own record, or the record of their current, former, or deceased spouse may enroll in TRICARE Prime. See the TRICARE Operations Manual (TOM), [Chapter 6, Section 1, paragraph 7.5.4](#).

1.1.1.5 TRICARE Prime enrollments for eligible enrollees shall be automatically renewed upon the expiration of the enrollment unless the enrollee declines renewal, is no longer eligible for Prime enrollment or fails to pay the enrollment fee on a timely basis.

1.1.1.6 Dependents of Activated Members of Reserve Components (RCs). Dependents of members of RCs who have been ordered to active duty for a period of 31 days or more may enroll in

TRICARE Prime. RCs include both reservists and members of the National Guard. Members of the National Guard are included only if ordered to federal duty. All requirements of this and other services apply to these beneficiaries. Activated members of RCs are treated the same as any other active duty member.

1.1.2 Enrollment Protocols

1.1.2.1 No eligible beneficiary who resides in the TRICARE region shall be denied enrollment or re-enrollment in, or be required to disenroll from, the TRICARE Prime program because of a prior or current medical condition.

1.1.2.2 The contractor shall provide beneficiaries who enroll full and fair disclosure of any restrictions on freedom of choice that may be applicable to enrollees including the Point of Service (POS) option.

1.1.2.3 TRICARE for Life beneficiaries (retirees and their dependents who are age 65 and over and are eligible for both Medicare and TRICARE) cannot enroll in TRICARE Prime. However, any beneficiary who is enrolled in TRICARE Prime at the time they attain their Medicare entitlement based on age will be permitted to enroll with a Military Treatment Facility (MTF) through TRICARE Plus, to the extent capability and capacity exists in the MTF. There shall be no TRICARE Plus affiliation with network providers.

1.1.2.4 Dual eligibles under age 65 (retirees and their dependents who have Medicare Parts A and B) and dual eligibles who are Active Duty Family Members (ADFMs) (any age) are eligible to enroll in TRICARE Prime. See the TOM, Chapter 6, Section 1.

1.1.2.5 TRICARE and the Military Health System (MHS) beneficiaries who are not eligible to enroll in TRICARE Prime may register for the purpose of accessing space-available care in the MTF and customer services. This registration is NOT enrollment in TRICARE Prime and no TRICARE Prime program benefits or services (other than access to customer services and network providers) applies to this beneficiary group.

1.1.3 Retroactive Enrollment

For emergency cases that should be placed under immediate case management, MTF Commanders may approve exceptions on a case-by-case basis for retroactive enrollment with an effective date not earlier than the first day of the month that the application is submitted. Regional Directors (RDs) may approve exceptions on a case-by-case basis for retroactive enrollment to a network provider with an effective date not earlier than the first day of the month that the application is submitted.

1.1.4 Effective Date of Enrollment

1.1.4.1 All initial enrollment periods shall begin on the first day of the month following the month in which the enrollment application and enrollment fee payment, if applicable, are received by the contractor. If an application and fee are received after the twentieth (20th) day of the month, enrollment will begin on the first day of the second month after the month in which they were received by the contractor.

1.1.4.2 Reenrollments for those who were enrolled in Prime immediately prior to a change in their status:

1.1.4.2.1 When an active duty member's retirement is effective other than the first of the month. A Prime application to reenroll must be completed within 30 days of the member's retirement. Otherwise, the application shall be considered an initial enrollment in Prime. The effective date of reenrollment shall be the date of retirement which will then result in seamless TRICARE Prime benefits with no break in coverage.

1.1.4.2.2 When an active duty member separates other than the first of the month, but continues to be eligible (e.g., is the spouse of an active duty member; or is eligible for Transitional Assistance Management Program (TAMP) they and any eligible family members shall be allowed to reenroll in TRICARE Prime with no break in coverage. TAMP eligibles must complete an application for Prime prior to the expiration of their period of TAMP eligibility to reenroll in Prime. Non-TAMP eligibles separating but who remain eligible for TRICARE must complete the application for Prime within 30 days of their change in status. Otherwise, the application shall be considered an initial enrollment in Prime. The effective date of reenrollment shall be the start date of TAMP eligibility or the date of the separation which will then result in seamless TRICARE Prime benefits with no break in coverage.

1.1.4.2.3 TAMP eligible family members who were enrolled in Prime immediately prior to their sponsor's change in status to active duty may continue their enrollment in TRICARE Prime with no break in coverage if they reenroll in TRICARE Prime within 30 days of their sponsor's return to active duty status. If they reenroll by completing an enrollment form within 30 days of the sponsor's return to active duty status, the reenrollment will be retroactive to the date of the change in status from TAMP to active duty. If reenrollment and completion of an enrollment form is not accomplished within 30 days of the sponsor's return to active duty status, the twentieth of the month rule will apply. For information on the effective dates of enrollments for Active Duty Service Members (ADSMs), see the TOM, [Chapter 6, Section 1](#).

1.1.5 Beneficiaries shall be disenrolled when they are no longer eligible for TRICARE or when they do not submit payment for prescribed enrollment fees by the required date.

1.2 Portability. Enrollees may transfer enrollment when they move (within a contract area or outside a contract area). The losing contractor shall provide continuing coverage until (1) the enrollee applies for enrollment in the new location, (2) the enrollee disenrolls, (3) the enrollee is no longer eligible for enrollment in TRICARE Prime, or (4) the contractor must disenroll the beneficiary for failure to pay required enrollment fees, whichever occurs first. The authorization and referral rules of the losing contractor will continue to apply until enrollment is transferred or the beneficiary is disenrolled ([see the TOM, Chapter 6, Section 2](#)).

- END -

Chapter 10

Section 4.1

Continued Health Care Benefit Program (CHCBP)

Issue Date: September 8, 1994

Authority: Section 4408 of Public Law 102-484, [32 CFR 199.20](#)

1.0 ISSUE

Establishing eligibility for coverage in the Continued Health Care Benefit Program (CHCBP) for certain TRICARE beneficiaries who lose eligibility for coverage under a health benefits plan under 10 United States Code (USC) Chapter 55 or 10 USC § 1145(a).

2.0 BACKGROUND

Implementation of the CHCBP was directed by Congress in section 4408 of the National Defense Authorization (NDAA) Act for Fiscal Year (FY) 1993, Public Law 102-484, which amended 10 USC, by adding § 1078a. This law directed the implementation of a program of temporary continued health benefits coverage comparable to the health benefits provided for former civilian employees of the Federal government. A 2008 change to 10 USC § 1078a expanded CHCBP to all who the Secretary specifies in regulation who lose eligibility to health care services under 10 USC Chapter 55 or 10 USC § 1145(a). **The effective date of coverage for these additional former beneficiaries is no earlier than October 16, 2011.** The CHCBP is a premium based transitional health care coverage program that will be available to qualified beneficiaries after eligibility for coverage ends under a health benefits plan under 10 USC Chapter 55 or 10 USC § 1145(a). Medical benefits under this program generally model the TRICARE Standard and Extra Plans only.

3.0 POLICY

3.1 Eligibility

Individuals identified in [Figure 10.4.1-1](#), regardless of their place of residence (e.g., overseas or in the United States), may qualify to purchase CHCBP effective the day following the day they lose eligibility for coverage. 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.

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FIGURE 10.4.1-1 CHCBP ELIGIBILITY TABLE

CHCBP ELIGIBILITY FOR MEMBERS*			
FORMER CATEGORY	NO LONGER ENTITLED OR ELIGIBLE FOR	ELIGIBILITY FOR CHCBP COVERAGE	ELECTION OF COVERAGE
Active Duty	TRICARE coverage under 10 USC § 1074(a)	Up to 18 months: 10 USC § 1078a(g)(1)(A).	Latter of 60 days from: <ul style="list-style-type: none"> • Date of discharge from active duty or • Date of notification of CHCBP eligibility from the Uniformed Services.
Full-time National Guard (NG)	Health care benefits due to separation from full-time NG status	Up to 18 months: 10 USC § 1078a(g)(1)(A).	Latter of 60 days from: <ul style="list-style-type: none"> • Date of discharge from full-time NG or • Date of notification of CHCBP eligibility from the Uniformed Services.
Member eligible for Transitional Assistance Management Program (TAMP)	TRICARE coverage under TAMP: 10 USC § 1145(a)	Up to 18 months: 10 USC § 1078a(g)(1)(A).	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility for TAMP ends or • Date of notification of CHCBP eligibility from the Uniformed Services.
Selected Reserve (SelRes) member enrolled in TRICARE Reserve Select (TRS)	TRS coverage under 10 USC § 1076d	Up to 18 months: 10 USC § 1078a(b)(4).	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility for TRS ends or • Date of notification of CHCBP eligibility from the Uniformed Services.
Retired Reserve member enrolled in TRICARE Retired Reserve (TRR)	TRR coverage under 10 USC § 1076e	Up to 18 months: 10 USC § 1078a(b)(4).	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility for TRR ends or • Date of notification of CHCBP eligibility from the Uniformed Services.
SelRes member	Other specific statutory authority under 10 USC Chapter 55 pertaining to a SelRes member.	Up to 18 months.	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility for 10 USC Chapter 55 ends or • Date of notification of CHCBP eligibility from the Uniformed Services.

*Members of the Uniformed Services who are discharged or released from active duty (or full-time NG duty), whether voluntarily or involuntarily, under other than adverse conditions as characterized by the Secretary.

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FIGURE 10.4.1-1 CHCBP ELIGIBILITY TABLE (CONTINUED)

CHCBP ELIGIBILITY FOR FORMER DEPENDENTS			
CATEGORY	NO LONGER ENTITLED OR ELIGIBLE FOR	ELIGIBILITY FOR CHCBP COVERAGE	ELECTION OF COVERAGE
Dependent Spouse	TRICARE coverage under 10 USC Chapter 55 or 10 USC § 1145a.	Up to 36 months: 10 USC § 1072(b)4.	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility as a dependent spouse per 10 USC § 1072(A) ends or • Date of notification of CHCBP eligibility from the Uniformed Services.
Dependent Child <ul style="list-style-type: none"> • Child who marries: 10 USC § 1072(6). • Child under age 21 (under 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), or incapable of support: 10 USC § 1072(2)(D). • Legal ward under age 21, (under 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), or incapable of support: 10 USC § 1072(2)(I). • Child over age 21 (over 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) after TRICARE Young Adult (TYA) coverage ends: 10 USC § 1110b. 	TRICARE coverage under 10 USC Chapter 55 or 10 USC § 1145(a).	Up to 36 months: 10 USC 1078a(g)(1)(B). Note: There are no financial responsibility requirements for CHCBP.	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility as a dependent child per 10 USC § 1072(2)(D), 10 USC § 1072(I), or 10 USC § 1110b ends or • Date of notification of CHCBP eligibility from the Uniformed Services.

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FIGURE 10.4.1-1 CHCBP ELIGIBILITY TABLE (CONTINUED)

CHCBP ELIGIBILITY FOR UNREARRIED FORMER SPOUSES (URFSs)			
CATEGORY	NO LONGER ENTITLED OR ELIGIBLE FOR	ELIGIBILITY FOR CHCBP COVERAGE	ELECTION OF COVERAGE
URFS of member or former member who on the day before the date of the final divorce decree, dissolution, or annulment, was covered by 10 USC Chapter 55 or 10 USC § 1145(a)	TRICARE coverage under 10 USC Chapter 55 or 10 USC § 1145(a).	Up to 36 months: 10 USC § 1078a(g)(3); starts after one year of additional TRICARE coverage if eligible per 10 USC § 1072(2)(H).	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility as a URFS per 10 USC § 1072(2) ends or • Date of notification of CHCBP eligibility from the Uniformed Services.
URFS of a member or former member (other than the former spouse) whose marriage was dissolved after the separation of the member from the service unless such separation was by retirement if former spouse: <ul style="list-style-type: none"> • Has not remarried before age of 55; and • Eligible for TRICARE or enrolled in CHCBP during 18 month period before date of divorce, dissolution, or annulment; and • Receiving a portion of retired or retainer pay of member or former member or an annuity based on the retainer pay of the member; or • Has court order for payment of any portion of the retired or retainer pay or has a written agreement (voluntary or pursuant to a court order) which provides for an election by the member or former member to provide an annuity to the former spouse. 	TRICARE coverage under 10 USC Chapter 55 or 10 USC § 1145(a).	Unlimited per 10 USC § 1078a(g)(4).	Latter of 60 days from: <ul style="list-style-type: none"> • Date eligibility as a URFS per 10 USC § 1072(2) ends or • Date of notification of CHCBP eligibility from the Uniformed Services.

3.2 Notification of Eligibility

The Uniformed Services notify members eligible to receive health benefits under the CHCBP as part of pre-separation counseling and the Defense Manpower Data Center (DMDC) will notify other eligibles in writing. The 60-day application period begins the day following the end date of TRICARE coverage.

3.3 Purchase Period

To obtain continued coverage, written application by an eligible beneficiary must be submitted to the contractor before the end of the 60-day purchase period beginning as shown in [Figure 10.4.1-1](#) or the date the former beneficiary receives notification of eligibility. This date will correspond to the date of CHCBP brochures, fact sheets, etc., of which beneficiaries are expected to be aware.

3.7 Premiums

3.7.1 Rates

Premium rates are established by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) for two rate groups--individual and family. The rates are based on Federal Employee Health Benefit Program (FEHBP) employee and agency contributions required for a comparable health benefits plan, plus an administrative fee. The administrative fee, not to exceed 10% of the basic premium amount, is determined based on actual expected administrative costs for administration of the CHCBP. Premium rates may be updated annually and will be published when updated.

3.7.1.1 Rate Groups

3.7.1.2 Members or former members must select their rate group at the time they apply--either individual or family. If the member or former member purchases family coverage, family members cannot purchase self-only coverage. Otherwise, all other CHCBP purchasers must select the individual option.

3.7.1.3 Changing Rate Groups

Only the member or former member identified in [Figure 10.4.1-1](#) is eligible to change rate groups.

3.7.1.3.1 Family to Individual. After purchasing coverage, the member or former member may change from family to individual at any time by notifying the contractor in writing. At that point, only the member or former member can be covered under CHCBP.

3.7.1.3.2 Individual to Family. Changes from individual to family may be made by the member or former member when one of the following qualifying events has occurred:

- The birth of a child;
- Marriage of the member or former member;
- Legal adoption of a child;
- Placement by a court of a child as a legal ward in the member's or former member's home; or
- A child is no longer eligible to purchase TYA coverage.

3.7.1.3.3 If one of the above qualifying events has occurred, the member or former member may change his/her coverage from individual to family, effective the date of the qualifying event, if:

- The qualifying event occurred after the initial purchase of CHCBP coverage;

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- The member or former member sends a written request to the contractor no later than (NLT) 60 days from the date of the qualifying event (date of birth (DOB), date of marriage, etc.);
- The written request includes documentation of the qualifying event (a copy of the birth certificate, etc.) and the necessary additional premium. Premiums are to be prorated based upon the days of each type of coverage.

3.7.2 Payments

3.7.2.1 Premiums must be paid quarterly to the contractor NLT 30 days after the start of the coverage quarter.

3.7.2.2 Failure to make a premium payment as required will result in denial of continued CHCBP coverage and denial of payment for any services provided on or after the first day of the coverage quarter for which the premium payment was not paid. Beneficiaries denied coverage due to lack of premium payments will be locked out of the CHCBP as of the paid-through coverage end date, and will not be permitted to re-enroll.

4.0 EFFECTIVE DATES

4.1 October 1, 1994.

4.2 The effective coverage date for former beneficiaries not previously eligible to purchase CHCBP coverage before the NDAA for FY 2008, is no earlier than October 16, 2011.

- END -

TRICARE For Life (TFL) And Other Medicare-Eligible Beneficiaries

Issue Date: September 25, 2001
Authority: 10 USC 1086(d)

1.0 DESCRIPTION

Medicare eligibles who are beneficiaries based on age and whose TRICARE eligibility is determined by 10 United States Code (USC) Section 1086, are eligible for Medicare Part A, and who are enrolled in Medicare Part B, are eligible for the TRICARE For Life (TFL) benefit. Beneficiaries under age 65 who are also Medicare eligible, are also eligible for TFL (see the TRICARE Operations Manual (TOM), [Chapter 20, Section 1, paragraphs 2.4 and 2.5](#)).

2.0 POLICY

2.1 Introduction

Section 712 extends TRICARE eligibility to persons who would otherwise have lost their TRICARE eligibility due to attainment of entitlement to hospital insurance benefits under Part A of Medicare based on age. In order for these individuals to retain their TRICARE eligibility, they must **have Medicare Part B (Supplementary Medical Insurance (SMI))**. In general, **when medical care or, adjunctive dental care is provided to these individuals and payment may be made under both Medicare and TRICARE, Medicare is the primary payer and TRICARE will normally pay the actual out-of-pocket costs incurred by the person.**

2.2 Eligibility

The contractors shall determine from the Defense Enrollment Eligibility Reporting System (DEERS) if the individual is eligible for TFL. TFL claims are processed in accordance with TRICARE Operations Manual (TOM), [Chapter 20](#).

2.3 TFL beneficiaries, in most cases, are not eligible to enroll in TRICARE Prime (i.e., retirees and their family members who are 65 years of age or older, and who are entitled to Medicare Part A and who have Medicare Part B). See the TOM, [Chapter 6, Section 1, paragraph 2.0](#) for exceptions.

2.4 Appeal rights are covered in the TOM, [Chapter 12](#).

3.0 OTHER DUAL ELIGIBLE BENEFICIARIES

In addition to TFL beneficiaries, there are other categories of beneficiaries who have dual eligibility under both TRICARE and Medicare:

3.1 TRICARE beneficiaries who are age 65 or older and who are not entitled to premium-free Medicare Part A on their own record or the record of their current, former, or deceased spouse, but have Medicare Part B, remain TRICARE eligible and are eligible to enroll in TRICARE Prime.

3.2 Active Duty Family Members (ADFMs) who are age 65 or older and who are entitled to premium-free Medicare Part A only remain TRICARE eligible and are eligible to enroll in TRICARE Prime.

3.3 TRICARE beneficiaries (retirees and family members under age 65) who are entitled to premium-free Medicare Part A and have Medicare Part B are eligible to enroll in TRICARE Prime.

3.4 ADFMs under the age of 65 who are entitled to premium-free Medicare Part A remain TRICARE eligible and eligible to enroll in TRICARE Prime. (See Note regarding special enrollment periods for certain ADFMs.)

3.5 TRICARE eligible individuals who are entitled to premium-free Medicare Part A because of a disability, where Social Security Disability Insurance (SSDI) is awarded on appeal and there is a minimum six month gap between Medicare Part A and Part B effective dates, remain TRICARE eligible for the period where only Part A was effective. If a beneficiary declines Part B coverage, he/she will be ineligible for TRICARE from the original effective date of Part B until Part B coverage is established.

3.6 TRICARE beneficiaries eligible for premium-free Medicare Part A generally must have Medicare Part B to remain TRICARE eligible. If Part B coverage is required, but the beneficiary does not have it, the beneficiary is not eligible for any TRICARE benefits. If the beneficiary refused or declined Part B coverage when they first became eligible and subsequently enroll in Part B at a later date, TRICARE eligibility is restored on the Part B effective date of coverage. In the following circumstances, Part B is not required:

- Family Members of ADSMs;
- Enrollment in the Uniformed Services Family Health Plan (USFHP);
- Enrollment in the TRICARE Retired Reserve (TRR); or
- Enrollment in TRICARE Reserve Select (TRS).

Note: ADFMs whose Medicare entitlement is based on a disability are not required to have Part B until the sponsor retires and may enroll in Part B during a special enrollment period. 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 the family member enrolls in Part B after the sponsor's retirement date, there will be a break in TRICARE coverage. This special enrollment period does not apply to ADFMs whose Medicare entitlement is based on ESRD. While ADFMs with ESRD and USFHP/TRS enrollees are not required to have Medicare Part B, enrollment in Part B when the individual is first

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Chapter 10, Section 6.1

TRICARE For Life (TFL) And Other Medicare-Eligible Beneficiaries

eligible is encouraged. ESRD patients and USFHP/TRS enrollees may be required to pay the 10% Medicare surcharge for each 12-month period they were eligible to enroll in Part B, but did not. When USFHP/TRS beneficiaries are no longer enrolled in these programs, or when the sponsor of an ADFM with ESRD retires, they are not eligible for other TRICARE coverage without Part B.

- END -

TRICARE Reserve And National Guard (NG) Family Member Benefits

Issue Date: June 5, 2009

Authority: [32 CFR 199.4\(f\)\(2\)\(i\)\(H\)](#), Public Law 108-375, Sections 704 and 705

1.0 DESCRIPTION

1.1 The provisions of this section apply to family members who become eligible for TRICARE as a result of their Reserve Component (RC) sponsor (including those with delayed effective date orders up to **180** days) being called or ordered to active duty for more than 30 days in support of a federal contingency operation and choose to participate in TRICARE Standard or Extra, rather than enroll in TRICARE Prime.

1.2 These provisions help ensure timely access to health care and maintain clinically appropriate continuity of health care to family members of Reservists and **NG** members activated in support of a federal contingency operation, limit the out-of-pocket health care expenses for those family members, and remove potential barriers to health care access by **NG** and Reserve families.

2.0 BACKGROUND

2.1 Section 704 of the National Defense Authorization Act for Fiscal Year 2005 (NDAA FY 2005) (Public Law 108-375) established the authority to waive the annual TRICARE Standard deductible for RC family members who became eligible for TRICARE as a result of their sponsor's activation in support of a contingency operation. By law, the TRICARE Standard deductible for Active Duty Family Members (ADFM) is \$150 per individual, \$300 per family (\$50/\$100 for E-4s and below). Waiving the TRICARE deductible appropriately limits out-of-pocket expenses for these RC family members, many of whom may have already paid annual deductibles under their civilian health plans.

2.2 Section 705 of the NDAA FY 2005 established the authority to increase TRICARE payments up to 115% of the TRICARE maximum allowable charge, less the applicable patient cost share if not previously waived under the provisions of Section 704, for covered inpatient and outpatient health services received from a provider that does not participate (accept assignment) under TRICARE. This allows this group of RC family members to continue to see civilian providers with whom they have established relations and promotes access and clinically appropriate continuity of care.

2.3 The provisions outlined above were previously provided to RC family members under the provisions of the Operation Noble Eagle/Operation Enduring Freedom Reservist and National Guard (**NG**) Benefits Demonstration (TRICARE Operations Manual (TOM), [Chapter 18, Section 9](#)). This demonstration was effective for claims for services provided on or after September 14, 2001, and before November 1, 2009.

3.0 POLICY

3.1 This benefit is authorized for family members of RC members who are called or ordered to active duty for a period of more than 30 days, or NG members who are called or ordered to full-time federal NG duty for a period of more than 30 days in support of a contingency operation (as defined in 10 United States Code (USC) 101(a)(13)).

Note: This special benefit does not apply to Prime beneficiaries. Family members of Reservists or members of the NG who are called to active duty in support of operations identified in [paragraph 3.1](#) and who are enrolled in Prime will be protected when they receive services outside the network under the provisions of [the TOM, Chapter 8, Section 5](#).

3.2 Claims are to be paid from financially underwritten funds. On claims for care from non-participating professional providers, contractors shall allow the lesser of the billed charges or the balance billing limit (115% of the allowable charge). If the charges on a claim from a non-participating professional provider are exempt from the balance billing limit, the contractor shall allow the billed charges. This applies to all claims from non-participating professional providers for services rendered to Standard beneficiaries. In double coverage situations, normal double coverage requirements shall apply.

3.3 In order to protect beneficiaries from incurring greater out-of-pocket costs under these special procedures, the beneficiary cost-share for these claims will be limited to what it would have been in the absence of the higher allowable amount under this benefit. That is, the cost-share is 20% of the lesser of the CHAMPUS maximum Allowable Charge (CMAC) or the billed charge. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

3.4 The TRICARE Encounter Data (TED) record for each claim received subsequent to policy specified in [paragraph 3.1](#) must reflect the Special Processing Code "EF".

3.5 TED records submitted for non-participating professional claims that are reimbursed at the lesser of the balance billing limit or the billed charge are to be identified with Pricing Rate Code "W", but only if the allowed amount is greater than the CMAC. If the billed charge equals or is less than the CMAC, Pricing Rate Code "W" is not to be used. On the other hand, when the claim is reimbursed as billed because the billed charge is greater than the CMAC but less than the balance billing limit, or the charges are exempt from the balance billing limit, Pricing Rate Code "W" is to be used.

3.6 All Non-Availability Statement (NAS) requirements are waived for beneficiaries identified by Health Care Delivery Program (HCDP) Special Entitlement codes "02" or "03".

3.7 The TRICARE Standard and Extra deductible is waived for all beneficiaries identified by HCDP Special Entitlement codes "02" or "03".

- END -

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