

## DOUBLE COVERAGE

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### I. ISSUE

How are benefits to be coordinated when a beneficiary has coverage under another insurance plan, medical service or health plan (double coverage).

### II. POLICY

A. Existence of Other Coverage. Prior to payment of any claim for services or supplies rendered to any TRICARE beneficiary, regardless of eligibility status, it must be determined whether other coverage exists under any other insurance plan, medical service or health plan. If other coverage exists, TRICARE coverage is available only as secondary payer, and only after a claim has been filed with the other plan and a payment determination issued. This must be done regardless of any provisions contained in the other coverage. For example, a dependent child who is eligible through his/her natural parent may also be eligible for some other coverage through a step-parent. The step-parent's coverage is primary payer, regardless of any provision in that coverage which provides that the natural parent's coverage is primary.

B. Last Pay Limitation. Except for certain situations in which Medicare is the primary payer (see [paragraph II.H.](#), below), no more can be paid as secondary payer than would have been paid in the absence of other coverage.

C. Lack of Payment by Other Health Insurer. Amounts which have been denied by the other coverage simply because the claim was not filed timely with the other coverage or because the beneficiary failed to meet some other requirement of coverage cannot be paid. If a statement from the other coverage as to how much would have been paid had the claim met the other coverage's requirements is provided to the contractor, the claim can be processed as if the other coverage actually paid the amount shown on the statement. If no such statement is received, the claim is to be denied.

#### D. Definitions.

1. Insurance plan. An insurance plan is any plan or program which is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is

entitled by law or as a result of employment or membership in, or association with, an organization or group. An insurance plan provided to a beneficiary as a result of his or her status as a student (student insurance) is also included.

a. Not included are:

(1) So-called supplemental insurance plans which, for all categories of beneficiaries, provide solely for cash payment of deductibles, cost-shares, and amounts for non-covered services due to program limitations or for which the enrollee is liable; or

(2) Income maintenance programs which provide cash payments for periods of hospitalization or disability, regardless of the amount or type of services required or the expenses incurred. These plans are not intended to actually pay for medical services, but are intended only to supplement the beneficiary's income during a time of increased expenses, and perhaps lowered income. On the other hand, a plan which varies its benefits depending on the care received or the patient's diagnosis would be considered health insurance coverage as opposed to an income supplement and would be primary payer to TRICARE. Any payment made directly to the provider of care as opposed to the beneficiary can be assumed to be an insurance plan and not an income supplement; or

(3) State Victims of Crime Compensation Programs.

2. Medical service or health plan - A medical service or health plan is any plan or program of an organized health care group, corporation or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled by law or as a result of employment or membership in, or association with, an organization or group.

a. Not included are:

(1) Certain federal government programs which are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment or monetary contribution (e.g., Medicaid and Worker's Compensation).

(2) Health care delivery systems not considered within the definition of either an insurance plan, medical service or health plan including the Veterans Administration, the Maternal and Child Health Program, the Indian Health Services, and entitlement to receive care from Uniformed Services Medical Treatment Facility. These programs are designed to provide benefits to a distinct beneficiary population, and they require no premium payment or monetary contribution prior to obtaining care. When an individual is entitled to Veterans Administration service because of a service-connected disability and also is TRICARE-eligible, the individual must chose the program to use for each episode of care. Once that individual has selected the program of choice, crossover is not permitted for that episode of care.

E. No Waiver of Benefit From Other Insurer. Beneficiaries may not waive benefits due from any plan which meets the above definitions. Benefits are considered to be the services available. For example, if the other plan includes psychotherapy as a benefit, but only by a

psychiatrist, the beneficiary cannot elect to waive this benefit in order to receive services from a psychologist. For TRICARE for Life claims, an exception exists for mental health counselors and pastoral counselors.

F. **Beneficiary Liability.** In all double coverage situations, a beneficiary's liability is limited by all TRICARE provisions. As a result, a provider cannot collect from a CHAMPUS beneficiary any amount that would result in total payment to the provider that exceeds CHAMPUS limitations. For example, a beneficiary is not liable for any cost-sharing or deductible amounts required by the primary payer, if the sum of the primary payer's and TRICARE's payments are at least equal to the TRICARE negotiated allowable amount for a network provider. Similarly, if the sum of the primary payer's and TRICARE's payments are at least equal to 115% of the TRICARE allowable amount for a non-participating provider, the beneficiary is not liable for any additional amounts. This is true whether TRICARE actually makes any payment or not. This also applies to claims from participating non-network providers. Because of the payment calculations, the provider usually will receive payments from the primary payer and from TRICARE that equal the billed charges. In those rare cases where this does not occur, the provider cannot collect any amount from the beneficiary that would result in payment that exceeds the TRICARE allowable amount.

NOTE: It is important to note that this paragraph addresses beneficiary liability and does not change in any way the amounts TRICARE will pay based on provisions elsewhere in this section and in the Operations Manual.

G. Claims processed under the TRICARE/CHAMPUS DRG-based payment system or the inpatient mental health per diem payment system. When double coverage exists on a claim processed under the TRICARE/CHAMPUS DRG-based payment system or the inpatient mental health per diem payment system, the TRICARE payment cannot exceed an amount that, when combined with the primary payment, equals the lesser of the TRICARE/CHAMPUS DRG-based amount per diem based amount or the hospital's charges for the services (or the amount the hospital is obligated to accept as full payment). Thus, when the DRG-based amount or the per diem based amount is greater than the hospital's actual billed charge, and the primary payer has paid the full billed charge, TRICARE will make no additional payment. When the DRG-based amount or the per diem based amount is less than the hospital's actual billed charge, and the primary payer has paid the full DRG-based amount or per diem based amount, no additional payment can be made. Nor can the hospital bill the beneficiary for any amounts because of the participation limitations.

H. TRICARE and Medicare. Usually, whenever a TRICARE beneficiary is also eligible for Medicare benefits (either under Part A, "Hospital Insurance", or Part B, "Supplementary Medical Insurance"), Medicare is the primary payer. All claims for which the beneficiary is also eligible for Medicare are to be processed in accordance with [Chapter 4, Section 5, paragraph I](#). For clarification, when Medicare denies a claim as not a benefit; i.e., prescription drugs, and the service is a TRICARE benefit, the claim shall be adjudicated with TRICARE as primary payor. However, if Medicare denies a claim based on a medical necessity determination, no TRICARE benefits may be extended. The beneficiary may appeal to Medicare and if Medicare overturns their original decision, TRICARE will then adjudicate the claim as secondary payor. TRICARE will not accept appeals in any case, but will advise the beneficiary to appeal through Medicare.

I. TRICARE and Medicaid. Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting P.L. 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less.

J. Worker's compensation. All TRICARE benefits are specifically excluded for any medical service and supply provided to a TRICARE beneficiary to treat a work-related illness or injury for which benefits are available under a worker's compensation program. The TRICARE beneficiary may not elect to waive worker's compensation benefits in favor of using TRICARE, and it is the beneficiary's responsibility to apply for worker's compensation benefits.

1. Extending TRICARE Benefit.

a. The agency having authority to do so (as designated under the applicable worker's compensation law) shall have final authority in the determination of whether or not an illness or injury is work-related. If a TRICARE beneficiary exhausts available worker's compensation benefits, TRICARE will assume the case and benefits for otherwise covered services and supplies may be extended.

b. In worker's compensation cases which involve a lengthy investigation by the applicable worker's compensation agency before a decision can be made as to whether a case is work-related, or which involve an unusual delay because the TRICARE beneficiary elects to appeal an adverse decision by the worker's compensation agency, TRICARE benefits may be extended for otherwise covered services and supplies when authorized by the Executive Director, TMA (or a designee).

K. Program for Persons with Disabilities-PFPWD. All double coverage rules and procedures which apply to claims under the basic program are also to be applied to PFPWD claims. All local resources must be considered and utilized before TRICARE benefits under the PFPWD may be extended. If a TRICARE beneficiary who is otherwise eligible for benefits under the PFPWD is eligible for other federal, state, and/or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only on a secondary payer basis. The sponsor does not have the option of waiving available federal, state, and/or local assistance in favor of using TRICARE benefits.

L. The requirements of paragraph II.K. notwithstanding, TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individualized Family Service Plan and that are otherwise allowable under the TRICARE Basic Program or the PFPWD.

M. Claims with discounted rate agreements. Under special programs approved by the Executive Director, TMA (e.g., the Health Care Finder and Participating Provider Program),

where there is a negotiated (discounted) rate agreed to by the provider, benefits should be coordinated in accordance with the steps found in the Operations Manual.

**N.** Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

**O.** Medicaid. An exception to this policy is entitlement under any plan administered under Title XIX of the Social Security Amendments of 1965 (79Stat.286), Medicaid. TRICARE remains first pay to Medicaid.

**P.** No Legal Obligation to Pay. Payment should not be extended for services and supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary was not an eligible TRICARE beneficiary. Whenever possible, all double coverage claims should be accompanied by an explanation of benefits (EOB) from the primary insurer. If the existence of a participating agreement limiting liability of a beneficiary is evident on the EOB, payment is to be limited to that liability; however, if it is not clearly evident, the claim is to be processed as if no such agreement exists.

**Q.** Surrogate arrangements. Contractual arrangements between the surrogate mother and the adoptive parents are considered Other Coverage. TRICARE will cost share on the remaining balance of otherwise covered benefits related to the surrogate mother's medical expenses after the contractually agreed upon amount has been exhausted. This applies where contractual arrangements for payment include a requirement for the adoptive parents to pay all or part of the medical expenses of the surrogate mother as well as where contractual arrangements for payment do not specifically address reimbursement for the mother's medical care.

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