



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 88
7950.1-M
MARCH 14, 2011

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE SYSTEMS MANUAL (TSM), AUGUST 2002**

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

CHANGE TITLE: TRICARE YOUNG ADULT (TYA) PROGRAM

CONREQ: 15257

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): While not specifically mandated by the Patient Protection and Affordable Care Act (PPACA), once passed into law, the TYA Program will markedly mimic the extended dependent coverage up to age 26 coverage provided under the PPACA. The TYA Program will provide extended dependent coverage for qualified military dependents who age out of TRICARE coverage at age 21 (age 23 if a full-time college student) and provide premium-based TRICARE Standard/Extra coverage up to age 26.

EFFECTIVE DATE: January 1, 2011 (Standard Only).

IMPLEMENTATION DATE: May 1, 2011 (Standard Only).

This change is made in conjunction with Aug 2002 TOM, Change No. 115.


Jack Arendale
Chief, Purchased Care Systems
Integration Branch

ATTACHMENT(S): 18 PAGES
DISTRIBUTION: 7950.1-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

CHANGE 88
7950.1-M
MARCH 14, 2011

REMOVE PAGE(S)

CHAPTER 2

Section 5.1, pages 7 through 10
Section 6.3, pages 17 through 20
Addendum M, pages 5 and 6

CHAPTER 3

Section 1.3, pages 11 through 16

INSERT PAGE(S)

Section 5.1, pages 7 through 10
Section 6.3, pages 17 through 20
Addendum M, pages 5 through 7

Section 1.3, pages 11 through 17

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

**ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (SPONSOR)
(1-066) (CONTINUED)**

		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
		412	TRS SURVIVOR NEW FAMILY COVERAGE OR
		413	TRS MEMBER-ONLY COVERAGE OR
		414	TRS MEMBER AND FAMILY COVERAGE OR
		418	TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE OR
		419	TRR MEMBER AND FAMILY COVERAGE OR
		420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
		421	TRR SURVIVOR FAMILY COVERAGE
1-066-02R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
		G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
		J	ACADEMY STUDENT OR
		P	TAMP MEMBER OR
		S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
1-066-03R	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN ONE OCCURRENCE OF OVERRIDE CODE =	M	NATO

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CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (1-070)

VALIDITY EDITS

1-070-01V MUST BE A VALID HCC MEMBER RELATIONSHIP CODE (REFER TO [CHAPTER 2, SECTION 2.5](#))

RELATIONAL EDITS

1-070-01R IF PATIENT AGE¹ < 17
 THEN HCC MEMBER RELATIONSHIP CODE ≠ A SELF

1-070-02R IF PATIENT AGE¹ < 12
 THEN HCC MEMBER RELATIONSHIP CODE ≠ B SPOUSE **OR**
 G SURVIVING SPOUSE
 UNLESS ONE OCCURRENCE OF
 OVERRIDE CODE = B PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE

1-070-04R IF PATIENT AGE¹ < 34
 THEN HCC MEMBER RELATIONSHIP CODE ≠ H FORMER SPOUSE (20/20/20) **OR**
 I FORMER SPOUSE (20/20/15) **OR**
 J FORMER SPOUSE (10/20/10) **OR**
 K FORMER SPOUSE (TRANSITIONAL ASSISTANCE (COMPOSITE))
 AND HCC MEMBER CATEGORY CODE ≠ W FORMER SPOUSE
 UNLESS ONE OCCURRENCE OF
 OVERRIDE CODE = I PATIENT IS A FOMER SPOUSE UNDER 34 YEARS OF AGE

1-070-05R IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER
 AND HCC MEMBER RELATIONSHIP CODE ≠ A SELF
 THEN HCC MEMBER RELATIONSHIP CODE MUST = B SPOUSE **OR**
 C CHILD OR STEPCHILD **OR**
 D PRE-ADOPTIVE CHILD **OR**
 E WARD (COURT ORDERED)

1-070-06R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
 THEN HCC MEMBER RELATIONSHIP CODE MUST = B SPOUSE **OR**
 C CHILD OR STEPCHILD **OR**
 D PRE-ADOPTIVE CHILD **OR**

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (1-070) (CONTINUED)	
	E WARD (COURT ORDERED) OR
	G SURVIVING SPOUSE
1-070-07R	IF HCC MEMBER CATEGORY CODE =
	H MEDAL OF HONOR RECIPIENT
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	A SELF OR
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	G SURVIVING SPOUSE
1-070-08R	IF HCC MEMBER CATEGORY CODE =
	T FOREIGN MILITARY MEMBER
	AND HCC MEMBER RELATIONSHIP CODE =
	A SELF
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	AN SHCP - NON-REFERRED CARE OR
	AR SHCP - REFERRED OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
	OR ENROLLMENT/ HEALTH PLAN CODE MUST =
	SN SHCP - NON-MTF REFERRED OR
	SO SHCP - NON-TRICARE ELIGIBLE OR
	SR SHCP - REFERRED
	UNLESS TYPE OF SUBMISSION =
	D COMPLETE DENIAL OF INITIAL TED
	THEN BYPASS THIS EDIT
¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.	

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: PERSON LAST NAME (PATIENT) (1-076)

VALIDITY EDITS

1-076-01V MUST BE AT LEAST 1 CHARACTER (LEFT-JUSTIFIED).

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON FIRST NAME (PATIENT) (1-077)

VALIDITY EDITS

NONE

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON MIDDLE NAME (PATIENT) (1-078)

VALIDITY EDITS

NONE

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON CADENCY NAME (PATIENT) (1-079)

VALIDITY EDITS

NONE

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON IDENTIFIER (PATIENT) (1-080)

VALIDITY EDITS

1-080-01V MUST BE 9 NUMERIC DIGITS AND CANNOT EQUAL ALL BLANKS.

RELATIONAL EDITS

NONE

ELEMENT NAME: PERSON IDENTIFIER TYPE CODE (PATIENT) (1-081)

VALIDITY EDITS

1-081-01V MUST HAVE A VALID VALUE LISTED IN [CHAPTER 2, SECTION 2.7](#).

RELATIONAL EDITS

NONE

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: PAY PLAN CODE (SPONSOR) (2-292)	
VALIDITY EDITS	
2-292-01V	MUST BE A VALID PAY PLAN CODE (SPONSOR) (REFER TO SECTION 2.7)
RELATIONAL EDITS	
2-292-01R	IF HCC MEMBER CATEGORY CODE =
	T FOREIGN MILITARY MEMBER
	THEN PAY PLAN CODE (SPONSOR) MUST =
	FA FOREIGN SERVICE CHIEFS OF MISSION OR
	FC FOREIGN COMPENSATION AGENCY FOR INTERNATIONAL DEVELOPMENT OR
	FD FOREIGN DEFENSE OR
	FE SENIOR FOREIGN SERVICE OR
	FO FOREIGN SERVICE OFFICERS OR
	FP FOREIGN SERVICE PERSONNEL OR
	FZ CONSULAR AGENT DEPARTMENT OF STATE OR
	MC CADET OR
	ME ENLISTED OR
	MO OFFICER OR
	MW WARRANT OFFICER OR
	ZZ NOT APPLICABLE
2-292-02R	IF SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) =
	H PHS OR
	O NOAA
	THEN PAY PLAN CODE (SPONSOR) MUST ≠
	ME ENLISTED
2-292-03R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF ECHO
	THEN PAY PLAN CODE (SPONSOR) MUST =
	ME ENLISTED OR
	MO OFFICER OR
	MW WARRANT OFFICER OR
	ZZ NOT APPLICABLE

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295)

VALIDITY EDITS

2-295-01V MUST BE A VALID HCC MEMBER RELATIONSHIP CODE (REFER TO [SECTION 2.5](#))

RELATIONAL EDITS

2-295-01R IF PATIENT AGE¹ < 17.

THEN HCC MEMBER RELATIONSHIP CODE MUST ≠ A SELF

2-295-02R IF PATIENT AGE¹ < 12

THEN HCC MEMBER RELATIONSHIP CODE MUST ≠ B SPOUSE **OR**
G SURVIVING SPOUSE

UNLESS ONE OCCURRENCE OF OVERRIDE CODE = B PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE

2-295-04R IF PERSON BIRTH CALENDAR DATE (PATIENT) INDICATES AGE¹ < 34

THEN HCC MEMBER RELATIONSHIP CODE ≠ H FORMER SPOUSE (20/20/20) **OR**
I FORMER SPOUSE (20/20/15) **OR**
J FORMER SPOUSE (10/20/10) **OR**
K FORMER SPOUSE (TRANSITIONAL ASSISTANCE (COMPOSITE))

AND HCC MEMBER CATEGORY CODE ≠ W FORMER SPOUSE

UNLESS ONE OCCURRENCE OF OVERRIDE CODE = I PATIENT IS A FORMER SPOUSE UNDER 34 YEARS OF AGE

2-295-05R IF HCC MEMBER CATEGORY CODE =

T FOREIGN MILITARY MEMBER

AND HCC MEMBER RELATIONSHIP CODE ≠ A SELF

THEN HCC MEMBER RELATIONSHIP CODE MUST CODE MUST = B SPOUSE **OR**

C CHILD OR STEPCHILD **OR**

D PRE-ADOPTIVE CHILD **OR**

E WARD (COURT ORDERED)

2-295-06R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =

PF ECHO

THEN HCC MEMBER RELATIONSHIP CODE MUST = B SPOUSE **OR**

C CHILD OR STEPCHILD **OR**

D PRE-ADOPTIVE CHILD **OR**

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.

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CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (2-295) (CONTINUED)	
	E WARD (COURT ORDERED) OR
	G SURVIVING SPOUSE
2-295-07R	IF TYPE OF SERVICE (FIRST POSITION) =
	A AMBULATORY SURGERY COST-SHARED AS INPATIENT
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	A SELF OR
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	D PRE-ADOPTIVE CHILD OR
	E WARD (COURT ORDERED) OR
	G SURVIVING SPOUSE OR
	Z UNKNOWN
	AND HCC MEMBER CATEGORY CODE ≠
	W FORMER SPOUSE
	UNLESS ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SC SHCP - NON-TRICARE ELIGIBLE
2-295-08R	IF HCC MEMBER CATEGORY CODE =
	H MEDAL OF HONOR RECIPIENT
	THEN HCC MEMBER RELATIONSHIP CODE MUST =
	A SELF OR
	B SPOUSE OR
	C CHILD OR STEPCHILD OR
	G SURVIVING SPOUSE
2-295-10R	IF HCC MEMBER CATEGORY CODE =
	T FOREIGN MILITARY MEMBER
	AND HCC MEMBER RELATIONSHIP CODE =
	A SELF
	THEN ANY OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	AN SHCP - NON-REFERRED CARE OR
	AR SHCP - REFERRED CARE OR
	SC SHCP - NON-TRICARE ELIGIBLE OR
	SM SHCP - EMERGENCY
	OR ENROLLMENT/ HEALTH PLAN CODE CODE MUST =
	SN SHCP - NON-MTF REFERRED OR
	SO SHCP - NON-TRICARE ELIGIBLE OR
	SR SHCP - REFERRED OR
	SU SHCP - REFERRAL DESIGNATION UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = ZERO

¹ **PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.**

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CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

**ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE
(2-295) (CONTINUED)**

THEN BYPASS THIS EDIT

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN CARE DATE.

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CHAPTER 2, ADDENDUM M

DATA REQUIREMENTS - HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE VALUES

VALID VALUE	DESCRIPTION
214	TRICARE Dental Plan Individual Coverage for Active Guard/Reserve (AGR) Family Members
215	TRICARE Dental Plan Family Coverage for Active Guard/Reserve (AGR) Family Members
216	TRICARE Dental Plan Individual Remote Coverage for Active Guard/Reserve (AGR) Family Members
217	TRICARE Dental Plan Family Remote Coverage for Active Guard/Reserve (AGR) Family Members
218	TRICARE Dental Plan Individual Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
219	TRICARE Dental Plan Family Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
220	TRICARE Dental Plan for Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
221	TRICARE Dental Plan Individual Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Member
222	TRICARE Dental Plan Family Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
223	TRICARE Dental Plan Individual Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
224	TRICARE Dental Plan Family Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
225	TRICARE Dental Plan Individual Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors
226	TRICARE Dental Plan Family Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors
227	TRICARE Dental Plan for Non-Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
228	TRICARE Dental Plan Individual Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
229	TRICARE Dental Plan Family Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
230	TRICARE Dental Plan Individual Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
231	TRICARE Dental Plan Family Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
301	BRAC Pharmacy
302	Pharmacy Redesign Pilot Project (PRPP)
400	TRICARE Extended Care Health Option (ECHO) Program

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CHAPTER 2, ADDENDUM M

DATA REQUIREMENTS - HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE VALUES

VALID VALUE	DESCRIPTION
401	TRICARE Reserve Select Tier 1 Member-Only Coverage (Contingency Operations)
402	TRICARE Reserve Select Tier 1 Member and Family Coverage (Contingency Operations)
403	Tobacco Cessation Demonstration Program
404	Weight Management Demonstration Program
405	TRICARE Reserve Select Tier 2 Member-Only Coverage (Certified Qualifications)
406	TRICARE Reserve Select Tier 2 Member and Family Coverage (Certified Qualifications)
407	TRICARE Reserve Select Tier 3 Member-Only Coverage (Service Agreement)
408	TRICARE Reserve Select Tier 3 Member and Family Coverage (Service Agreement)
409	TRICARE Reserve Select Survivor Continuing with Individual Coverage
410	TRICARE Reserve Select Survivor Continuing with Family Coverage
411	TRICARE Reserve Select Survivor New Individual Coverage
412	TRICARE Reserve Select Survivor New Family Coverage
413	TRICARE Reserve Select Member-Only Coverage
414	TRICARE Reserve Select Member and Family Coverage
415	Wounded, Ill, and Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))
416	Wounded, Ill, and Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))
417	Transitional Care For Service-Related Conditions (TCSRC)
418	TRICARE Retired Reserve Member-Only Coverage
419	TRICARE Retired Reserve Member and Family Coverage
420	TRICARE Retired Reserve Survivor Individual Coverage
421	TRICARE Retired Reserve Survivor Family Coverage
422	TRICARE Young Adult TRICARE Standard for Active Duty Family Members
423	TRICARE Young Adult TRICARE Standard for Retired and Medal of Honor Family Members
424	TRICARE Young Adult TRICARE Reserve Select
425	TRICARE Young Adult TRICARE Retired Reserve
426	TRICARE Young Adult TRICARE Prime for Active Duty Family Members
427	TRICARE Young Adult TRICARE Prime Remote for Active Duty Family Members
428	TRICARE Young Adult TRICARE Prime for Retired and Medal of Honor Family Members

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CHAPTER 2, ADDENDUM M

DATA REQUIREMENTS - HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE VALUES

VALID VALUE	DESCRIPTION
429	TRICARE Young Adult TRICARE Overseas Prime for Active Duty Family Members
430	TRICARE Young Adult TRICARE Overseas Prime Remote for Active Duty Family Members
602	Direct Care and TRICARE Mail Order Pharmacy (TMOP) and Retail Pharmacies
603	Direct Care Only
999	Unverified Newborn

PCM. Since in some locations PCMs are not available, **ADFM**s may be enrolled in TPR without a PCM assignment.

There is a Point of Service (POS) option under this program. TRICARE utilization review and utilization management requirements do apply to this program.

6.1.2.5. Health Care Plan: TRICARE Plus

The TRICARE Plus program is a **DC**-based program that became effective October 1, 2001. Enrolled beneficiaries must be eligible for DC, and may or may not have an entitlement to **CHC**. There are two types of TRICARE Plus coverage to differentiate between those beneficiaries with a CHC entitlement and those without. Coverage is at the individual level. There are no family policies. A family may have more than one individual policy, with each family member holding an individual policy.

6.1.2.6. Health Care Plan: USFHP

The USFHP is a TRICARE program for major medical health care, preventive care, and medically necessary care including prescription drug coverage. The USFHP is currently composed of civilian health care facilities contracted by the DoD to provide health care through the USFHP. USFHP enrollees are enrolled into the TRICARE Prime coverage plans with a USFHP PCM **Network Provider Type Option Code of 'U'**. The USFHP also covers beneficiaries age 65 and over that are Medicare-eligible, as well as dependent parent and parent-in-laws that have been grandfathered into the program. The beneficiaries are enrolled in separate USFHP plans for persons only having a DC entitlement. (See [Chapter 3, Addendum C for HCDP and PCM Network Provider Type Codes.](#))

6.1.2.7. Health Care Plan: TRICARE Senior Prime (TSP)

This coverage plan is referenced for historical purposes only.

Beneficiaries who were eligible for DC as well as Medicare may have chosen to enroll into the **TSP** coverage plan demonstration. Enrollees in this program selected a PCM in a participating MTF and were enrolled for the longevity of the program, which ended on December 31, 2001. Enrollment fees did not apply to this program. **TSP** did not offer a family coverage option, but allowed more than one individual plan for a family.

6.1.2.8. Health Care Plan: FEHBP Demonstration Project

The **NDAA** FY 1999 directed the DoD and the Office of Personnel Management (OPM) to develop a demonstration project to allow Medicare eligible military retirees age 65 and over, their family members, certain unremarried former spouses of military members or former members, and family members of deceased military members or former members to enroll into an FEHBP coverage plan for their health care.

The FEHBP demonstration project lasts three years at ten demonstration sites. Health care coverage began January 1, 2000 and ends December 31, 2002. Enrollment is managed through the FEHBP Demonstration Project Information Processing Center. The eligibility criteria and program requirements are beyond the scope of this document.

MCSCs do not perform enrollments for FEHBP.

6.1.2.9. Health Care Plan: CHCBP

The CHCBP is optional coverage to which beneficiaries may subscribe for a specified period (not to exceed 36 months) after the sponsor's entitlement to DoD benefits ends. Enrollment into the CHCBP program is performed by the CHCBP enrollment contractor. Details of this program are beyond the scope of this document (see the TPM, [Chapter 10, Section 4.1](#)).

6.1.2.10. Health Care Plan: TRICARE Reserve Select (TRS) Program

The TRS program is optional coverage to which Reserve Component (RC) members may subscribe when they commit to continued service in the Selected Reserve after release from AD to which the member was called or ordered for a period of more than 30 days on or after September 11, 2001, under one of the activation authorities in Section 101(a)(13)(B) of Title 10, [United States Code \(USC\)](#) and have served continuous for 90 days or more pursuant to such call or order to AD unless such continuous service on AD is less than 90 days solely due to an injury, illness or disease incurred or aggravated while deployed. Beneficiaries enrolled in the TRS program are not entitled to care at the MTF and must pay a premium for coverage.

6.1.2.11. Health Care Plan: TRICARE Retired Reserve (TRR) Program

TRR is a premium-based TRICARE health plan available for purchase by qualified members of the Retired Reserve and qualified survivors that offers health coverage for Retired Reserve members and their eligible family members. The RCs will validate members' and survivors' qualifications to purchase TRR coverage and will identify qualified members/survivors in the DEERS. Beneficiaries enrolled in the TRR program are entitled to care at the MTF.

6.1.2.12. Health Care Plan: TRICARE Young Adult (TYA) Standard

TYA Standard is a premium-based TRICARE health plan available for purchase by qualified young adult dependents/survivors of ADSMs, retired service members, members of the Selected Reserve, and members of the Retired Reserve. This plan allows young adult dependents to purchase TRICARE Standard coverage until reaching the age of 26, after they have lost eligibility for TRICARE due to age and not otherwise eligible for TRICARE Program medical coverage. Beneficiaries purchasing TYA Standard coverage are entitled to space available care at the MTF.

6.1.2.13. Health Care Plan: TRICARE Young Adult Prime

TYA Prime is a premium-based TRICARE health plan available for purchase by qualified young adult dependents/survivors of ADSMs and retired service members. These plans allow young adult dependents to purchase TRICARE Prime coverage until reaching the age of 26, after they have lost eligibility for TRICARE due to age and not otherwise eligible for TRICARE Program medical coverage. Beneficiaries may enroll to a PCM in their regional contractor network, within a MTF, or a USFHP.

6.2. Special Health Care Programs

6.2.1. DEERS supports any special health care program mandated by the DoD. These special health care programs are programs into which a beneficiary can enroll or register, regardless of other assigned or enrolled health care coverage plans to which they are entitled.

6.2.2. TRICARE Extended Care Health Option (ECHO). ECHO beneficiaries must be ADFMs, have a qualifying condition, and be registered to receive ECHO benefits on DEERS. MCSCs and USFHP providers are required to review appropriate documentation, including registration documents, and ascertain that individuals are ECHO eligible. Once a determination that an individual is ECHO eligible, MCSCs and USFHP providers must register the individual on DEERS. Registration will be performed through a Government Furnished Equipment (GFE) application and will include entering at least the following information, 1) ECHO, as a Special Health Care Coverage Plan Code, and 2) Registration Start Date. (NOTE: If the Begin Date is not entered, DOES will enter a default date using the 20th of the month rule.) ECHO-related codes needed for claims processing purposes shall be returned as a Special Health Care Program within the Health Care Coverage Claims Response. Contractors may also utilize the web-based General Inquiry of DEERS (GIQD) application to obtain ECHO coverage information. See the TPM and TRICARE Operations Manual (TOM) for details regarding this program.

7.0. IDENTIFICATION SCHEMA FOR ELECTRONIC DATA INTERCHANGE (EDI)

7.1. Primary And Secondary Identifiers

Identification of persons in the DEERS database is established via primary identifiers and secondary identifiers. A primary identifier must be unambiguous, so that information systems and software can process it without the need for intervention by users or artificial intelligence technology. Secondary identifiers can be ambiguous and must be processed by users who match these secondary identifiers to persons in the DEERS database. Because secondary identifiers are ambiguous, system users generally use more than one secondary identifier to minimize mistakes in the identification process. More information on primary and secondary identifiers is explained in the next section of this document.

7.2. Person Identification

Sources external to DEERS identify persons initially in the DEERS database using only secondary identifiers. DEERS is the definitive system for person identification. The secondary identifiers are:

- Sponsor's SSN
- First three characters of the last name
- DOB

If only the SSN is provided, duplicate records are often resolved manually and thus system-to-system identification cannot be done. The last name and DOB are used to resolve duplications when two or more individuals have the same SSN, and to correct inaccurate identification of persons caused by using only the SSN. Usually, a person may be positively

identified by an end user by matching an SSN along with the first three characters of the last name and the DOB. Data for both sponsors and individual family members may be accessed in this manner.

Since DEERS does not contain every family member's SSN, the user may access these individuals by using the sponsor's secondary identification information. This returns a list of each family member associated with the sponsor.

7.3. Beneficiary Identification

Beneficiaries in the DEERS database are positively identified using a system-generated DEERS ID. DEERS IDs are internal to DEERS and its interface systems, and therefore are not entered by users. As previously stated, each DEERS ID is a primary identifier, and formed by a combination of the following:

- Family ID, a DEERS-assigned nine-digit number unique to each family, plus a
- Beneficiary ID, a DEERS-assigned two-digit number unique to each individual in a family

Although a person may have more than one DEERS ID, stemming from multiple entitlements (defined previously), DEERS IDs positively identify each beneficiary. DEERS IDs, therefore, serve as primary identifiers and are used by information systems when passing data about individual beneficiaries and families.

A person may have multiple DEERS IDs over time and some of these instances are described as follows:

- A person may be entitled to DoD benefits via his or her simultaneous association to more than one sponsor. For example, a person may be a family member in two sponsored families at the same time. This situation occurs when both spouses in a family are sponsors. This condition is known as multiple entitlements.
- Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and he or she becomes a sponsor. In this case, the person would have a DEERS ID as a family member and as a sponsor. However, becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

7.4. Secondary Identification

In order to obtain a DEERS ID for a beneficiary, a system interfacing with DEERS must provide secondary identification information in one of several forms. This ensures the correct beneficiary is found, received, and stored with a DEERS ID. In the table below, the "Inquiry Information" column describes required information entering DEERS, and the "Response" column describes information returned by DEERS.

FIGURE 3-1.3-1 SECONDARY IDENTIFICATION

INQUIRY INFORMATION	RESPONSE
Family Member's Person Identifier and Person Identifier Type Code (S=SSN, D=DEERS assigned Temporary ID, F=DEERS assigned Foreign ID), Inquiry Person Type Code (sponsor or family member), Last Name and DOB (optional).	Family member option may return more than one DEERS ID if this beneficiary is in more than one family. User must then select correct beneficiary.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional), and family option.	Returns entire family of beneficiaries (one DEERS Family ID). User must select beneficiary from family.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional). AND Family Member's Person Identifier and Person Identifier Type Code (S=SSN, D=DEERS assigned Temporary ID, F=DEERS assigned foreign ID).	Returns one beneficiary.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional). AND Family Member's First Name and DOB.	Usually returns only one beneficiary except in some rare cases of same named twins.

7.5. Patient Identification

Patients have a primary identifier called the Patient ID, which is a DEERS-assigned ten-digit number. This is used similarly to the DEERS ID, although the primary purpose is to reliably access patient and person level information. DEERS generates a Patient ID to link all MHS systems. The MCSC system must accommodate both the DEERS Patient ID and the HIPAA Patient ID.

7.6. Person Identification For Business Events

The following table identifies the options and type of data necessary to perform a DEERS/Medical business event for system-to-system interactions.

Legend (an "X" in a column indicates that the information may be used):

- Secondary identification: refer to the secondary identification section above.
- Individual/Family: indicates if the business event can be done for an individual, a family, or both.
- Refer to the specific business events throughout the Interface Operational Description (IOD) and the DEERS Business Rules for additional information.

FIGURE 3-1.3-2 PERSON IDENTIFICATION FOR BUSINESS EVENTS

PERSON IDENTIFICATION FOR BUSINESS EVENTS				
SECONDARY IDENTIFICATION	DEERS ID	PATIENT ID	INDIVIDUAL/FAMILY	BUSINESS EVENT
	X	X	I	Policy Notification
	X (Subscriber only)		I, F Depending on policy type	Enrollment Fee Payment
	X (Subscriber only)		I, F Depending on policy type	Disenrollment for failure to pay fees
X			I, F Depending on policy type	Enrollment Fee Payment Transaction History Request
X			I, F	Health Care Coverage Inquiry for Claims
	X		I	Catastrophic Cap & Deductible Updates
X			I, F	Catastrophic Cap & Deductible Transaction History Request
	X		I, F	Catastrophic Cap & Deductible Totals Inquiry
		X	I	OHI Notification
		X	I, F	OHI Inquiry
		X	I, F	OHI Policy Add/Update
		X	I, F	OHI Cancellation

7.7. HCDP Enrollment Management Contractor Identification

HCDP Enrollment Management Contractors are entities that are authorized to enroll MHS-eligible sponsors and family members into DoD coverage plans and are responsible for maintaining an individual’s HCDP policy. The organizations include MCSCs and USFHP providers and are referred to as enrolling organizations. DEERS tracks the enrolling organization that is responsible for an individual’s policy. A person only has one enrollment management contractor that is responsible for managing their coverage at any given point in time. DEERS creates a system identifier for each enrolling organization, and distributes the identifier to each system. Each MCSC and USFHP provider system has a system identifier for each contract, not region. This system identifier is used to identify the MCSC or USFHP provider system in system-to-system interactions with DEERS.

7.8. PCM Enrolling Division Identification

The PCM Enrolling Division is the organization that is primarily responsible for delivering the beneficiary’s health care. This represents a grouping of providers in the Civilian, DC, resource sharing, and USFHP networks. Examples include MTFs, satellite clinics of MTFs, and possibly clinics within the MTF. DEERS maintains a table of organizations into which eligible subscribers and family members are enrolled. These organizations are identified by Defense Medical Information System (DMIS) IDs, which are associated to the regions in which they are located.

The MCSC shall implement each monthly DMIS table on the first day of the month following the download. Downloads are available on the DMIS web site.

7.9. PCM Identification

DEERS uses the MCSC PCM ID as an interim solution until a National Provider Identifier (NPI) becomes available. At that time, DEERS will utilize the NPI. MCSCs must not re-use PCM IDs. The MCSC is responsible for providing a crosswalk for converting PCM assignments from the MCSC provider ID to the national provider ID. The PCM ID cannot exceed 32 bytes.

7.10. Policy Identification

The MCSC must be able to match a policy using this information. DEERS uses the following combination to uniquely identify a policy:

- DEERS Family ID
- HCDP Type
- HCDP Plan Coverage Code
- DEERS Policy Begin Date

A sponsor can be a subscriber to multiple policies.

