OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 94
7950.1-M
MAY 7, 2012

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: **ENROLLMENT FEES/PREMIUM SYSTEM CHANGES**

CONREQ: 16001

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change adds the new process for managing fees and premiums collected and posted to Defense Enrollment Eligibility Reporting System (DEERS), adds language on how the paid-through dates are calculated by DEERS, adds the new Fiscal Year (FY) 2012 TRICARE Prime Enrollment Fees, and adds two categories of beneficiaries exempted from paying any future increases to the TRICARE Prime Fees: Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Service Members and their dependents

EFFECTIVE DATE: October 1, 2011: For adding the new FY12 Enrollment Fee and the two categories of beneficiaries exempted.
October 1, 2012: For the new process and paid-through date.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TOM, Change No. 141 and Aug 2002 TRM, Change No. 151.

Jack Arendale
Chief, Purchased Care Systems
Integration Branch

ATTACHMENT(S): **60 PAGES**
DISTRIBUTION: **7950.1-M**

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

REMOVE PAGE(S)	**INSERT PAGE(S)**
CHAPTER 2	
Addendum M, pages 1 through 7	Addendum M, pages 1 through 7
CHAPTER 3	
Section 1.5, pages 1 through 49	Section 1.5, pages 1 through 53

CHAPTER 2
ADDENDUM M

DATA REQUIREMENTS - HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE VALUES

VALID VALUE	DESCRIPTION
000	No health care coverage plan (transfer records only)
001	Direct Care for Active Duty Sponsors
002	Direct Care for Active Duty Family Members
003	TRICARE Standard for Active Duty Family Members
004	Direct Care for Survivors of Active Duty Deceased Sponsors
005	TRICARE Standard for Survivors of Active Duty Deceased Sponsors
006	Direct Care for Transitional Assistance Family Members
007	TRICARE Standard for Transitional Assistance Sponsors and Family Members
008	Direct Care for Retired Sponsors and Family Members
009	TRICARE Standard for Retired and Medal of Honor Sponsors and Family Members
010	TRICARE Standard for Transitional Survivors of Active Duty Deceased Sponsors
011	Direct Care for CONUS DoD Affiliates
012	TRICARE Standard for CONUS DoD Affiliates
013	Direct Care for OCONUS DoD Affiliates
014	Direct Care for Transitional Survivors of Active Duty Deceased Sponsors
015	TRICARE Standard for Transitional Survivors of Guard/Reserve Deceased Sponsors
016	Direct Care for Survivors of Guard/Reserve Deceased Sponsors
017	TRICARE Standard for Survivors of Guard/Reserve Deceased Sponsors
018	TRICARE for Life for Retired Sponsors and Family Members and Medal of Honor
019	Limited Direct Care with Line of Duty Injuries for Guard/Reserve Sponsors
020	TRICARE for Life for Transitional Survivors of Active Duty Deceased Sponsors
021	TRICARE for Life for Survivors of Active Duty Deceased Sponsors
022	TRICARE for Life for Transitional Survivors of Guard/Reserve Deceased Sponsors
023	TRICARE for Life for Survivors of Guard/Reserve Deceased Sponsors
024	Direct Care for Transitional Survivors of Guard/Reserve Deceased Sponsors
025	Direct Care Dental For Active Duty Sponsors
026	Direct Care Dental For Active Duty Foreign Military

VALID VALUE	DESCRIPTION
027	Direct Care for Early Alert for Guard/Reserve Service Members
028	TRICARE Standard for Medically Retired Sponsors and Family Members
029	TRICARE for Life for Medically Retired Sponsors and Family Members
101	CHAMPUS Reform Initiative (CRI) - CHAMPUS Prime (history)
102	Fort Sill - Catchment Area Management (CAM) Program (history)
103	Fort Carson – Catchment Area Management (CAM) Program (history)
104	Bergstrom Air Force Base (AFB) - Catchment Area Management (CAM) program (history)
105	Luke/Williams Air Force base (AFB) - Catchment Area Management (CAM) Program (history)
106	TRICARE Prime Individual Coverage for Active Duty Sponsors
107	TRICARE Prime Individual Coverage for Active Duty Family Members
108	TRICARE Prime Family Coverage for Active Duty Family Members
109	TRICARE USFHP Direct Care Coverage for Active Duty Family Members
110	TRICARE Prime for Individual Coverage for Survivors of Active Duty Deceased Sponsors
111	TRICARE Prime Family Coverage for Survivors of Active Duty Deceased Sponsors
112	TRICARE Prime Individual Coverage for Transitional Assistance Sponsors and Family Members
113	TRICARE Prime Family Coverage for Transitional Assistance Sponsors and Family Members
114	TRICARE USFHP Direct Care Individual Coverage for Survivors of Active Duty Deceased Sponsors
115	TRICARE USFHP Direct Care Family Coverage for Survivors of Active Duty Deceased Sponsors
116	TRICARE Prime Individual Coverage for Retired and Medal of Honor Sponsors and Family Members
117	TRICARE Prime Family Coverage for Retired and Medal of Honor Sponsors and Family Members
118	TRICARE USFHP Direct Care Individual Coverage for Retired Sponsors and Family Members
119	TRICARE USFHP Direct Care Family Coverage for Retired Sponsors and Family Members
120	TRICARE Senior Prime Individual Coverage for Retired Sponsors and Family Members
121	Continued Health Care Benefits Program Individual Coverage
122	Continued Health Care Benefits Program Family Coverage

VALID VALUE	DESCRIPTION
123	Federal Employees Health Benefits Program (FEHBP) Individual Standard Coverage
124	Federal Employees Health Benefits Program (FEHBP) Family Standard Coverage
125	Federal Employees Health Benefits Program (FEHBP) Individual High Coverage
126	Federal Employees Health Benefits Program (FEHBP) Family High Coverage
127	TRICARE Senior Supplement
128	TRICARE Remote Individual Coverage for Active Duty Sponsors
129	TRICARE Remote Individual Coverage for Active Duty Family Members
130	TRICARE Remote Family Coverage for Active Duty Family Members
131	TRICARE Prime Individual Coverage for Transitional Survivors of Active Duty Deceased Sponsors
132	TRICARE Prime Family Coverage for Transitional Survivors of Active Duty Deceased Sponsors
133	TRICARE USFHP Direct Care Coverage for Transitional Survivors of Active Duty Deceased Sponsors
134	TRICARE Prime Individual Coverage for Transitional Survivors of Guard/ Reserve Deceased Sponsors
135	TRICARE Prime Family Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
136	TRICARE Prime Individual Coverage for Survivors of Guard/Reserve Deceased Sponsors
137	TRICARE Prime Family Coverage for Survivors of Guard/Reserve Deceased Sponsors
138	TRICARE USFHP Direct Care Individual Coverage for Survivors of Guard/ Reserve Deceased Sponsors
139	TRICARE USFHP Direct Care Family Coverage for Survivors of Guard/Reserve Deceased Sponsors
140	TRICARE Plus with CHC Coverage for Active Duty Family Members
141	TRICARE Plus Coverage for Transitional Survivors of Active Duty Deceased Sponsors
142	TRICARE Plus with CHC Coverage for Transitional Survivors of Active Duty Deceased Sponsors
143	TRICARE Plus Coverage for Survivors of Active Duty Deceased Sponsors
144	TRICARE Plus with CHC Coverage for Survivors of Active Duty Deceased Sponsors
145	TRICARE Plus Coverage for Retired Sponsors, Family Members and Medal of Honor
146	TRICARE Plus with CHC Coverage for Retired Sponsors, Family Members and Medal of Honor

VALID VALUE	DESCRIPTION
147	TRICARE Plus with CHC Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
148	TRICARE Plus Coverage for Survivors of Guard/Reserve Deceased Sponsors
149	TRICARE Plus Coverage with CHC for Survivors of Guard/Reserve Deceased Sponsors
150	TRICARE Plus Coverage for Active Duty Family Members
151	TRICARE Plus Coverage for Transitional Survivors of Guard/Reserve Deceased Sponsors
152	TRICARE Overseas Prime Individual Coverage for Active Duty Sponsors
153	TRICARE Overseas Prime Individual Coverage for Active Duty Family Members
154	TRICARE Overseas Prime Family Coverage for Active Duty Family Members
155	TRICARE Global Remote Overseas Prime Individual Coverage for Active Duty Sponsors
156	TRICARE Global Remote Overseas Prime Individual Coverage for Active Duty Family Members
157	TRICARE Global Remote Overseas Prime Family Coverage for Active Duty Family Members
158	TRICARE Remote Individual Coverage for Transitional Survivors of Active Duty Deceased Sponsors
159	TRICARE Remote Family Coverage for Transitional Survivors of Active Duty Deceased Sponsors
160	TRICARE Prime Individual Coverage for Medically Retired Sponsors and Family Members
161	TRICARE Prime Family Coverage for Medically Retired Sponsors and Family Members
201	TRICARE Dental Plan Individual Coverage for Active Duty Family Members
202	TRICARE Dental Plan Family Coverage for Active Duty Family Members
203	TRICARE Dental Plan Individual Remote Coverage for Active Duty Family Members
204	TRICARE Dental Plan Family Remote Coverage for Active Duty Family Members
205	TRICARE Dental Plan Individual Coverage for Survivors of Active Duty Deceased Sponsors
206	TRICARE Dental Plan Family Coverage for Survivors of Active Duty Deceased Sponsors
207	TRICARE Dental Plan Individual Coverage for Selected Reserve (SelRes) Sponsors
208	TRICARE Dental Plan Individual Coverage for Selected Reserve (SelRes) Family Members

VALID VALUE	DESCRIPTION
209	TRICARE Dental Plan family coverage for Selected Reserve (SelRes) family members
210	TRICARE Dental Plan Individual Remote Coverage for Selected Reserve (SelRes) Family Members
211	TRICARE Dental Plan Family Remote Coverage for Selected Reserve (SelRes) Family Members
212	TRICARE Dental Plan Individual Coverage for Survivors of Selected Reserve (SelRes) Deceased Sponsors
213	TRICARE Dental Plan Family Coverage for Survivors of Selected Reserve (SelRes) Deceased Sponsors
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

VALID VALUE	DESCRIPTION
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
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

VALID VALUE	DESCRIPTION
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
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

CHAPTER 3
SECTION 1.5

DEERS FUNCTIONS

1.0. As the centralized data repository of Department of Defense (DoD) personnel and medical data and the National Enrollment Database (NED) for the portability of the MHS worldwide TRICARE program, the DEERS is designed to provide benefits eligibility and entitlements, TRICARE enrollments and claims coverage processing.

This chapter will detail the events to verify eligibility, perform enrollments, assign a Primary Care Manager (PCM), transfer enrollments, perform a claims inquiry, and the associated updates of address information, Catastrophic Cap and Deductible Database (CCDD) information, Other Health Insurance (OHI) and the Standard Insurance Table (SIT). The expected data stores for the contractor (Regional Contractors and Designated Providers/ Uniformed Service Family Health Plan (DP/USFHP)) are illustrated in Figure 3-1.5-1. Deviation from the intended concept of operations between the contractor and DEERS shown in the figure below is at the contractors technical and financial risk.

1.1. Partial Match

DEERS provides two views of benefits and entitlements information: Eligibility for Enrollment and Coverage. [NOTE: The Eligibility for Enrollment view is provided through the DEERS Online Enrollment System (DOES) application only.] Both views of eligibility may result in a partial match situation due to person ambiguity. Person ambiguity can occur when two or more persons have the same Social Security Number (SSN) within DEERS. As mentioned previously with multiple entitlements, a person's role within DEERS may change over time, meaning he or she may be both a family member and a sponsor. Therefore, DEERS uses the Person Type Code (sponsor or family member) to identify the role the person is representing in the family. If the request uses the SSN of the sponsor, DEERS conducts the search where the SSN is used for a person representing a sponsor. If DEERS determines that the SSN is associated with multiple sponsors, DEERS provides a partial match response.

Likewise, if the request uses the SSN of a family member, DEERS conducts the search where the SSN is used for a person representing a family member. If DEERS determines that the SSN is associated with multiple family members, DEERS provides a partial match response.

If there is ambiguity, then a partial match response is returned. There will be a separate listing for each person or family matching the requested SSN. The listing includes the sponsor and family member identification information needed to determine the correct beneficiary or family including the DEERS Identifier (ID), the Patient ID, or possibly both. The requesting organization must select which of the multiple listings is correct based on documents or information at hand. A partial match response may be returned for any inquiry that does not use a DEERS ID or Patient ID.

After this selection, the requesting organization would use the additional information returned (e.g., Date of Birth (DOB), Name) "to resend the inquiry."

When implementing applications that use system to system interfaces that return partial matches (such as claims), those applications need to allow for their operator to be able to view and select the correct individual, as described above. The partial match response is designed to provide unique identifiers (Patient ID [Electronic Data Interchange Person Number - EDIPN] or DEERS ID) that can ensure that subsequent processing will uniquely identify the correct individual or beneficiary.

1.2. Health Care Delivery Program (HCDP) Eligibility and Enrollment

The rules for determining a beneficiary's entitlement to health care benefits are applied by rules-based software within DEERS. DEERS is the sole repository for these DoD rules, and no other eligibility determination outside of DEERS is considered valid. Whenever data about an individual sponsor or a family member changes, DEERS reapplies these rules. DEERS receives daily, weekly, and monthly updates to this data, which is why organizations must query DEERS for eligibility information before taking action. This insures that the individual is still eligible to use the benefits and that the contractor has the most current information.

A beneficiary who is considered eligible for DoD benefits, according to DoD Instruction (DoDI) 1000.13, is not required to "sign up" for the TRICARE Standard benefits or any other DEERS assigned plan. If an authorized organization inquires about that beneficiary's eligibility, DEERS reflects if he or she is eligible to use the benefits. The effective and expiration dates for assigned plan coverage are derived from DoDI 1000.13 rules and supporting information.

1.2.1. Enrollment-Related Business Events

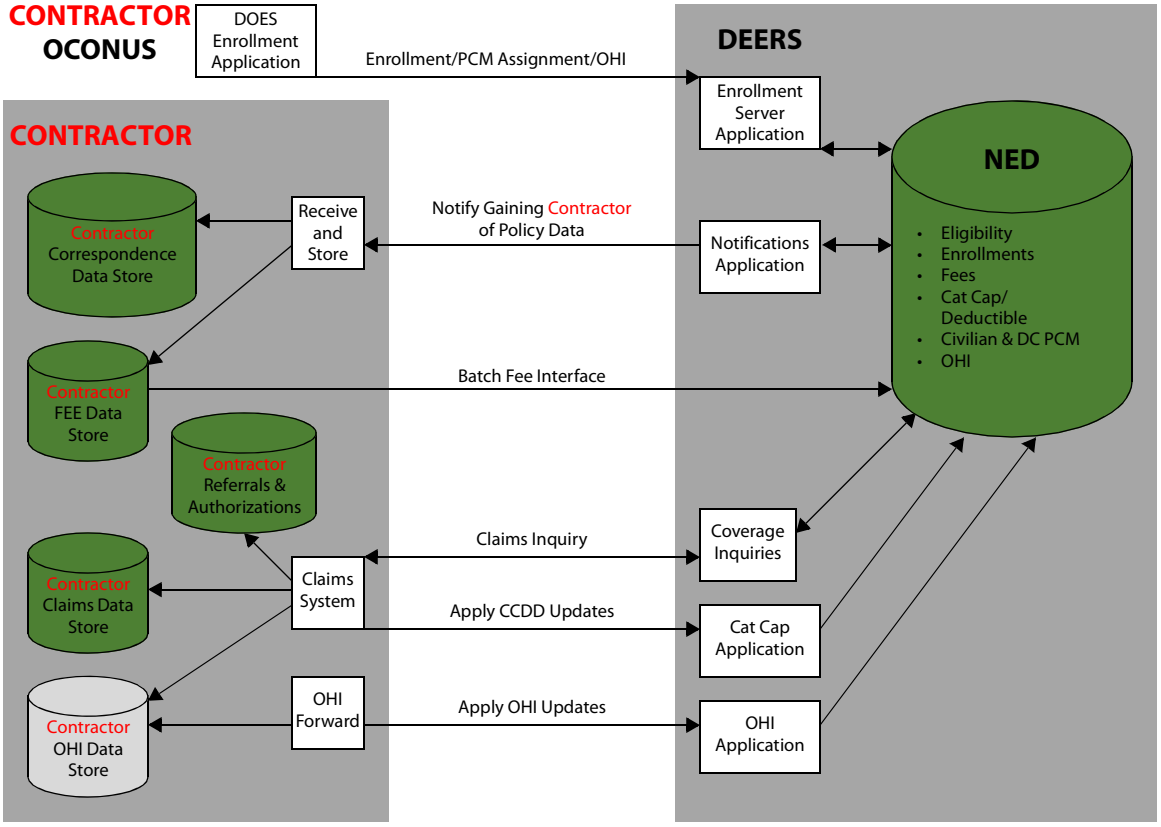
Enrollment related business events include:

- Eligibility for enrollment identifies current enrolled coverage plans and eligibility for enrollment into other coverage plans
- New enrollments are used for enrolling eligible sponsors and family members into HCDP coverage plans or for adding family members to an existing family enrollment. Enrollments begin on the date specified by the enrolling organization and extend through the beneficiaries' end of eligibility for the HCDP. New enrollments may also perform the following functions:
  - Specify enrollment fee information
  - PCM selection
  - Update address, email address and/or telephone number
  - Record that the enrollee has OHI

- Modifications of the current enrollment (updates) are used to change some information in the current enrollment plan. Modifications of the current enrollment include the following functions:
  - Change or cancel a PCM selection
  - Transfer enrollment (enrollment portability) or cancel a transfer
  - Change enrollment begin date
  - Cancel enrollment/disenrollment
- Individual fee waiver information is used to indicate that an enrollee is exempt from paying enrollment fees.
- Enrollment fee payments and enrollment fee exceptions are used to indicate payment of, or exception from payment of, enrollment fees. The Fee/CCDD History application is used to view this detailed information for a specified policy.
- Disenrollments are used to terminate the specified beneficiary's enrollment. Disenrollments are used for disenrolling a beneficiary only when he or she has lost eligibility, voluntarily disenrolls (e.g., chooses not to re-enroll) or involuntarily disenrolls (e.g., fails to pay enrollment fees).
- Modifications to a previous enrollment (updates) are used to change some information in the previous enrollment plan. Modifications of the previous enrollment include the following functions:
  - Change enrollment end date
  - Change enrollment end reason
- Request an enrollment card replacement
- Add OHI information for an enrollee
- Request a replacement letter for PCM change or disenrollment

The following figure shows the data and process flow required by the Government. Deviations from this diagram are at the contractor's technical and financial risk.

FIGURE 3-1.5-1 DEERS ENROLLMENT AND CLAIMS INTERACTION



1.2.2. Defense Online Eligibility And Enrollment System (DOES)

DOES is a full function Government Furnished Equipment (GFE) application developed by Defense Manpower Data Center (DMDC) to support enrollment-related activity and research. DOES interacts with both the main DEERS database as well as the NED satellite database to provide enrolling organizations with eligibility and enrollment information, as well as the capability to update the NED with new enrollments and modifications to existing enrollments. Contractors are required to perform enrollment related functions through DOES, including:

- Enrollment
- Disenrollment
- PCM Change
- PCM Cancellation and Transfer Cancellation
- Transfer
- Enrollment Period Change
- Enrollment End Reason Code Change
- Enrollment/Disenrollment Cancellation

- Enrollment Fee Waiver Update for an Individual
- Beneficiary Update
- OHI Add
- Confirm Enrollment/PCM change (to support beneficiary web enrollment)

NOTE: The web version of the DOES application (Web DOES) does not allow enrollment fee payments or enrollment fee waiver updates. Web DOES will display enrollment fees for the last Fiscal Year (FY) that DEERS has fees applied to the policy.

The DOES application meets Health Insurance Portability and Accountability Act (HIPAA) guidelines for a direct data-entry application, and is data-content compliant for enrollment and disenrollment functions.

The NED (DOES) Training document may be referenced for examples of screens for DOES (Chapter 3, Section 1.2).

1.2.3. Beneficiary Self-Service

The Government will provide a web application for the beneficiary to perform enrollment-related activities. This application Beneficiary Web Enrollment (BWE) will serve all TRICARE eligible beneficiaries and will support most enrollment programs. BWE will interface with the contractor systems for the purposes of accommodating on-line payment of enrollment fees. See the BWE Enrollment Fee Gateway Technical Specification for more detail.

The web application will include all of the data elements contained on the Office of Management and Budget (OMB) approved universal enrollment/PCM change form. DEERS will pre-populate data elements where possible. The beneficiary can perform the following enrollment events:

- PCM change
- Address update
- Transfer of enrollment (as a result of address update)
- Disenrollment
- Limited cancellation events
- Request a new enrollment card
- Submit an initial enrollment application, including any required fee payment
- Add limited OHI
- Electronic Funds Transfer (EFT) or Recurring Credit/Debit Card (RCC) payment election
- Allotment payment election (Prime only)

The web application will contain checks for beneficiary eligibility and hard edits requiring the beneficiary to fulfill established DEERS business rules and enrollment criteria. Upon completion of the web application, the beneficiary is informed that the enrollment actions will be reviewed by the appropriate contractor for accuracy and compliance with established Regional requirements, and that they will receive further notice from the contractor as to any need for additional information. DEERS will send the contractor a Policy Notification, informing the contractor that a pending enrollment exists for the beneficiary.

Using DOES, the contractor shall review and acknowledge all pending enrollment-related activities (including, but not limited to, enrollments, PCM changes, and transfers of enrollment). All reviews and acknowledgements shall be accomplished within six calendar days of receipt of the information. DEERS will perform a daily process to finalize pending enrollment actions after six calendar days of no action by the contractor. DEERS will send a policy notification indicating that the contractor has approved the enrollment action in DOES. Additionally, within six calendar days of the submission, the contractor shall contact the beneficiary to resolve discrepancies in the web-submitted application (if necessary). If the application is not accepted, the contractor shall send the beneficiary an explanatory letter within five calendar days. The contractor shall also cancel the enrollment using DOES. The contractors shall consider beneficiary provided data on the enrollment web application as having the same validity as beneficiary provided data on paper enrollment forms. DEERS will not provide support or interfaces to contractor web applications that perform any enrollment-related functions.

The following descriptions provide an overview of each enrollment-related business event.

1.2.4. Eligibility For Enrollment

The DoD provides assigned HCDPs and plans when a person joins the DoD. DEERS determines coverage plans for which a beneficiary is eligible to enroll by using the DoD-assigned coverage in conjunction with additional eligibility information. The Eligibility for Enrollment Inquiry in DOES is used to view a person's or family's eligibility to enroll. [NOTE: The Eligibility For Enrollment Inquiry in DOES should not be used for other eligibility determinations. For example, USFHP providers should use General Inquiry of DEERS (GIQD) and not DOES to determine if a person is eligible for a hospital admission.]

DEERS provides coverage plan information identifying the period of eligibility and/or enrollment for the coverage plan. A beneficiary can only be enrolled into the coverage plans that have an "eligible for" status. Refer to Chapter 3, Addendum C, HCDP Plan Coverage Details, for additional information on the coverage plans a beneficiary is eligible for based on the DEERS assigned coverage.

When a sponsor and family member are first added into DEERS, DEERS determines basic eligibility for health care benefits based on DoDI 1000.13 and establishes an assigned HCDP coverage plan together with coverage dates.

For example, when an Active Duty (AD) sponsor and family members are added to DEERS:

- A sponsor is assigned a Direct Care (DC) plan for AD Sponsors in which he or she is the subscriber and the insured with DC entitlement only. The dates on the coverage represent the dates determined by the eligibility rules.
- A sponsor with family members is listed as the subscriber under the TRICARE Standard for Active Duty Family Members (ADFMs) assigned plan. The sponsor is not insured under this coverage plan.

- Eligible family members are assigned a TRICARE Standard plan for ADFMs as insured with both DC and civilian health care coverage. The coverage plan dates are determined by the eligibility rules. There are no enrollment dates, since this option requires no enrollment.

1.2.5. Prime Enrollment

The assigned plans provide the foundation for enrollment into various coverage plans. Enrollments cannot span multiple assigned plans.

Enrollments are at the individual or family level, depending on the number of family members wishing to enroll. DEERS allows one family member to enroll in a family plan, but does not allow more than one family member to enroll in an individual plan when a family plan is available. DEERS creates a policy that encompasses all enrollments for a family and a HCDP. DEERS automatically switches enrollment policies from individual to family upon the enrollment of a second family member; however, DEERS does not make automatic adjustments from family to individual policies upon the disenrollment of all but one family member. It is the contractor's responsibility to make such changes via DOES. Some HCDP's, such as TRICARE Plus, only offer enrollment on an individual basis, and there is no family option. For these plans, DEERS does not limit the number of individual policies that a family may have.

The contractor is required to enter the following information into DOES in order to complete an enrollment:

- Coverage plan
- Enrollment begin date (if different than DOES default)
- PCM assignment
  - PCM Network Provider Type Code (if not defaulted by DOES)
  - PCM Enrolling Division (if more than one is available for the coverage plan and PCM Network Provider Type Code)
  - Individual PCM selection

Restrictions on use and limits on how far an enrollment can be backdated are addressed in the Chapter 3, Addendum D, Medical Business Rules and the TRICARE Policy Manual (TPM).

Enrollment anniversary dates for all enrollees are being transitioned to a FY basis, i.e., October 1 through September 30. To accomplish this, on new enrollments or when a policy is up for renewal, the contractor shall only establish the policy and prorate the enrollment fees as described below. At the end of that fiscal year, the contractor shall renew the policy for the next fiscal year with an anniversary date of October. Through this transition, the enrollment year will become aligned with the fiscal year for all enrollments.

For Prime enrollees that pay fees on an annual basis, the contractor shall collect the entire prorated fee covering the period through September 30 of the current fiscal year.

For Prime enrollees that pay fees on a quarterly basis, the contractor shall collect a prorated fee covering the period until the next fiscal year quarter (e.g., January 1, April 1, July 1, October 1) and collect quarterly fees thereafter through September 30 of the current fiscal year. For enrollees that pay fees on a monthly basis (by EFT) or monthly allotments), contractors must collect and post an amount equal to three months of fees at the time of enrollment with monthly EFT or allotments beginning on the first day of the fourth month following the enrollment anniversary date.

- Enrollments Effective Prior to October 1, 2012: If during the transition from enrollment year to fiscal year, the first three-month payment crosses into the next fiscal year, the contractor shall send DEERS the three month payment amount, indicating the applicable paid-through date and a payment plan type of "Request to begin allotment". DEERS will apply one or two months of the three month payment (whichever is applicable) to the enrollment ending in the current fiscal year and the remaining one or two months of fees to the beginning of the new enrollment beginning on October 1 of the next fiscal year. When a three month fee is paid and monthly allotments or EFTs are indicated and there are less than 90 days but more than 45 days remaining on the policy ending September 30, DEERS will create the new policy (beginning October 1) and apply the one or two remaining fee payments from the previous policy.

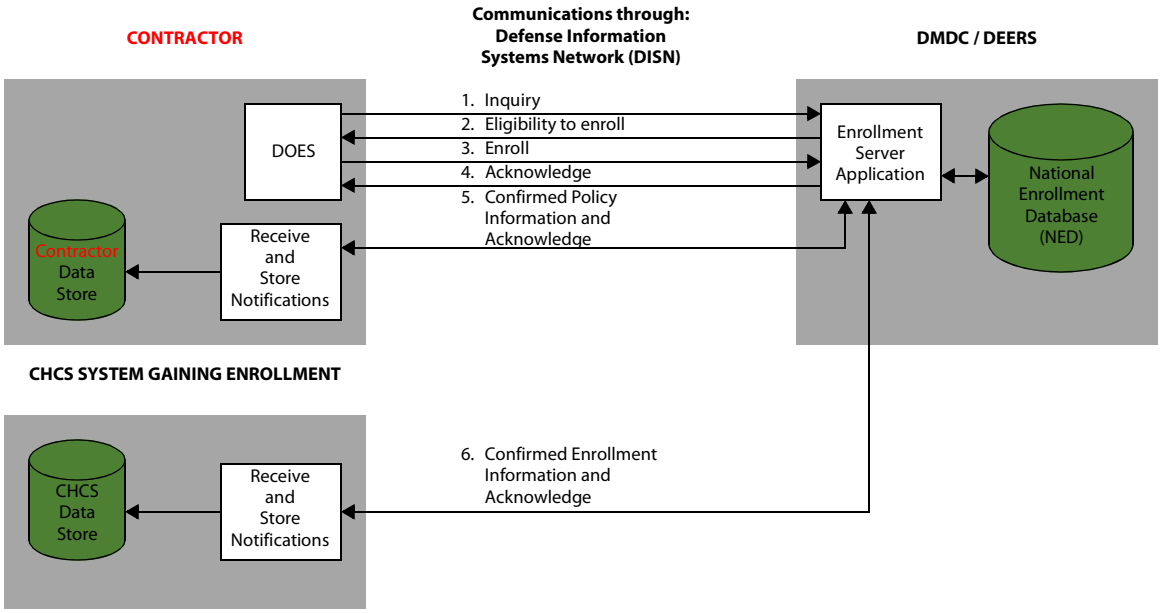
EXAMPLE: If a beneficiary's enrollment anniversary date is August 1 and they wish to pay by monthly allotment or EFT, the contractor should collect a full three months of enrollment fees and send that amount to DEERS. DEERS will apply two months of the fee to the enrollment covering the period August 1 through September 30 and the remaining one-month's fees to the new (fiscal year aligned) policy beginning October 1. The monthly allotments or EFT payments should start by November 1 (first day of the fourth month following the previous enrollment anniversary date of August 1). See paragraph 1.2.8.2. Contractors shall be responsible for accommodating enrollment periods that are not aligned with the fiscal year for transitioned and transferred policies as well as for new enrollment policies that begin on some date other than October 1.

NOTE: If the first three month payment crosses into FY 2013, the contractor shall send DEERS the portion that applies to FY 2012, indicating the applicable paid-through date and a payment plan type of "Request to begin allotment"; and shall send a second transaction containing the dollar amount of the payment that applies to FY 2013 to DEERS with a payment plan type of "Request to begin allotment" and DEERS will calculate the paid-through date and notify the contractor.

- Enrollments Effective On or After October 1, 2012: The contractor will send the fee amount collected for the first three month payment and a payment plan type of "Request to begin allotment" to DEERS and DEERS will calculate the paid-through date and notify the contractor.

The following figure illustrates the process of system interactions for enrollments and enrollment updates:

FIGURE 3-1.5-2 ENROLLMENT PROCESS



1.2.5.1. Enrollment Fees

1.2.5.1.1. Enrollment Year To Fiscal Year Alignment

By statute, enrollees are entitled to both an enrollment year and a fiscal year for the purposes of enrollment fees and catastrophic cap amounts. Tracking two sets of amounts for each enrollee is cumbersome, confusing, expensive, and can lead to inaccurate totals as well as negatively affecting enrollment portability. To ease portability and resolve problems, enrollment anniversary dates for all enrollees are being transitioned to a fiscal year basis, i.e., October 1 through September 30. To accomplish this, for new enrollments or policies that are up for renewal (that have not already been aligned to the fiscal year), enrollment policy anniversary and end dates must be adjusted and the associated enrollment fees and catastrophic cap amounts prorated. Upon transition from an outgoing contractor to an incoming contractor region, DEERS will provide the incoming contractor with a "Gold File" that contains enrollment information for enrollees being transitioned to the incoming contractor.

1.2.5.1.2. Enrollment Policy Anniversary, End, And Paid-Through Dates

For certain enrollments in the "Gold File," DEERS will have set the enrollment policy end dates to be September 30. For others, the enrollment policy end date will be as they were established by the outgoing contractor. The determining variable, as to whether an end date is set by DEERS to be September 30 or not, is who has responsibility for a particular re-enrollment during the fiscal year in which the transition is occurring, i.e., the current fiscal

year. If a re-enrollment is performed by an outgoing contractor (prior to the start of health care delivery of the incoming contractor) during the fiscal year in which the transition occurs, DEERS will set the policy end date of that re-enrollment on the "Gold File" to be September 30 or less depending on eligibility. For example, if an enrollment policy begins in March 2004 (FY 2004) and the contract transition is April 2004 (FY 2004), the FY 2004 re-enrollment was performed by the outgoing contractor; therefore, DEERS will set the policy end date to September 30 on the "Gold File". If a re-enrollment is due to be performed by the incoming contractor effective on or after the start of health care delivery, DEERS will not alter the enrollment policy end date. The incoming contractor, at the time of the re-enrollment, will set the enrollment end date to be September 30. For example, if an enrollment policy begins in June 2003 (FY 2003) and the contractor transition is April 2004 (FY 2004), the FY 2004 re-enrollment will be performed by the incoming contractor; therefore DEERS will not alter the enrollment policy end date.

The incoming contractor will receive from the outgoing contractor at transition, the contractor's fee information which will show the "paid-through" dates. The incoming contractor shall submit the fee amount and "paid-through" dates to DEERS for the policies on the "Gold File" **and for any new enrollments** using DOES or the Batch Fee Interface.

For enrollments performed during the current fiscal year by the outgoing contractor that are effective prior to the start of health care delivery of the incoming contractor, and where DEERS has set the enrollment policy end date to be September 30 on the "Gold File", the enrollment "paid-through" date may be before or after September 30 depending on whether the enrollee paid enrollment fees on an annual or quarterly basis.

If the enrollee paid the outgoing contractor on a quarterly basis, the quarterly payment dates may not fall precisely on a fiscal year quarter (October 1, January 1, April 1, or July 1). For an enrollment where the "paid-through" date does not fall precisely on a fiscal year quarter, the contractor shall collect a prorated fee covering the one or two month period until the next fiscal year quarter and collect quarterly fees thereafter through September 30.

If, for example, the outgoing contractor performed a re-enrollment effective November 1 and the enrollee is paying on a quarterly basis (and the incoming contractor start of health care delivery is April 1), the outgoing contractor fee information will show a "paid-through" date of April 30. In this case, the enrollee paid the outgoing contractor two quarterly payments, November 1 - January 31 and February 1 - April 30. The incoming contractor shall collect two months of enrollment fees covering May 1 through June 30 (the end of the current fiscal quarter) and resume collecting a full quarterly fee covering the period July 1 through September 30. NOTE: The "Gold File" enrollment policy end date for this example re-enrollment will already have been set by DEERS to be September 30 since the re-enrollment was performed by the outgoing contractor in the current fiscal year but prior to the start of health care delivery of the incoming contractor (April 1).

For enrollments performed by the outgoing contractor in the current fiscal year but prior to the start of health care delivery of the incoming contractor, DEERS will have set the enrollment policy end date on the "Gold File" to be September 30. For enrollees that paid fees on an annual basis, the outgoing contractor fee information will show the "paid-through" date to be what the outgoing contractor had established. In this case, when the

incoming contractor re-enrolls such individuals on October 1 (beginning of the next fiscal year), they shall collect a prorated fee for the period beginning on the first of the month following the "paid-through" date as shown in the outgoing contractor fee information. For example, if the outgoing contractor re-enrolled an individual effective November 1 and the enrollee paid the annual fee at the time of re-enrollment, then that enrollee is paid-through October 31 of the following year. The "Gold File" that the incoming contractor receives will show the enrollment end date to be September 30 but the "paid-through" date will be October 31. When the time comes to re-enroll this individual (within 45 days prior to September 30), the incoming contractor will re-enroll this individual effective October 1 but collect an 11 month prorated enrollment fee beginning with and covering the period from November 1 through the following September 30. This is because the enrollee had already paid-through October 31.

1.2.5.1.3. Prorated Enrollment Fees

For new enrollments DEERS will establish abbreviated (less than 12 months) policies ending September 30 and the contractor shall prorate the enrollment fees necessary to align the policy with the FY on a monthly basis. The monthly prorated enrollment fee is 1/12 of the respective annual enrollment fee (rounded down). At the end of the abbreviated enrollment (end of the current fiscal year), the contractor shall renew the policy for the next fiscal year with an anniversary date of October 1 **and resume collecting the full enrollment fees**.

For enrollees that pay fees on an annual basis, the contractor shall collect the entire prorated fee covering the period from the enrollment begin date through September 30 of the current fiscal year.

For enrollees that pay fees on a quarterly basis, the contractor shall collect a prorated fee covering the period from the new or re-enrollment effective date through the end of the current fiscal year quarter (e.g., September 30, December 31, March 31, June 30) and collect quarterly fees thereafter through September 30 of the current fiscal year.

For enrollees that pay fees on a monthly basis (by EFT or by monthly allotments), the contractor must collect and post the appropriate initial payment of fees at the time of enrollment with monthly EFT or allotments beginning on the first day of the fourth month following the enrollment begin date. If during the transition from enrollment year to fiscal year, the initial payment crosses into the next fiscal year, the contractor shall send DEERS the payment amount and a payment plan type of "Request to begin allotment." DEERS will apply the appropriate initial payment amount to the current fiscal year and the remaining amount to the next fiscal year.

For example, if a beneficiary's enrollment policy anniversary date is August 1 and they request to pay by monthly allotment or EFT, the contractor shall collect a full three months of enrollment fees and report that amount to DEERS. DEERS will apply two months of the fee to the enrollment period, August 1 through September 30, and the remaining one-month's fees to the new (fiscal year aligned) policy beginning October 1. In this example, the contractor shall send a "paid-through" date of October 31. The monthly allotments or EFT payments should start by November 1 (first day of the fourth month following the previous enrollment anniversary date of August 1). Contractors shall be responsible for

accommodating enrollment periods that are not aligned with the fiscal year for transitioned and transferred policies, as well as, for new enrollment policies that begin on some date other than October 1. **If fees are collected and these are more than 90 days remaining on the policy ending September 30, DEERS will store the fee amounts and apply any dollars to the next policy when DEERS creates.**

NOTE: See paragraph 1.2.5.1. for payments received before and on or after October 1, 2012, for the correct process for updating the amounts collected into DEERS.

1.2.5.1.4. Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Services Members and their Dependents

Effective FY 2012, beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their dependents, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying Prime plan. (This does not include TRICARE Young Adult (TYA) plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime. The fee for the dependent(s) of a medically retired Uniformed Services member shall not change if the dependent(s) is later re-classified a survivor.

1.2.5.1.5. Prorated Catastrophic Cap Amounts

1.2.5.1.5.1. TRICARE Prime enrollees who are other than AD or ADFMs, (e.g., Retirees and Retiree Family Members), are entitled to an enrollment year catastrophic cap. As with enrollment fees, these catastrophic cap amounts must also be aligned in order to complete the enrollment year to fiscal year alignment. In order to align enrollment year catastrophic cap amounts to the fiscal year, a one time prorated catastrophic cap credit will be applied to each new enrollment for each month that the beneficiary is not enrolled during the current fiscal year. The monthly prorated catastrophic cap credit for non-AD and non-ADFMs will be 1/12 of the annual catastrophic cap limit.

1.2.5.1.5.2. Catastrophic cap credits are always applied to the fiscal year in which the abbreviated enrollment occurs. The concept being that the Government is applying, through a credit, an amount that will permit an enrollee to meet the catastrophic cap amount during the initial abbreviated enrollment year. Only policies where fees are required will receive a one-time enrollment year catastrophic cap credit when out-of-pocket expenses cannot be applied during a full 12 months to the fiscal year catastrophic cap limit, to achieve the enrollment year catastrophic cap amount, i.e., those enrollments without an effective date of October 1.

1.2.5.1.5.3. Catastrophic cap credit amounts will be reported **by DEERS** to the DEERS CCDD. Catastrophic cap credits will always be applied toward the catastrophic cap of an individual enrollee and subsequently appear in the family total for that individual. For individual policies, the individual totals will be the same as the family totals for that individual. For family policies, the catastrophic cap credit will be applied to the sponsor's

individual catastrophic cap total and will subsequently appear in the sponsor's family total. Catastrophic cap credits shall be applied only once per family regardless of whether the family consists of just the sponsor or the family consists of the sponsor and other family members, or the family is split across multiple contracts.

1.2.5.1.5.4. If DEERS has applied a credit for an enrollment policy that is later cancelled or terminated within the first fiscal year, DEERS will remove the credit by applying a negative adjustment, with the exception of cases where the cancellation or termination was due to loss of eligibility. In such cases, if the catastrophic cap limit had not been reached by the application of the credit, and the enrollment policy was cancelled or terminated, no further action is required by the contractor. If the catastrophic cap limit had been reached due to the application of a claim or fee payment, the Purchased Care Contractor shall reprocess any claims or fee payments from the date and time the catastrophic cap was met in accordance with catastrophic cap application requirements.

1.2.5.1.5.5. When a TRICARE Standard beneficiary (non-AD and non-ADFM) enrolls in Prime, the catastrophic cap credit will be added to any fiscal year catastrophic cap amounts already paid during the current fiscal year. Application of the credit could cause the family total to come close to or actually meeting the catastrophic cap limit. Should this happen, the contractor shall determine the amount of the enrollment fees owed, if any, and collect accordingly. Of course, once an individual or family catastrophic cap limit has been met, no further covered out-of -pocket expenses shall be incurred by the individual or family. Expenses for non-covered services as well as Point of Service (POS) deductibles and cost-shares will continue to be paid by the individual or family even though the catastrophic cap limits have been reached.

1.2.5.1.6. Alignment of the enrollment year to the fiscal year must also be performed for enrollees of the USFHP. The process, as described for the contractors above, is the same for USFHP enrollments. See Chapter 3, Addendum E for charts detailing the enrollment year to fiscal year alignment of enrollment dates, prorated enrollment fees, and prorated catastrophic cap amounts for all contractors.

1.2.5.2. PCM Assignment Within The DOES Application

DEERS has a centralized PCM file containing all contractors' civilian network PCMs and PCMs for the DC systems. Additions and modifications of PCMs are performed in the contractor provider system. The contractors shall provide daily additions and modifications on their provider files for retrieval by DEERS. If a contractor wishes to deactivate or delete a PCM, they may send DEERS a modification where the PCM's effective date is equal to the PCM's end date, and DEERS will deactivate the PCM from the central file. DEERS will only delete PCMs from the central file if there have been no assignments to that provider. Contractors cannot reuse PCM IDs that are deactivated or deleted PCMs from their provider system. DEERS will not allow subsequent assignments to a deactivated PCM. The DOES application accesses the central PCM file to perform provider assignments.

1.2.5.3. DC PCM Assignment

The contractor shall perform DC PCM assignment at the time of enrollment in the DOES application. The contractor shall use the PCM preference indicated on the enrollment

form in addition to guidance contained in any MOU agreement or other government-provided direction, if available. For Active Duty Service Members (ADSMs), if the enrollment form has a UIC specified and the MTF has established a default provider for the UIC, the contractor should use the default. If the enrollment form contains a specialty or gender preference, the contractor shall use the preference filters available in DOES to select a PCM. In the case where a beneficiary has not indicated a preference and there is not precise direction in an MOU or other government direction, the contractor shall use the search criteria in DOES to select a PCM. DOES and BWE will only display PCMs with available capacity in the selected Defense Medical Information System-Identifier (DMIS-ID). The contractor is responsible for determining the appropriate DMIS-ID based on MOUs, access standards, and any specific guidance from the government. If there is no capacity at a DC facility, the contractor shall assign the beneficiary to the civilian network.

1.2.5.4. Civilian PCM Assignment (Contractor)

The contractor shall perform Civilian PCM assignment at the time of enrollment in the DOES application. The contractor shall use the PCM preference indicated on the enrollment form. If the enrollment form contains a specialty or gender preference, the contractor shall use the preference filters available in DOES to select a PCM. DOES and BWE have incorporated logic to search for providers using at least one of the following combinations and returns all PCM records matching the criteria:

- PCM ID, PCM Name (no wildcards)
- PCM Group Name (no wildcards)
- PCM Zip Code (entire zip code or the first three digits only)
- PCM City, PCM State
- PCM Specialty, PCM Zip Code (entire zip code or the first three digits only)
- PCM Specialty, PCM City, PCM State
- PCM Gender, PCM Zip Code (entire zip code or the first three digits only)
- PCM Gender, PCM City, PCM State
- DMIS ID (for DC PCMs)

1.2.6. Disenrollment

Once actively enrolled in a coverage plan, an individual or family may voluntarily disenroll or be involuntarily disenrolled. Voluntary disenrollment is self-elected. Involuntary disenrollment occurs from failure to pay enrollment fees or from loss of eligibility. Upon disenrollment, DEERS will notify the beneficiary of the change in or loss of coverage.

NOTE: DEERS will not send disenrollment letters to beneficiaries when the loss of eligibility is due to death.

1.2.6.1. Disenrollment - Loss Of Eligibility

A loss of eligibility includes both a loss or change in eligibility for: 1) DoD health care benefits according to the current DoDI 1000.13; or 2) an individual health coverage plan. The end of eligibility is sent to the contractor at the time of enrollment. Under these circumstances, DEERS terminates any current enrollment or cancels an enrollment effective

at a future date. DEERS sends an unsolicited disenrollment notification when loss of eligibility occurs, if eligibility ends on a date earlier than expected.

Because DEERS reapplies its rules-based logic each time benefits determination data about a sponsor or family member changes, certain events may trigger disenrollment.

For example, when the sponsor's eligibility terminates, such as upon separation from service at an earlier date than expected, this terminates the assigned coverage for the entire family. The termination of assigned coverage affects the insureds' enrollment information; therefore DEERS terminates their current enrollments and/or cancels future enrollments into an HCDP. Unsolicited disenrollment transactions are sent to the necessary systems notifying them of the termination of coverage benefits.

Since enrollments extend through the end of eligibility, DEERS does not send notifications for projected loss of eligibility communicated at the time of disenrollment. The end of eligibility is communicated to the contractor at the time of enrollment. The contractor systems must accommodate future end dates for policies and PCMs.

In cases where eligibility changes based on a change to the sponsor's affiliation with a DoD organization, DEERS will terminate any enrollment associated to the previous eligibility segment, but will not automatically enroll beneficiaries for the new eligibility segment. The most common example of this is when a service member retires. The loss of eligibility for TRICARE for ADSMs will terminate the individual's enrollment in that program.

1.2.6.2. Retroactive Eligibility/Enrollment Maintenance

There may be instances where DEERS receives notice of a loss of eligibility from the Uniformed Services, only to later be informed of the immediate reinstatement. Upon the receipt of the initial loss of eligibility, DEERS terminates the enrollment. Upon receipt of the notice of reinstatement, DEERS reinstates the eligibility and enrollment as long as there are no gaps in eligibility. DEERS will reinstate eligibility and enrollments only if DEERS receives new personnel information reinstating eligibility within 90 days of the initial loss of eligibility if the enrollee is a non-fee payer.

1.2.6.3. Disenrollment - Voluntary

An insured may choose to terminate his or her current enrollment prior to the end date, or choose not to re-enroll into the current coverage plan. This transaction is performed in DOES. DEERS then terminates the coverage plan for the insured and reverts to the DEERS-assigned coverage, starting on the day after the termination of the previous enrollment. If additional systems need notification of the disenrollment, DEERS sends disenrollment notifications as necessary, notifying them of the termination of coverage benefits.

1.2.6.4. Disenrollment - Involuntary

The subscriber may fail to pay enrollment fees. In this case, the enrolling organization performs a disenrollment with a reason code of "failure to pay fees". Individuals who are waived from paying enrollment fees are not disenrolled because of this

exemption from enrollment fee payments. Disenrollment for failure to pay fees is either performed in DOES or through a batch disenrollment for failure to pay fees' system to system interaction.

Prior to processing a disenrollment with a reason of "non-payment of fees", the contractor must reconcile their fee payment system against the fee totals in DEERS. Once the contractor confirms that payment amounts match, the disenrollment may be entered in DOES or through failure to pay fees batch interface.

When there is a disenrollment, the appropriate systems are notified, as necessary.

1.2.7. Modification Of Enrollment

There are several reasons to modify an enrollment:

- Change or cancel a PCM selection
- Transfer enrollment (enrollment portability) or cancel a transfer
- Change enrollment begin or end date
- Change enrollment end reason
- Cancel enrollment/disenrollment

When there is a modification to an enrollment, the appropriate systems are notified, as necessary.

1.2.7.1. PCM Change And Cancellation

PCM reassignments occur when the enrollee changes regions, or desires to change PCM's within the region or MTF. An enrollee changes PCMs by completing a PCM change request form and submitting the change request to the contractor, which makes the change via DOES. Only the current enrolling organization may change the PCM selection. A PCM change can occur at any time during an active or future enrollment; however, the effective date for the new PCM must fall within the defined business rules (see Chapter 3, Addendum D). DEERS terminates the previous PCM with an end date, which will be the day before the begin date for the new PCM. Upon change of PCM, DEERS will notify the enrollee of the new PCM information.

A PCM cancellation may be performed for the enrollment's most current PCM assignment and can only be performed in the DOES application. Cancellation of a PCM change can only be performed by the enrolling organization responsible for managing the enrollment, and must be performed within the time period specified in the business rules (see Chapter 3, Addendum D). When canceling a PCM, the enrolling organization may reinstate the previous PCM, or choose to select a new PCM to replace the one being cancelled. There can be no date gaps between PCM selections for plans that require a PCM. DOES will decrement and increment PCM capacities as PCM actions are performed.

DOES will allow PCM's with available capacities to be assigned as new PCM's. If a contractor is canceling a PCM assignment, DOES will permit reinstatement of a PCM whose capacity has been reached.

1.2.7.2. Civilian PCM Panel Reassignment

DMDC provides a Civilian PCM Panel Reassignment application to allow contractors to perform mass reassignments of a PCM's enrollees. Within a contractor, a contractor may move a Civilian PCM's entire panel to a new Civilian PCM.

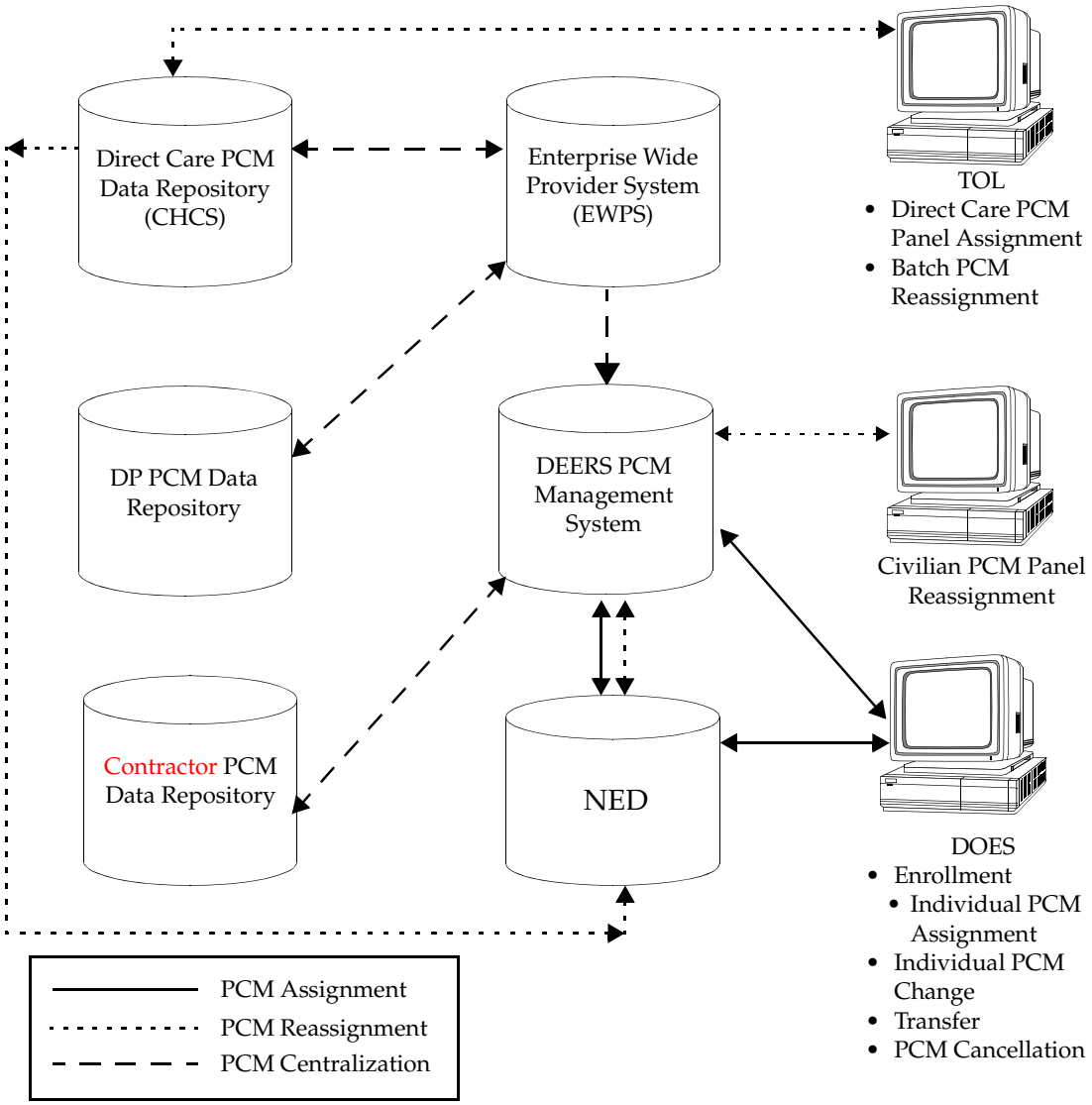
The reassignments selected by the contractor are processed periodically by DEERS. As the PCM reassignments are processed, DEERS sends notifications to the appropriate systems. DEERS will decrement and increment PCM capacities as necessary, but will not prevent the reassignment if the selected PCM does not have available capacity. For DC PCM panel reassignments, please refer to paragraph 1.2.5.3. and the TRICARE Operations Manual (TOM), Chapter 6, Section 1, paragraph 3.1.

1.2.7.3. DC PCM Panel Reassignment

MTFs have the responsibility for reassigning all enrollees assigned Resource Sharing PCMs under the current managed care support contracts to other MTF PCMs or "Pseudo" PCMs using Composite Health Care System (CHCS). These reassignments must be completed not later than 14 days prior to the start of health care delivery. If instructed by the MTF Commander, the incoming contractor will be required to reassign such enrollees to new DC PCMs using DOES/DEERS. The MTF's instructions to accomplish this task will be in writing and will include sufficient information to reasonably identify the beneficiary, as well as the PCM currently assigned and the PCM to be assigned. These DC PCM reassignments should not cross DMISs, CHCS platforms, or regions. They should be initiated by the MTF within 15 days of the start of health care delivery and will be completed by the contractor within 30 days of receipt.

Batch changes for DC PCMs may be performed in several ways. Changes between PCMs in DMIS IDs within a single CHCS platform must be coordinated between the MTF and the contractor. The contractor shall enter the PCM change criteria in a government-provided web application. Batch changes of DMIS IDs where the PCM assignment does not change must be coordinated with the MTF, contractor and DEERS. DEERS will effect the change in DMIS ID. If the PCM assignment must be changed in addition to the DMIS ID, the contractor must enter each PCM change transaction into the DOES application. Changes in DMIS IDs across CHCS platforms also must be performed individually by the contractor in DOES. In all cases, upon acceptance of the PCM change, DEERS will send a Policy Notification to the contractor and a PCM Change Letter to the beneficiary.

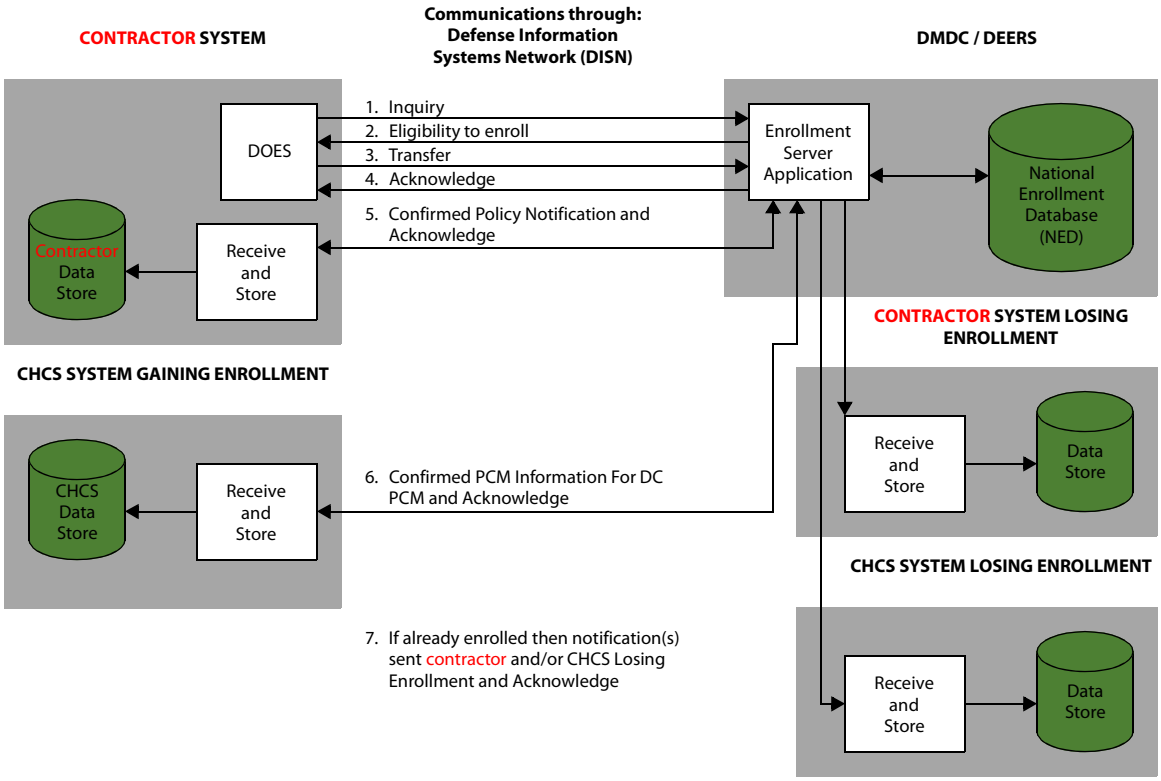
FIGURE 3-1.5-3 PCM ASSIGNMENT PROCESS



1.2.7.4. Transfer Of Enrollment And Transfer Cancellation

A transfer of enrollment moves the enrollment from one contract to another and thus moves the responsibility for the administration of the enrollment to the gaining contractor. DEERS supports transfers among coverage plans (e.g., medical, dental) within a health care plan (e.g., TRICARE Prime). Portability does not exist between some health care plans (e.g., TRICARE Prime and TRICARE Plus). If a beneficiary is enrolled in TRICARE Prime and wishes to enroll into TRICARE Plus or vice versa, upon moving to a new enrolling organization's region, a transfer of enrollment is not applicable. A disenrollment from TRICARE Prime with the previous contractor and a new enrollment into TRICARE Plus must be established with the new contractor. See Chapter 3, Addendum D, Medical Business Rules, for limitations regarding transfer and transfer cancellation transactions.

FIGURE 3-1.5-4 ENROLLMENT TRANSFER PROCESS



If an enrollment transfer is performed in error, a transfer cancellation may be performed. This action results in reinstatement of the enrollment with the previous enrolling organization.

1.2.7.5. Enrollment Period Change

This event is used to update an enrollee's begin or end date. These modifications can only be performed by the enrolling organization responsible for managing the enrollment, and must be performed within the timeframes established in the business rules (see Chapter 3, Addendum D). DEERS changes the date range for a PCM selection based on the enrollment period changes. If the enrollment end date is the same as the loss of eligibility date, the user is not allowed to change the end date to a greater date. If the enrollment has been terminated due to a voluntary disenrollment or failure to pay fees, the user may change the disenrollment end date in accordance with the business rules in Chapter 3, Addendum D. A change to an end date may only occur after a disenrollment. DEERS modifies the enrollee's policy based on the new date(s) if necessary.

If a person's eligibility in DEERS changes and affects an enrollment because the eligibility period is either greater or less than originally stated, DEERS updates the enrollment period and pushes the PCM and policy changes to the appropriate systems managing the enrollment. See the Unsolicited Notifications section for more information.

1.2.7.6. Enrollment End Reason Change

Disenrollments can be done for various reasons, and are mostly done by enrolling organizations. If a disenrollment is performed by an enrolling organization using an incorrect end reason code, the end reason code can be updated. However, enrolling organizations may not change an end reason indicating loss of eligibility without changing the end date.

1.2.7.7. Enrollment/Disenrollment Cancellation

Enrollment and disenrollment cancellations can only be performed by the entity managing the affected enrollment. An enrollment cancellation completely removes the enrollment from DEERS, and it will not be shown on subsequent inquiries. A disenrollment cancellation is used to reinstate the prior enrollment. Both events must be done within the time period prescribed in the business rules (see Chapter 3, Addendum D).

1.2.8. Enrollment Fees, Premiums, And Enrollment Fee Waivers

1.2.8.1. Enrollment Fee and Premium Payment Processing (For Enrollment Periods Prior to October 1, 2012)

DEERS records and displays enrollment fee payment information and returns accumulated enrollment fee payment information by policy for the enrollment/fiscal year in DOES. DEERS supports several enrollment-fee-related transactions:

- Enrollment Fee Payment (Visual Basic (VB) DOES and Batch Fee Interface)
- Update Individual Enrollment Fee Waiver Information (VB DOES)
- Terminate Policy For Failure To Pay Fees (VB DOES and Batch Fee Interface)

1.2.8.1.1. For contractors using Web DOES, DEERS records and displays enrollment fee payment information and returns accumulated enrollment fee payment information by policy for the enrollment year in the Fee/CCD Web Research application.

1.2.8.1.1.1. DEERS provides a number of applications to support enrollment-fee-related transactions:

- Enrollment Fee Payment (Fee/CCD Web Research application and Fee Interface)
- Update an enrollee's free-rider code (DOES)
- Terminate Policy For Failure To Pay Fees (DOES and Fee Interface)

1.2.8.1.1.2. DEERS will automatically set enrollment fee waivers for a policy based on the following events:

- One or more enrollees have Medicare Parts A and B
- The family has met their catastrophic cap
- Mid-month retiree enrollment

1.2.8.1.2. Fee waivers are stored at the family level. DEERS will provide the reason for fee waiver and the begin and end dates, a status code, and status date associated to that waiver on the PNT. The status code indicates whether the waiver is active or inactive.

Inactive waivers reflect waiver information that is no longer applicable because there has been a change to the fee waiver entitlement. Inactive waivers do not have an effect on the determination of fees due for the policy and are for audit purposes only. A fee waiver that indicates that a family has met their fiscal year catastrophic cap limit will be considered inactive if the fee waiver end date is not September 30th of the fiscal year for which the waiver exists. All waiver data is displayed in the Fee/CCD Web Research application and DOES (limited to only current fee waivers and those effective within the past two years).

1.2.8.1.3. DEERS will automatically maintain fee waiver entitlement data for families. Multiple fee waiver entitlements may exist at the same time (i.e., the family has a waiver for Medicare at the same time that they have met the catastrophic cap for part of a fiscal year). DEERS will supply all fee waiver entitlements and the contractor is responsible for calculating fees due based on all waiver entitlement data.

1.2.8.1.4. When new enrollments are processed, certain fee waiver entitlements will be immediately available on the enrollment PNT. Under certain circumstances (i.e., Medicare enrollments), the enrollment data will be processed and a PNT is sent prior to the calculation of the fee waiver entitlements. In such cases, a subsequent PNT will be sent immediately after the fee waiver entitlement recalculation that will include the updated waiver data.

1.2.8.1.5. When primary data changes in DEERS that affect fee waivers, the corresponding entitlement periods will be recalculated. If a fee waiver entitlement affects the current or future fiscal years for an active policy, DEERS will send an unsolicited notification to the most recent contractor.

1.2.8.1.6. Additionally, if primary data in DEERS changes that makes an existing entitlement invalid (i.e., the family going back under the catastrophic cap), the existing entitlement will be marked inactive and an unsolicited PNT will be sent to the contractor if it affects an active policy's current or future fiscal years.

1.2.8.2. Enrollment Premium/Fee Payment Processing (For Enrollment Periods Prior to October 1, 2012)

1.2.8.2.1. Enrollment Fee Payment

1.2.8.2.1.1. Enrollment fees may be paid periodically (e.g., monthly, quarterly, or annually). The beneficiary specifies this payment option during enrollment and the contractor may enter the fee information in VB DOES, the Fee/CCD Web Research Tool, or the batch fee interface as part of the enrollment transaction. To send DEERS fee information separate from the enrollment, contractor's should use the batch enrollment fee payment process. If this information is entered into VB DOES, DEERS includes it on the notification to the contractor. Contractors also update DEERS with subsequent enrollment fee payments for a policy when the quarterly or monthly option is selected or fee payment exception reason. The contractor shall send all fee payment updates, including any overpayments, to DEERS within one business day. As with any other enrollment fee or premium payment, overpayments are considered part of the fee or premium amount that must be reported to DEERS. The subscriber's DEERS ID, policy, and enrollment fee payment information are required when performing this transaction. DEERS keeps track of the accumulated enrollment fee payment information by policy for the enrollment/fiscal year.

1.2.8.2.1.2. DEERS will automatically apply any fee payments and adjustments posted through DOES or the Enrollment Fee Payment interface to the beneficiary's catastrophic cap. For individual policies, the beneficiary will be credited with the fee amount; for family policies, the fee will be posted under the sponsor's catastrophic cap. If the catastrophic cap is locked at the time the fee payment is sent, DEERS will reject the fee payment. The contractor shall resend the fee amount to DEERS at a later time when the lock is removed from the catastrophic cap.

1.2.8.2.1.3. Both VB DOES and the enrollment fee payment interface perform edits against the submitted fee data. The contractor shall research and correct any data discrepancies identified by DEERS (both warnings and errors) within the designated business days. The contractor shall reconcile and correct the fee payments for all such policies prior to the next reporting month.

1.2.8.2.1.4. For monthly EFT or monthly allotments, contractors must collect and post a quarterly amount at the time of enrollment with monthly EFT or allotments beginning on the first day of the fourth month following the enrollment anniversary date (beginning of the next quarter) (see the TOM, Chapter 6, Section 1, paragraph 8.1., "Monthly Payment Fee Option"). Regardless of the date the contractor receives the monthly EFT or allotment, the contractor must post the payment through to the end of the next applicable payment period by entering the enrollment fee collected and the "paid-through" date.

1.2.8.2.1.5. DEERS records both the enrollment fee payment date and the enrollment fee paid-through date. The enrollment fee paid-through date reflects the time period for which coverage is paid. The date represents neither when the enrollment fee payment information was received nor when it was sent to DEERS. The purpose of tracking the period an enrollment fee covers is to ensure portability. On an enrollment transfer, DEERS includes the fee information from the enrollee's policy on the notification to the new contractor.

NOTE: Enrolling organizations may update fees collected that would cross the fiscal year when collecting the initial three month enrollment fee when establishing monthly allotments or EFTs, if there are less than three months remaining in the policy.

1.2.8.2.1.6. DEERS does not prorate fees, determine the amount of the next enrollment fee payment, determine the date of the next enrollment fee payment, send enrollment fee payment due notifications, identify what entity is responsible for enrollment fee payments, or automatically apply enrollment fee payments to catastrophic cap accumulations. These actions are the responsibility of the enrolling organization. Additionally, the enrolling organization must be able to accommodate policies that are less than 12 months in length and prorate enrollment fees appropriately.

1.2.8.2.1.7. Under certain circumstances, enrollment fees may not be required because the catastrophic cap amount has been met or an enrollment fee payment is waived for an individual. If the catastrophic cap amount has been met for the family, no further enrollment fee payment should be collected for the remainder of that enrollment period. This non-payment fee information should be sent to DEERS by the enrolling organization indicating the catastrophic cap was met for this period. In the same way, an enrollment fee payment may be less than the amount expected for the coverage plan because there is an individual in the policy who is exempt from paying fees due to a waiver or the fee payment would exceed

the catastrophic cap limit. The reason for a partial or non-payment of enrollment fee information would be sent to DEERS using the HCDP Enrollment Fee Payment Exception Reason Code. It is necessary for DEERS to have this information for portability.

1.2.8.2.1.8. Contractors must remove all existing credits on DEERS prior to the initialization of the new premium model. Credits not refunded to the beneficiary must be re-posted as a FY 2012 credit or a FY 2013 payment after initialization. Any FY 2012 credits remaining on or after October 1, 2012, must be removed from FY 2012 and either refunded to the beneficiary or posted as a payment for FY 2013. For payments effective October 1, 2012 and later, DEERS will not post credits amounts to the catastrophic cap.

1.2.8.2.1.9. See Chapter 3, Addendum C, HCDP Plan Coverage Details and TOM, Chapter 6, Section 1, for application of enrollment fees.

1.2.8.2.2. Premium Payment Programs: TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR) and TYA (For Coverage Prior To October 1, 2012)

1.2.8.2.2.1. For the TRS, TRR, and TYA programs, DEERS will accept premium payment paid-through dates.

1.2.8.2.2.2. Contractors are required to submit paid-through dates to DEERS upon receipt of premium payments. Contractors will refund overpayments of premiums to the member. In the event the member moves from one region to another region, billings for premiums shall be initiated on the next month with coverage effective the first day following the previous paid-through date. Transfers shall be made per the TOM, Chapter 24, Section 1 and 2 and Chapter 25, Section 1.

1.2.8.2.2.3. As with any other enrollment fee or premium payment, overpayments are considered part of the fee or premium amount that must be reported to DEERS.

NOTE: TRS/TRR/TYA premium payments are not applicable to the FY catastrophic cap.

1.2.8.3. Enrollment Fee and Premium Payment Processing (For Enrollments Effective On Or After October 1, 2012)

1.2.8.3.1. Enrollment Fee Payment (For Enrollment Periods On Or After October 1, 2012)

1.2.8.3.1.1. Enrollment fees may be paid monthly, quarterly, or annually. The beneficiary specifies this payment option during enrollment and the contractor shall enter the dollar amount received from the beneficiary in the Premium/Fee Interface or the Fee/CCD Web Research application. DEERS will calculate the policy paid period end date and return the information to the enrolling contractor. Contractors shall send the dollar amount of all subsequent enrollment fee transactions to DEERS within one business day. With the exception of claims recoupments and Non-Sufficient Funds (NSF) fees, all monetary receipts from beneficiaries must be treated as premium/fee payments and be reported to DEERS as premium/fee payments, unless they are refunded to the beneficiary or forfeited by the beneficiary. The contractor's system shall be able to process fee refunds as necessary.

1.2.8.3.1.2. If applicable, DEERS will automatically apply fee transactions to the beneficiary's catastrophic cap. For individual policies, the beneficiary will be credited with the fee amount; for family policies, the fee will be posted under the sponsor's family contribution towards the catastrophic cap. If the catastrophic cap is locked at the time the fee payment is sent, DEERS will reject the fee payment. The contractor shall resend the fee amount to DEERS daily until it is accepted. If the record remains locked longer than 48 hours, the contractor should contact the claims processor that placed the lock to determine the reason for the lock and when it will be released.

1.2.8.3.1.3. The Premium/Fee Interface performs edits against the submitted fee data. The contractor shall research and correct any data discrepancies identified by DEERS (both warnings and errors) within three business days.

1.2.8.3.1.4. DEERS records both the enrollment fee payment date and the enrollment fee paid. The enrollment fee payment date reflects the date the fee was received by the contractor, the enrollment fee paid will be used by DEERS to calculate the paid period end date. DEERS includes the last fee information from the enrollee's policy on notifications to the contractors. DEERS also calculates and reports credits to all policies.

1.2.8.3.1.5. Contractors must remove all existing credits on DEERS prior to the initialization of the new premium model. Credits not refunded to the beneficiary must be re-posted as a FY 2012 credit or a FY 2013 payment after initialization. Any credits remaining on or after October 1, 2012, must be removed from FY 2012 and either refunded to the beneficiary or posted as a payment for FY 2013. For payments effective October 1, 2012 and later, DEERS will not post credits amounts to the catastrophic cap.

1.2.8.3.2. Premium/Fee Interface (For Enrollment Periods On Or After October 1, 2012)

1.2.8.3.2.1. The contractor will send premium/fee payment information to DEERS through a system-to-system interface. This interface includes new payments, and payment adjustments. DEERS will calculate the new paid period end date based on the amount submitted by the contractor. Contractors must correct and resubmit enrollment premium/fee payments rejected by DEERS or research, correct and resubmit premium/fee payments for which DEERS has provided a warning within three business days of the error.

1.2.8.3.2.2. DEERS calculates paid period end dates based on the premium/fee amounts collected and entered into DEERS by the contractor and applicable DEERS data. It does not determine the date of the next premium/fee payment, send premium/fee payment due notifications, or identify which entity is responsible for premium/fee payments. These actions are the responsibility of the contractors. Additionally, the contractors must be able to accommodate policies that are less than 12 months in length and prorate enrollment fees appropriately. DEERS will provide a Premium Billing Service to assist the contractors with determining the correct amount to collect from the beneficiary.

1.2.8.3.3. Premium Payment Programs: TRS, TRR, and TYA (For Coverage On or After October 1, 2012)

1.2.8.3.3.1. For the TRS, TRR, and TYA programs, the contractor will enter into DEERS the premium amount collected for the policy and DEERS will calculate and return to the contractor the paid period end date.

1.2.8.3.3.2. Contractors are required to submit all premium payments collected to DEERS upon receipt. Contractors will refund all overpayments of premiums to the member at termination of coverage. In the event the member moves from one region to another region, billings for premiums shall be initiated the next month with coverage effective the first day following the previous paid period end date. Transfers shall not be initiated except upon notification by the member of an address change to the contractor. Transfers shall be made per the TOM, Chapter 24, Section 1 and 2 and Chapter 25, Section 1.

1.2.8.3.3.3. As with any other enrollment fee or premium payment, overpayments are considered part of the fee or premium amount that must be reported to DEERS.

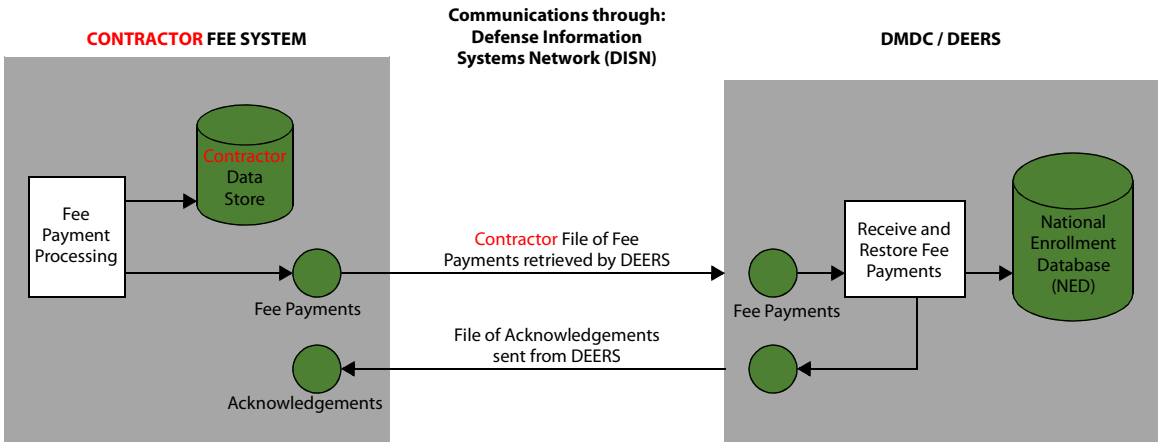
NOTE: TRS/TRR/TYA premium payments are not applied to the catastrophic cap.

1.2.8.4. Batch Fee Payments

In addition to sending enrollment fee payment information to DEERS through DOES, the contractor may also send the information to DEERS via the Fee/CCD Web Research Too, and in batch format. The batch fee payment updates include new payments, payment adjustments, and updates to enrollment paid-through dates. Contractors must correct and resubmit enrollment fee payments rejected by DEERS or research, correct and resubmit fee payments for which DEERS has provided a warning.

DEERS will automatically apply any fee payments posted through DOES or the Enrollment Fee Payment interface to the beneficiary's catastrophic cap. The following figure illustrates the process for sending batch fee payment updates to DEERS:

FIGURE 3-1.5-5 BATCH FEE PAYMENT PROCESS



1.2.8.5. Premium Payments (For Coverage Prior to October 1, 2012)

1.2.8.5.1. TRS/TRR/TYA Programs, DEERS will accept premium payment paid-through dates. Contractors are required to submit paid-through dates to DEERS upon receipt of premium payments. Contractors will refund all overpayments of premiums to the TRS member. In the event the TRS member moves from one region to another region, billings for premiums shall be initiated on the first day of the next month with coverage effective the first day following the previous paid-through date. In the event of a delinquent account, billing notification and delinquency actions may be required of the gaining contractor prior to the next billing cycle. Transfers shall be made per the TOM, Chapter 24, Section 1 and 2 and Chapter 25, Section 1.

1.2.8.5.2. For coverage on or after October 1, 2012, contractors shall submit premium payment amounts received, including any overpayments, to DEERS. As with any other enrollment fee or premium payment, overpayments are considered part of the fee or premium amount that must be reported to DEERS.

NOTE: TRS premium payments are not applicable to the FY catastrophic cap.

1.2.9. Enrollment Attribute Updates

The DOES application supports the entry of additional enrollment-related information to support contractor processing that is external to DEERS. The following sections describe the data that may be entered or updated in DOES. Upon update of this information, DEERS sends a notification to the contractor reflecting the update.

1.2.9.1. Enrollment Fee Waiver Update For An Individual (VB Does Only)

Under certain circumstances (e.g., beneficiaries under age 65 with Medicare Parts A and B), enrollment fees may be fully or partially waived. Fee waivers should not be confused with non-payment of enrollment fees due to meeting catastrophic cap amounts. Enrollment fee waivers are associated at the individual beneficiary level and should be sent to DEERS by the contractor. For example, if three family members are waived from paying enrollment fees, an enrollment fee waiver must be applied to each person individually. The waiver information is a reason that indicates that there is a waiver during an enrollment period. There are no dates associated with the enrollment fee waiver and waiver information can be updated at any time during the enrollment period. The fee payment waiver status for an individual is used to distinguish between enrollment fees that were waived versus ones that were not paid. If a family is disenrolled due to failure to pay enrollment fees, and there is an individual family member with an enrollment fee waiver, that individual cannot be disenrolled, because he or she is exempt from paying fees. The contractor is responsible for setting and removing enrollment fee waivers as appropriate as well as setting fee payment exception reason codes based on the existence of fee waivers.

NOTE: Contractors using Web DOES are not responsible for sending fee waiver information to DEERS.

1.2.9.2. Work Zip Code

A work zip code is supported for TRICARE Prime Remote (TPR) plan determinations. TPR plan determinations are based on the sponsor's daily work location and residential zip codes as well as the family member's residential zip code. Refer to Chapter 3, Addendum D, DEERS Business Rules, for more information.

1.2.10. Re-Enrollment

Many types of coverage plans require annual re-enrollment. The enrollment year will be aligned to the fiscal year for enrollment fee payments and CCDD accumulations. This applies to all new enrollments as well as renewals for transitioned or transferred policies. Annual re-enrollment, where required by plan, is handled simultaneously by the contractor and DEERS. DEERS will create a new enrollment year for the policies requiring re-enrollment on the 16th of the month prior to the month the policy expires. For example, if a policy ends on September 30th, the re-enrollment will occur on August 16th. If the enrolled beneficiaries lose eligibility prior to the end of the next enrollment year, DEERS adjusts the policy to the latest end of eligibility date for the family and notifies the contractor of the new policy end date. See "Enrollment" (paragraph 1.2.5.) for more details on the migration of enrollment year to fiscal year basis.

1.2.11. Beneficiary Web Enrollment Confirmation

Most actions performed in BWE require confirmation by the contractor in DOES. These transactions are identified by the 'pending' status on the Policy Notification Transaction (PNT) resulting from the BWE transaction. As part of the confirmation process, the contractor may modify the effective date and/or PCM assignment information. The confirmation (and modification, if applicable) will result in a subsequent PNT to update the contractor system with the confirmed enrollment action. See paragraph 1.4. for more information about Notifications.

1.3. Address And Telephone Number Updates

1.3.1. DEERS receives address information from a number of source systems. The mailing address captured on DEERS is primarily used to mail the enrollment card and other correspondence. The residential address is used to determine enrollment jurisdiction in cases where a beneficiary has separate mailing and residential addresses. Jurisdiction is performed at the zip code level. A beneficiary update is used to update addresses. Beneficiaries may provide up to two addresses (residential and mailing) which are entered into DEERS using DOES. The TRICARE enrollment form contains a mailing address and a residential address. Addresses are updated through the DOES application. DOES uses a commercial product to validate address information online.

1.3.2. DEERS has several types of telephone numbers for a person (e.g., home, work, and cellular). These telephone numbers can be added and updated as necessary by the MHS and contractor. Phone numbers are updated through the DOES application.

1.3.3. DEERS also stores a home e-mail address for a person. This e-mail address can be added and updated as necessary by the MHS and contractor. The home e-mail address is updated through the DOES application.

1.4. Notifications

Notifications are sent to contractor for various reasons, and reflect the most current policy information for a beneficiary. The contractor must accept, apply, and store the data contained in the notification as sent from DEERS. Notifications may be sent resulting from new enrollments or updates to existing enrollments. If the contractor does not have the information contained in the notification, the contractor shall add it to their system. If the contractor already has enrollment information for the beneficiary, the contractor shall apply all information contained in the notification to their system. The contractor shall use the DEERS ID to match the notification to the correct beneficiary in their system. There are also circumstances where a contractor may receive a notification that does not appear to be updating the information that the contractor already has for the enrollee. Such notifications shall not be treated as errors by the contractor system and must be applied. The contractor is expected to acknowledge all notifications sent by DEERS. If DEERS does not receive an acknowledgement, the notification will continue to be sent until acknowledgement is received. The following information details examples of events that trigger DEERS to send notifications to a contractor.

1.4.1. Notifications Resulting From Enrollment Actions

1.4.1.1. DEERS sends notifications to contractors detailing any policy or PCM update performed in the DOES or BWE application. This includes address updates and some demographic changes made for enrollees, regardless of the update source. DEERS will also send notifications for fee updates the contractor makes in the Fee/CCDD Research application. Additionally, DOES supports a feature for the contractor to request a notification to be sent without updating any address or enrollment information. The purpose of this request is to re-sync the contractor system with the latest DEERS policy data.

1.4.1.2. Notifications sent as a result of enrollments, transfers, or PCM changes in BWE will indicate a pending status. This notification should trigger the contractor to confirm the enrollment. A second notification is sent when the action is confirmed in DOES. If the DOES operator modified the enrollment or PCM data, the second notification will contain the corrected data in a non-pending status.

1.4.1.3. During transfers in BWE, one non-pending disenrollment notification is sent to the losing contractor. There is no subsequent notification sent to the losing contractor when the enrollment information is confirmed in DOES.

1.4.2. Unsolicited Notifications

These types of notifications are unsolicited to the contractor and result from updates to a sponsor or family member's information made by an entity other than the enrolling contractor. Unsolicited notifications may result from various types of updates made in DEERS, to include ECHO registration and the TRS program:

- Change to eligibility. As updates are made in DEERS that affect a beneficiary's entitlements to TRICARE benefits, DEERS modifies policy data based on those changes and sends notifications to the contractor and to CHCS, if appropriate. One example of this type of notification is notification of loss of eligibility.
- Extended Eligibility. For example, in the case of a 21-year old child that shows proof of being a full-time student, eligibility is extended until the 23rd birthday.
- SSN, name, and DOB changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or DOB are communicated via unsolicited notification to the contractor.
- Address changes. The notification also includes information as to which type of entity made the update. Address changes performed by CHCS are also sent to the contractor.
- Data corrections made by DMDC Support Office (DSO) or the DOES Help Desk. If a contractor requests the DSO to make a data correction for a current or future enrollment that the contractor cannot make themselves, notification detailing the update is sent to the contractor, and to CHCS, if appropriate.
- Automatic approvals of BWE actions. DEERS will send unsolicited notifications for all BWE actions approved without contractor action in DOES.
- Fee waiver updates. Changes to an enrolled sponsor or beneficiary's fee waiver status will be sent via unsolicited notifications to the contractor.

NOTE: Fee waiver updates only apply when the contractor is using Web DOES.

- Changes to premium information as a result of a premium or fee recalculation by DEERS.

1.4.3. Patient ID Merge

Occasionally, incomplete or inaccurate person data is provided to DEERS, and a single person may be temporarily assigned two Patient IDs. When DEERS identifies this condition, DEERS makes this information available online for all contractors. The contractor is responsible for retrieving and applying this information on a weekly basis. The merge brings the data gathered under the two IDs under only one of the IDs and discards the other. Although DEERS retains both IDs for an indefinite period, from that point on only the one remaining ID shall be used by the contractor for that person and for subsequent interaction with DEERS and other MHS systems. If there are enrollments under both records being merged that overlap, the enrolling organizations are responsible for correcting the enrollments. DEERS merges OHI by assigning the last updates of OHI active policies (not cancelled or systematically terminated) to the remaining Patient ID.

1.5. Enrollment Cards And Letter Production

1.5.1. DEERS is responsible for producing the TRICARE universal beneficiary card for both CONUS and OCONUS. The cards are produced for beneficiaries enrolled in TRICARE

Prime, TRICARE Remote, and TRS coverage plans. Enrollment cards are not produced for enrollments with the contractors.

1.5.2. New enrollment cards are automatically sent upon a new enrollment or an enrollment transfer to a new contractor, unless the enrollment operator specifies in DOES not to send an enrollment card. Cards are also automatically generated upon a PCM change to a new TRICARE region that has different information-line phone numbers than the previous region or upon a change of a coverage plan that changes the type of card.

1.5.3. A contractor may request a replacement enrollment card for an enrollee at any time. DEERS sends enrollment card request information in a notification to the contractor indicating the last date an enrollment card was generated for the enrollee.

1.5.4. Along with the enrollment card, DEERS sends a letter to the beneficiary indicating their PCM selection as entered in DOES for TRICARE Prime and TRICARE Remote enrollment.

1.5.5. The contractor may initiate a PCM change that does not require a new enrollment card. In these cases, DEERS sends a PCM change letter to the beneficiary. In the event PCM change letters or enrollment cards are returned to the contractor due to a bad address, the contractor researches the address, corrects it on DEERS, and re-mails the correspondence to the beneficiary.

1.6. Claims, Catastrophic Cap, And Deductible Data

DEERS is the system of record for eligibility and enrollment information. As such, in the process of claims adjudication, the contractor shall query DEERS to determine eligibility and/or enrollment status for a given period of time. The contractor shall use DEERS as the database of record for:

- Person Identification
- Eligibility
- Enrollment and PCM information
- Enrollment/fiscal year to date totals for CCDD amounts
- Other Government Program (OGP)

Upon receipt of this data from DEERS, the contractor shall not override this data with information from other sources.

Although DEERS is not the database of record for OHI, it is a centralized repository of OHI information that is reliant on the MHS organizations to verify, update and add to at every opportunity. An MHS organization can verify, update or add OHI during eligibility and enrollment claims inquiries, or direct OHI related events identified in the OHI section of this document. The OHI data received as part of the claims inquiry shall be used as part of the claims adjudication process. If the contractor has evidence of additional or more current OHI information they shall process claims using the additional or more current information. After the claims adjudication process is complete, the contractor shall send the updated or additional OHI information to DEERS using the system to system process or other mechanisms identified in the OHI section of this document.

DEERS stores enrollment/fiscal year CCDD data in a central repository. DEERS stores the current and the two prior enrollment/fiscal year CCDD totals. The purpose of the DEERS CCDD repository is to maintain and provide accurate CCDD amounts, making them universally accessible to DoD claims-processors.

1.6.1. Data Events: Inquiries And Responses

This section identifies the main events, including the inquiries and responses between the contractors and DEERS, associated with CCDD transactions. The main events to support processing this information include:

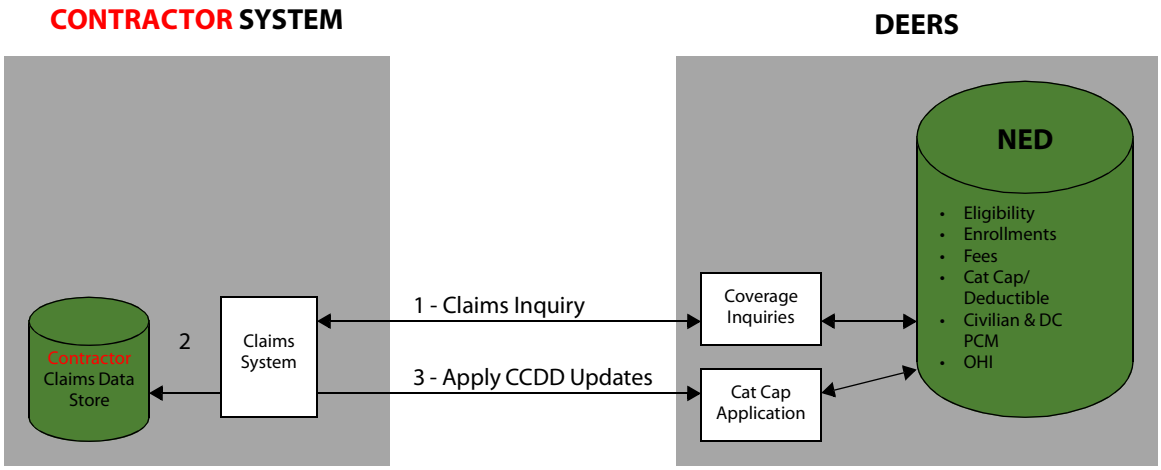
- Health Care Coverage Inquiry for Claims
- CCDD Totals Inquiry
- CCDD Amounts Update
- CCDD Transaction History Request

1.6.1.1. Health Care Coverage Inquiry For Claims

The contractor shall install a prepayment eligibility verification system into its TRICARE operation that results in a query against DEERS for TRICARE claims and adjustments. The interface should be conducted early in the claims processing cycle to assure extensive development/claims review is not done on claims for ineligible beneficiaries.

The DEERS Health Care Coverage Inquiry for Claims supports business events associated with health care coverage and CCDD data for processing medical claims. This inquiry may also be used for general customer service requests or for referrals and authorizations.

FIGURE 3-1.5-6 CLAIMS INQUIRY TO DEERS



The contractor must use the eligibility, enrollment, OHI, OGPs (e.g., Medicare), PCM, and CCDD information returned on the DEERS response to process the claim.

There are multiple options for inquiring about coverage information while including CCDD information. These different inquiry options allow the inquirer to receive coverage information and CCDD totals without locking the CCDD information for the family. A coverage inquiry and lock of the CCDD accumulations is necessary prior to updating this data on DEERS.

For audit and performance review purposes, the contractor is required to retain a copy of every transaction and response sent and received for claims adjudication procedures. This information is to be retained for the same period as required by the TPM or TOM.

Unless notified by the contracting officer, the contractor may not bypass the query/response process for the prior day's claims if either DEERS or the contractor is down for 24 hours or any other extended period of time. Instead, when this situation occurs, the contractor shall work directly with DEERS to develop a mutually agreeable schedule for processing the backlog. The contractor shall develop a method for ensuring the query/response process continues, even if an extended period of downtime occurs. This alternative method can be either a batch backup to the on-line system, weekend processing, off-hours processing, or any other method proposed by the contractor and accepted by DEERS and TMA.

1.6.1.1.1. Exceptions To The DEERS Eligibility Query Process

Claims processing adjudication requires a query to DEERS except in cases where a claim contains only services that will be totally denied and no monies are to be applied to the deductible.

There are three exceptions to the requirement for sending a query for TRICARE adjustments. No query is needed for:

- Another claim or adjustment for the same beneficiary that is being processed at the same time. (A contractor may query for a claim or money adjustment using a "claim status query" for one of several claims.")
- Negative Adjustments
- Total Cancellations

1.6.1.1.2. Information Required For A Health Care Coverage Inquiry For Claims

The information needed to perform this type of coverage inquiry includes:

- Person identification information, including person or family transaction type
- Begin and end dates for the inquiry period

1.6.1.1.3. Person Identification

A beneficiary's information is accessed with the coverage inquiry using the identification information from the claim. DEERS performs the identification of the individual and returns the system identifiers (DEERS ID and Patient ID). The DEERS IDs shall be used for subsequent communications on this claim. See Chapter 3, Section 1.3, paragraph 3.3. and 3.4. for more information on the identification of beneficiaries.

1.6.1.1.4. Inquiry Options: Person Or Family

The inquirer must specify if the coverage inquiry is for a person or the entire family. The person inquiry option should be used when specific person identification is known. If person information is incomplete, the family inquiry mode can be used. In family inquiries, the Inquiry Person Type Code is required to indicate if the SSN, Foreign ID, or Temporary ID is for the sponsor or family member. In such inquiries, DEERS returns both sponsor and family member information. If there is more than one person or family match, the correct person must be selected, then the coverage inquiry re-sent.

FIGURE 3-1.5-7 INQUIRY PERSON TYPE CODE

PERSONS TO RETURN	WHAT INFORMATION IS AVAILABLE FROM THE CLAIM	VALUES TO SET	USAGE
RETURN ONLY A SINGLE SPONSOR/FAMILY MEMBER (PNF_TXN_TYP_CD = P)	SPONSOR INFORMATION IS PROVIDED (INQ_PN_TYPE_CD = S)	INQUIRY SPONSOR INFO SECTION:	
		SPN_INQ_PN_ID	R
		SPN_INQ_PN_ID_TYP_CD	R
		SPN_PN_LST_NM	O
		SPN_PN_1ST_NM	O
		SPN_PN_BRTH_DT	O
		INQUIRY PERSON INFO SECTION*:	
		INQ-PN_ID	S
		INQ-PN_ID_TYP_CD	S
		and/or	
		PN-LST-NM	NA
		PN-1ST_NM	S
		PN_BRTH_DT	S
RETURN ONLY A SINGLE PERSON SINGLE SPONSOR/ FAMILY MEMBER (PNF_TXN_TYP_CD = P)	NO SPONSOR INFORMATION IS PROVIDED** (INQ_PN_TYP_CD = P)	INQUIRY SPONSOR INFO SECTION:	NA
		INQUIRY PERSON INFO SECTION:	
		INQ_PN_ID	R
		INQ_PN_ID_TYP_CD	R
		PN_LST_NM	O
		PN_1ST_NM	O
		PN_BRTH_DT	O
RETURN THE WHOLE FAMILY (PNF_TXN_TYP_CD = F)	SPONSOR INFORMATION PROVIDED (INQ_PN_TYP_CD = S)	INQUIRY SPONSOR INFO SECTION:	
		SPN_INQ_PN_ID	R
		SPN_NQ_PN_ID_TYP_CD	R
		SPN_PN_LST_NM	O
		SPN_PN_1ST_NM	O
		SPN_PN_BRTH_DT	O
		INQUIRY PERSON INFO SECTION:	NA

LEGEND: R - REQUIRED; O - OPTIONAL; S - SITUATIONAL

NOTE: * The Inquiry Person information section on a family member inquiry must either have the INQ_PN_ID and INQ_PN_TYP_CD OR if none is available then at least a PN_1ST_NM and PN_BRTH_DT.

**The period of time required for this type of inquiry to DEERS is significantly longer than for a family member based inquiry using a sponsor and should be used only infrequently when NO sponsor PN_ID information is provided on the claim.

The HICN (H) is only valid in the Person Inquiry section, not in the sponsor section and only on PERSON pulls (leave sponsor section blank).

1.6.1.1.5. Inquiry Period

In addition to identifying the correct person or family, the inquirer must supply the inquiry period. The inquiry period may either be a single day or span multiple days. Historical dates are valid, as long as the requested dates are within five years. The inquirer queries DEERS for information about the coverage plans in effect during that inquiry period for the sponsor and/or family member. The reply may include one or more coverage plans in effect during the specified period. For claims, the contractor shall use the dates of service on the claim.

1.6.1.2. Information Returned In The Health Care Coverage Inquiry For Claims

The DEERS ID is returned in response to a coverage inquiry. The contractor should store the DEERS ID for use in subsequent update transactions for this claim. The DEERS ID ensures correct person identification and provides uniform beneficiary identification across the MHS. In addition, the Patient ID is returned in the coverage response. The contractor is required to store the Patient ID. The Patient ID provides uniform person identification and patient identification across the MHS. The contractor must put the Patient ID and DEERS ID on the TRICARE Encounter Data (TED) record.

1.6.1.2.1. Data Returned In A Coverage Inquiry That Repeats For Every Coverage Plan

In response to a Health Care Coverage Inquiry for Claims, DEERS returns the specified coverage information in effect for the inquiry period. The following list shows the information DEERS returns for each coverage plan in effect during the inquiry period:

- Coverage plan information (assigned or enrolled)
- Coverage plan begin and end dates for inquiry period
- Sponsor branch of service and family member category and relationship to the sponsor during coverage period

NOTE: Newborn coverage information will only be reflected when the newborn is added to DEERS. See paragraph 1.6.1.5.2.6.

1.6.1.2.2. Data Returned In A Coverage Inquiry Independently From The Coverage Plan Information

The DEERS coverage response could include PCM, OHI and OGP information, and CCDD totals and lock information, independently from the health care coverage information. If no PCM, OHI, and OGP information is returned, this means that DEERS does not have this information in effect for the requested inquiry dates.

- Sponsor Personnel Information: All current personnel segments will be returned, including dual eligible segments. The contractor shall not use this information for claims processing. This information is intended to be used for the TED only.
- PCM information: PCM information is returned for some enrolled coverage plans. No PCM information is present for the DoD-assigned coverage plans

and some enrolled coverage plans. PCM information provided includes DMIS, the PCM Network Provider Type Code, and individual PCM information if available in DEERS.

- OHI: Limited OHI information is returned.
- OGPs: Complete OGP information is provided in the response. OGPs include CHAMPVA and Medicare.
- CCDD totals: Both family and individual CCDD accumulations are provided in the coverage response.

1.6.1.2.3. Health Care Coverage Copayment Factor For Coverage Inquiries

The copayment for an insured is determined using information provided by DEERS and may also include treatment information from a claim. The different factors are determined by legislation, which considers factors such as pay grade and personnel category, such as retired sponsor or AD.

The Health Care Coverage Copayment Factor Code is determined by DEERS and is returned on a claims inquiry. The contractor shall use this factor code to determine the actual copayment for the claim. Examples of copayment factors are:

- Pay Grade Corporal/Sergeant or Petty Officer Third Class and below rate
- Pay Grade Sergeant/Staff Sergeant or Petty Officer Second Class and above rate
- Retiree and Surviving family members of deceased activity duty sponsors rate
- Foreign Military rate

NOTE: More rate codes can be added, as required by the DoD.

Although the rates are based on the population to which they pertain, such as retired sponsor, these rates also apply to a sponsor's family members.

1.6.1.2.4. Special Entitlements

Congressional legislation may effect deductibles and rates. The Special Entitlement Code, and dates if applicable, provide information to support this legislation. Examples are:

- Special entitlement for participation in Operation Joint Endeavor – this code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the Special entitlement section of the data returned.
- Special entitlement for participation in Operation Noble Eagle – this code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the

effective and expiration dates of the Special entitlement section of the data returned. In addition, non-participating physicians will be paid up to 115% of the CMAC or billing charges whichever is less.

Effective dates will also be included in the response from DEERS. A person may have multiple special entitlements. Refer to TOM and TPM.

1.6.1.3. Multiple Responses To A Single Health Care Coverage Inquiry for Claims

DEERS may need to send multiple responses to a single Health Care Coverage Inquiry for Claims, and these responses are returned in a single transaction. This situation could occur if a person has multiple DEERS IDs within the inquiry period. It is necessary for DEERS to capture family member entitlements and benefit coverage corresponding to each instance of the person's DEERS ID. For example, in a joint service marriage, a child may be covered by the mother from January through May (DEERS ID #1) and covered by the father from June through December (DEERS ID #2).

FIGURE 3-1.5-8 HEALTH CARE COVERAGE INQUIRY FOR CLAIMS: RESPONSES AND ACTIONS

CONDITION	RESPONSE	CONTRACTOR ACTION
Based on INQUIRY PERSON TYPE CODE of 'S' (individual family member inquiry with Sponsor and family member information provided)		
1. Multiple sponsors matched	Partial match transfer with multiple families TXN_TYP_CD = 'F' Return Status 0 and Return Code 00000 in header section	Select correct sponsor, re-query DEERS using the selected sponsor's SPN_PN_ID and SPN_PN_ID_TYP_CD, SPN_PN_LST_NM and SPN_PN_BRTH_DT and at least the PN_ID, PN_ID_TYP_CD of the family member selected.
2. Sponsor found, family member not found	Partial match transfer with one family TXN_TYP_CD = 'F' Return Status 0 and Return code 00000 in header section	Select correct family member, re-query DEERS using both the returned sponsor's and family members PN_ID and PN_ID_TYP_CD.
3. Sponsor found, multiple family members matched	Partial match transfer with one family TXN_TYP_CD = 'F' Return Status 0 and Return Code 00000 in header section	Select correct family member, re-query DEERS using the originally sent sponsor data but now add PN_ID and PN_ID_TYP_CD returned to the new inquiry
4. Sponsor found, family member found	Health care coverage transfer TXN_TYP_CD = 'P' Return Status 0 and Return Code 00000 in header section	Adjudicate claim based on response.
Based on INQUIRY PERSON TYPE CODE of 'P' (person inquiry with no sponsor information available)		
1. Person found in multiple families during inquiry period	Partial match transfer with multiple families	Select correct sponsor, re-query DEERS using both the returned sponsor's and family members PN_ID and PN_ID_TYP_CD.
2. Person found in single family during inquiry period	Health care coverage response	Adjudicate claim based on response.
Based on TRANSACTION TYPE CODE of 'W', 'E', or 'S' (errors or warnings encountered)		

FIGURE 3-1.5-8 HEALTH CARE COVERAGE INQUIRY FOR CLAIMS: RESPONSES AND ACTIONS

CONDITION	RESPONSE	CONTRACTOR ACTION
1. Person not found	Application Warning or Error Transfer TXN_TYP_CD = 'W' Return Status 4 and Return Code 00001 in header section	Deny claim and direct beneficiary to a military ID card facility to have information updated in DEERS.
2. Application Error or warning other than Person not found	Application Warning or Error Transfer TXN_TYP-CD = 'W' Return Status 4 and Return Code 00002 through 99999 in header section	For action, see Return Code section 10.0 of the Technical Specification.
3. Inquiry Transfer handling Error	Application Warning or Error Transfer TXN_TYP_CD = 'E' Return Status 1 and Return Code 00001 through 99999 in header section	For action, see Return Code section 10.0 of the Technical Specification.
4. System Error	Application Warning or Error Transfer TXN_TYP_CD = 'S' Return Status 1, 2, 3, 5, 6, 7, 8, 9 and Return Code 00001 through 99999 in header section	For action, see Return Code section 10.0 of the Technical Specification.

If the contractor is unable to select a patient from the family listing provided by DEERS, the contractor shall check the patient's DOB. If the DOB is within 365 days of the date of the query (i.e., a newborn less than l year old), the contractor shall release the claim for normal processing.

If the DOB is over 365 days from the date of query, the contractor shall check the duty station or residence of the sponsor. If the sponsor resides overseas and/or an APO/FPO address is indicated for the sponsor, the claim shall be released for normal processing.

Contractors shall deny a claim (either totally or partially) if the services were received partially or entirely outside any period of eligibility.

CHAMPVA claims shall be forwarded to Health Administration Center, CHAMPVA Program, PO Box 65024, Denver CO 80206-5024.

A list of key DSO personnel and the Joint Uniformed Services Personnel Advisory Committee (JUSPAC) and Joint Uniformed Services Medical Advisory Committee (JUSMAC) members is provided at the TMA web site at http://www.tricare.mil. These individuals are designated by the TMA to assist DoD beneficiaries on issues regarding claims payments. In extreme cases the DSO may direct the claims processor to override the DEERS information; however, in most cases the DSO is able to correct the database to allow the claim to be reprocessed appropriately. The procedure the contractor shall use to request data corrections is in Chapter 3, Section 1.6.

Any overrides issued by the DSO will be in writing detailing the information needed to process the claim. Overrides cannot be processed verbally, and overrides are not allowed in cases where correction of the data is the appropriate action. Only in cases of aged data that can not be corrected will DSO authorize an override. The contractor will provide designated Points of Contact (POC) for the DSO personnel and the JUSPAC/JUSMAC members identified on the TMA web site.

1.6.1.4. CCDD Totals Inquiry

The CCDD Totals Inquiry is used to obtain CCDD balances for the fiscal year(s) that correspond to the requested inquiry period. The contractor must inquire and lock CCDD totals before updating DEERS CCDD amounts with enrollment fee payment information.

1.6.1.4.1. Information Required To Inquire For Totals

The following information details the data required to inquire for CCDD totals.

1.6.1.4.1.1. Person Information

The contractor must have the DEERS ID, returned by DEERS on the policy notification or coverage response, for this inquiry. Either the sponsor's or family member's DEERS ID is used for the totals inquiry. Even though only one person's DEERS ID is used, both individual and family totals will be returned in the response.

1.6.1.4.1.2. Other Persons Not On DEERS

A catastrophic cap record is not required for persons who are not on DEERS, for example, prisoners and MTF employees. The purpose of the catastrophic cap is to benefit those beneficiaries who are eligible for MHS benefits through their registration on DEERS, therefore, those persons that are authorized benefits, who would not under any other circumstances be eligible, are not subject to catastrophic cap requirements.

1.6.1.4.1.3. CCDD Totals Inquiry Period

The inquiry period used for the CCDD Totals Inquiry may be a single date or a date range, not more than three years (current year and two prior years) in the past. Future dates are not valid.

1.6.1.4.1.4. Lock Indicator

The contractor chooses whether to lock CCDD totals. However, if the contractor intends to update the CCDD amounts, the contractor must lock the CCDD totals. See locking description in the Health Care Coverage Inquiry section. At TMA discretion, certain non-contractor organizations are waived from locking prior to updating CCDD (for example: Pharmacy Data Transaction System (PDTS)).

1.6.1.4.1.5. Response To CCDD Totals Inquiry

The following information details the information returned from a CCDD totals and inquiry.

1.6.1.4.1.6. CCDD Totals

DEERS sends a response showing year-to-date CCDD totals for each FY, based on the inquiry dates requested, not greater than three years in the past. Both individual and family totals are displayed, showing CCDD balances separately. If there are no CCDD totals

accumulated for any FY in the inquiry period requested, DEERS will show a zero value for that FY.

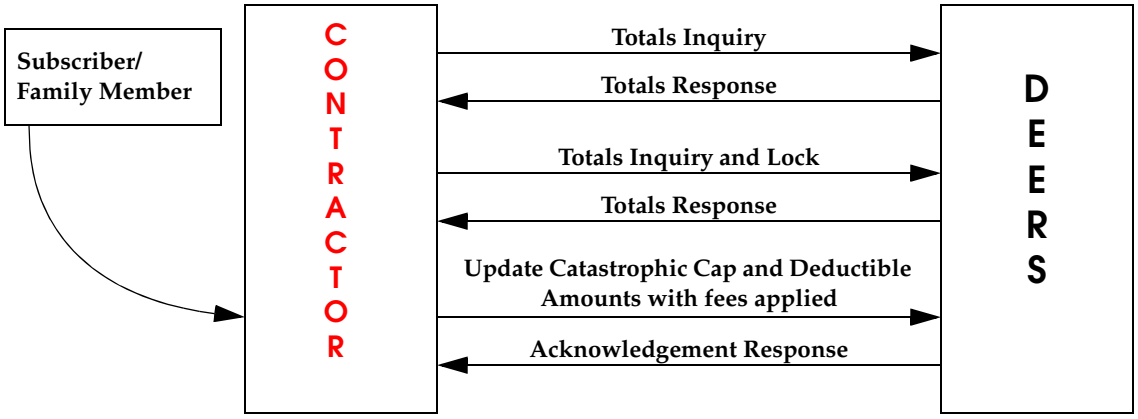
If the inquiry period spans fiscal or enrollment years, the CCDD totals would repeat multiple times. For example, if the inquiry dates are September 1, 2003 through October 25, 2003, there would be two sets of fiscal year totals, one for FY 2003 and one for FY 2004.

1.6.1.4.1.7. Lock Information

If an contractor inquires for CCDD totals and does not place a lock on the totals, DEERS returns any totals accumulated for the inquiry period and lock information if the totals were presently locked. If a contractor inquires for totals with a lock and the totals were not presently locked, DEERS would return the accumulated totals and that contractor's lock information, including their lock organization, lock date, and lock time. If an contractor inquires and locks CCDD totals for a beneficiary whose totals are already locked, only the lock organization, lock date, and lock time will be returned. No totals will be returned in this situation.

The following diagram depicts a CCDD Totals Inquiry.

FIGURE 3-1.5-9 CCDD TOTALS INQUIRY



1.6.1.5. Updating CCDD Amounts

The FY CCDD total can be updated online for the current and two prior fiscal years. This update transaction requires the DEERS ID, which may be obtained from a coverage or CCDD totals inquiry. Claim extension identifier note: If claim does not span multiple fiscal years, the claim extension identifier should be set to '000'. A split claim will set the claim extension identifier to '001' for the first FY the claim occurs in and increment the claim extension identifier for each additional FY the claim occurs. Only the same organization that placed the lock may update the locked record and remove the lock. DEERS validates that the updating organization is the same as the organization that placed the lock. If there is a discrepancy, DEERS does not allow the update and sends a response that the update was not successful. If there are more claims outstanding for the same family, the

contractor may choose not to remove the lock. In this case, the record would remain locked until the 48-hour time period expires, or the lock is removed, whichever comes first.

CCDD amounts can be updated online for the current year and two prior fiscal years. Each transaction should only include updates for one claim. CCDD amounts for multiple claims should be sent in separate transactions. In the split claim situation, multiple transactions must be sent for the same claim. For example, if a claim spans fiscal years and is split, updates for FY 2000 and FY 2001 must be sent in two transactions using the claim extension identifier (explained below) to distinguish the two updates from one another.

Do not send CCDD updates for programs for which they do not apply (e.g., ECHO). See the TPM.

If cost-shares, copays, or deductibles have been collected, these amounts must be posted to the CCDD, even if the limit has been met.

1.6.1.5.1. Information Required To Update CCDD Amounts

The contractor must provide the following information to update the CCDD amounts:

- DEERS ID: This identifies the beneficiary for whom the update is applied.
- Catastrophic cap, deductible, and/or Point of Service (POS) dollar amount

The contractor sends DEERS the CCDD amount for the beneficiary. DEERS knows to which family the beneficiary belongs and rolls up the totals for the correct family using the DEERS ID.

- Identifier for the claim, enrollment fee, or adjustment

NOTE: If there is a discrepancy between the identifier used for locking and the identifier used for updating, DEERS does not allow the update.

- Claim extension identifier

When a claim spans fiscal years, the claim extension is used to identify a split claim. These claims should have the same claim identifier with a different claim extension identifier. Splitting the claim is the responsibility of the claims processor, who splits the claim, adds the claim extension, and sends this information to DEERS.

- Lock information (remove or do not remove lock).
- Dates provided for the catastrophic cap and/or deductible update.

The dates may include the date(s) of service for the claim (both begin and end date) or the fiscal year, as appropriate. These dates are necessary for accumulating the CCDD totals for the correct time period and HCDP.

- For fiscal year updates, the contractor must send DEERS the fiscal year for which the CCDD applies.

- For updates associated with a claim, the period of service for the claim should be sent to DEERS, so that the information can be referenced with CCDD details.

1.6.1.5.2. Types Of CCDD Updates

DEERS supports CCDD update functionality including adding, adjusting, and canceling amounts. Adds, adjustments, and cancellations may be made for the previous three years.

1.6.1.5.2.1. Adds

The contractor utilizes the CCDD update to add new CCDD amounts to the DEERS CCDD repository.

1.6.1.5.2.2. Adjustments

The contractor utilizes the CCDD update to adjust posted CCDD amounts. The same claim identifier as the original claim must be provided for the adjustment. A negative or positive amount should be entered, in order to correct the net amount. In order to adjust a claim, a contractor must provide the same information for updating a claim as outlined in the previous section. For example, a contractor updates a claim with a $50 catastrophic cap amount, then two weeks later discovers that the claim was incorrectly adjudicated and the catastrophic cap amount should have been $35. The contractor would then update the beneficiary's catastrophic cap for the same claim number with an amount of -$15. The DEERS catastrophic cap balance would then show $35 for that claim.

1.6.1.5.2.3. Canceling A Catastrophic Cap Or Deductible Amount

The contractor utilizes this update transaction to cancel (zero out a posted amount) a previously submitted catastrophic cap or deductible amount.

Claim cancellations are handled similarly to adjustments. For example, a contractor updates a claim with a $120 deductible amount, then one week later discovers that this was incorrect, and there should not have been any adjudicated deductible amount. The contractor would then update the insured's deductible with an amount of -$120. This would zero out the previous amount applied for that claim.

1.6.1.5.2.4. The 48-Hour Rule

DEERS enforces a 48-hour lockout rule. If a contractor places a lock on a record and fails to update that record within the specified 48-hour time period, the contractor will be unable to update CCDD amounts, because the lock will have expired.

1.6.1.5.2.5. Removing A Lock

If a contractor places a lock, then realizes the lock is unnecessary, the preferred way to remove that lock is to perform a CCDD update specifying to remove the lock. In this

case, the contractor would send no catastrophic cap or deductible amounts, only an indication of the removal of the lock.

1.6.1.5.2.6. Add Newborn

CCDD amounts for a newborn are posted to DEERS by using the CCDD update transaction and setting the Newborn Addition Indicator Code to 'Y'. The 'Y' code indicates that a newborn is to be added. If DEERS returns an error code on a newborn and that person is already on the database, then the contractor should query to determine if this is the same person. If so, then use the return information to apply the CCDD. The field for "Person First Name" should be populated with 'NEWBORN' or 'developed first name'. If the record is required for a multiple birth, the contractor should submit a request for the addition of an additional placeholder record to DSO via the DSO Web Request (DWR) web-based application (an on-line system), and submit an actual name for the additional record(s). Contractors should request the first name of the initial placeholder record to be changed from 'NEWBORN' to the developed name for multiple births upon completion of development activities. DMDC's expected turnaround for the processing of requests for additional placeholder records is six work days. If the contractor has not received the placeholder record, they may contact DSO to follow-up on their request. When sponsors register their newborn children in Real-Time Automated Personnel Identification System (RAPIDS), the Verifying Official will change the placeholder field for "Person First Name" to the actual name of the newborn child. All catastrophic cap records for the placeholder record will be merged under the verifying record as appropriate.

The CCDD update transaction shall include both the newborn information and the CCDD amounts. After the newborn has been added to DEERS, the CCDD update will be posted to the database (provided that the family record is not locked). In the event that the CCDD update was unable to be posted, it is the contractor's responsibility to query DEERS to verify that the newborn has been created. The contractor is then to resend the CCDD update transaction, setting the Newborn Addition Indicator Code to 'N'.

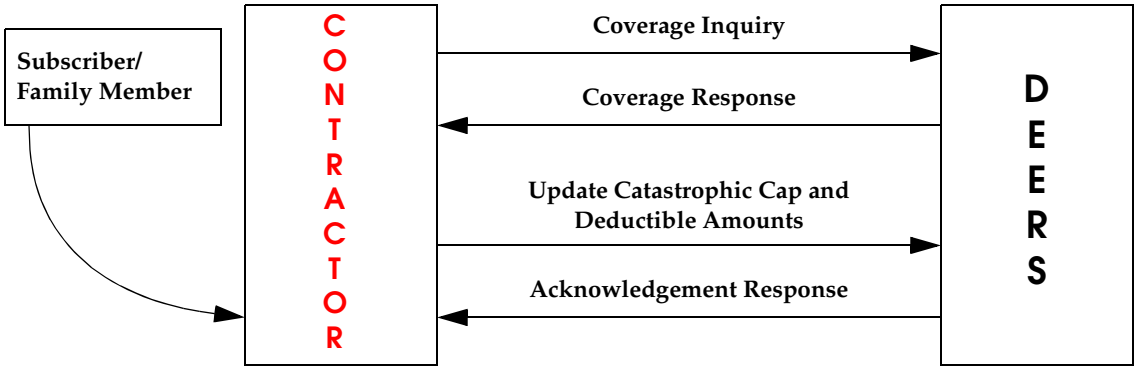
Adding the newborn in DEERS via CCDD updates will not generate eligibility for the newborn, but the newborn will show in GIQD and in claims responses. Once the sponsor "adds" the newborn in DEERS through RAPIDS, the newborn will be eligible like any other beneficiary.

NOTE: When the addition of a newborn placeholder is requested by the pharmacy contractor, see Chapter 3, Addendum F for procedures.

1.6.1.6. Response To Updating CCDD Amounts

DEERS sends an acknowledgement message after a successful CCDD update. The following figure details the flow of a CCDD Amounts Update.

FIGURE 3-1.5-10 COVERAGE INQUIRY AND CCDD UPDATE PROCESS



1.6.2. CCDD Transaction History Request

CCDD transaction history information is useful for customer service requests, for auditing purposes, or for researching any problems associated with CCDD updates in relation to a particular claim. DEERS maintains a record of each update transaction applied toward CCDD information. This detailed transaction information is available through the CCDD transaction history request. The following transaction history request types are available via the Catastrophic Cap and Fee Research Web application:

- Service Period Dates
- Claim ID

1.6.2.1. Information Required To Request A CCDD Transaction History

The required information for a transaction history request includes:

- Subscriber Person ID and ID Type Code
- Fiscal year

1.6.2.1.1. Inquiry Period

The inquiry period may be either a fiscal year or three fiscal years (current plus past two). Historical dates are valid, as long as the requested dates are within three years.

1.6.2.1.2. Detail Identifier

The inquirer may filter for CCDD transaction history information for a specific update using the detail identifier. The detail identifier corresponds to the claim number, enrollment fee identifier, or adjustment identifier used for posting the CCDD amounts.

1.6.2.2. Information Returned In Response To A CCDD Transaction History Request

DEERS returns each individual CCDD detail that was applied during the inquiry period for each member of the family inquired upon. Amounts returned in the response may include both positive and negative amounts.

For example, if the inquiry period were FY 2001, all CCDD amounts that were applied to the FY 2001 are returned in the transaction history response regardless of the date in which the update was actually sent to DEERS. DEERS does not use the transaction date to determine what detail to return in the response. DEERS uses the period to which the update actually applies.

1.6.2.3. CCDD Data Transfer

TRICARE Standard CCDD data has been maintained in the Central Deductible and Catastrophic Cap File (CDCF) since FY 1995 for claims with a date of service on or after October 1, 1994. This data will be transferred to the new contractor during transition. It is the responsibility of the new contractor to ensure DEERS reflects the correct TRICARE Prime Point of Service (POS) deductible total for all FYs stored on DEERS. This data will be migrated from the CDCF to the DEERS CCDD repository via initial load.

Under previous contracts, TRICARE Prime Point of Service (POS) deductible data has been maintained separately by contractor's. Under current contracts, TRICARE Prime Point of Service (POS) deductible data will be stored by DEERS for enrollees under the new regional contracts.

1.6.2.4. CCDD Data Storage

DEERS stores CCDD data both by beneficiary and fiscal year. For TRICARE Standard and Extra, DEERS tabulates and stores CCDD balances by fiscal year, which is October 1 through September 30. DEERS treats Standard and Extra as one type of catastrophic cap.

For TRICARE Prime Point of Service (POS), DEERS tabulates and stores the deductible balance by fiscal year.

DEERS stores and archives CCDD data. The most recent three years of CCDD data is maintained online after contract transition.

1.6.3. Point of Sale (POS) for Pharmacy Inquiries

DEERS has implemented a dedicated eligibility interface for the TRICARE pharmacies called the Point of Sale (POS). This interface provides current eligibility only, and is implemented to ensure sub second response times required by the retail pharmacies, where beneficiaries are waiting for a response at the counter. The Point of Sale (POS) interface is used for all TRICARE Retail Pharmacy (TRRx) and TRICARE Mail Order Pharmacy (TMOP) transactions that are not date of service based paper claims. For date of service based claims, the claims interface must be used.

1.6.3.1. Point of Sale (POS) Inquiry

The Point of Sale (POS) is an XML-based web application that accepts secondary identification based on sponsor or primary identification based on the Patient ID. The pharmacy should base inquiries primarily on the sponsor's family member attributes. For example, sponsor SSN, family member DOB from the ID card. The Patient ID can be used in situations where secondary identification cannot yield a single beneficiary (i.e., twins with the same name).

1.6.3.2. Point of Sale (POS) Response

The Point of Sale (POS) response returns the Patient ID (which is needed for drug utilization review) as well as an eligibility indicator, Plan, CCDD contributions, OHI indicators, and Medicare indicators. This data is necessary to both grant eligibility and determine correct copayment or cost share amounts to be collected in real time at the pharmacy.

1.6.3.3. Person Demographics Service (PDS) for Pharmacy Inquiries

The PDS is an XML-based batch interface used to query additional data attributes required for TED submissions that are included in the Point of Sale (POS) response. The PDS batch interface is used to request demographics for the previous days eligibility inquiries that resulted in eligible responses. The PDS response only returns data current at the time of the PDS batch inquiry. When TED records reject because of demographics, the pharmacy should utilize the claims interface to correct the data based on the date of service.

1.6.3.4. PDS Inquiry

The PDS is an XML-based web application that accepts multiple Patient IDs. Batch submission should be limited to sizes of 10,000 records to minimize potential processing problems that can occur on large files.

1.6.3.5. PDS Response

The PDS response returns data elements required for TED processing. When no person is found, the submitted Patient ID is returned. When the person is found, but not eligible, only person attributes are returned. When a person currently eligible for pharmacy benefits is returned, Plan, PCM (when available), Medicare and sponsor personnel data is also returned.

1.7. OHI

OHI identifies non-DoD health insurance held by a beneficiary. The requirements for OHI are validated by the TMA Uniform Business Office (UBO). OHI information includes:

- OHI policy and carrier
- Policyholder
- Type of coverage provided by the additional insurance policy
- Employer information offering coverage, if applicable

- Effective period of the policy

OHI transactions allow adding, updating, canceling, or viewing all OHI policy information. OHI policy updates can accompany enrollments or be performed alone.

OHI information can be added to DEERS or updated on DEERS through multiple mechanisms. At the time of enrollment the contractor will determine the existence of OHI. The contractor can add or update minimal OHI data through the DOES application used by the contractor to enter enrollments into DEERS. Other MHS systems can add or update the OHI through the OHI/SIT web application provided by DEERS. In addition, DEERS will accept OHI updates from a claims processor through a system to system interface. The presence of an OHI Policy discovered during routine claims processing shall be updated on DEERS within two business days of receipt of the required information.

The minimum information necessary to add OHI to a person record is:

- Policy Identifier (policy number)
- OHI Effective Date
- HIPAA Insurance Type Code
- HIPAA Person Association Code
- Claim Filing Code
- OHI Coverage Type Code
- OHI Coverage Payer Type Code
- OHI Coverage Effective Date
- OHI Policy Coverage Precedence Code
- HIC Name or HIC ID
- Health Insurance Coverage Type Code
- Health Insurance Payer Type Code

NOTE: There are additional data elements necessary if the policy being added is a Group Employee policy. Please see the "Technical Specifications for the Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (OHI)" for more detailed information.

These fields are the minimum-required data entered at the time of enrollment or during any beneficiary contact when the beneficiary indicates he or she has OHI. If only the minimum required data is entered by the contractor, the contractor is required to fully develop for the remaining OHI data necessary to complete the OHI record within 15 business days. Detailed requirements for the exchange of OHI information is contained in the "Technical Specifications for the Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (OHI)." HIC information is validated against the SIT which maintains the valid insurance carrier information on DEERS.

DEERS requires the contractor to perform an OHI Inquiry before attempting to add or update an OHI policy. The MHS organizations are reliant on the individual beneficiary to provide accurate OHI information and DEERS is reliant on the MHS organizations for the accurate assignment of policy information to the individual record. DEERS is not the system of record for OHI information. Performing an OHI Inquiry on a person before adding or

attempting to update an OHI policy helps ensure that the proper policy is updated based on the most current information for the person.

Examples of OHI coverages are:

- Comprehensive Medical coverage (plans with multiple coverage types)
- Medical coverage
- Dental coverage
- Inpatient coverage
- Outpatient coverage
- Long-term care coverage
- Pharmacy coverage
- Mental health coverage
- Vision coverage
- Partial hospitalization coverage
- Skilled nursing care coverage

The default coverage will be Comprehensive Medical Coverage unless another of the above coverages is selected. In addition, each OHI policy carries a code indicating whether the policy is active, inactive, or deactivated. The deactivation of an OHI policy only occurs when the DoD Verification Point of Contact (VPOC) at TMA deactivates the HIC on the SIT. Refer to the SIT section for more information. DEERS retains OHI policy data for five years after an OHI policy expires or is deactivated or terminated.

1.7.1. OHI Policy Inquiry

1.7.1.1. Person Identification For OHI Policy Inquiry

OHI information is requested using the Patient ID, which is person-level identification. Person identification is used for the sponsor or family member. If the Patient ID is unknown, a coverage inquiry to DEERS can be performed to obtain it.

1.7.1.2. OHI Person Inquiry

The OHI data is by person. A system-to-system OHI inquiry is only for individual person requests. The OHI/SIT web application allows a family OHI inquiry. DEERS allows multiple OHI policies for each person. DEERS does not support an inquiry that shows all insured persons in a particular policy.

1.7.1.3. OHI Information

There are multiple ways the requester can specify the OHI information for the inquiry. The requester must specify a time period (begin and end date) or through combinations of the time period, the HIC ID or the HIC Name, the OHI Policy ID and the OHI Coverage Type Code.

The HIC ID represents the identifier assigned to insurance carriers in the SIT provided by the DoD VPOC to DEERS. A requester can seek information on a specific coverage for a beneficiary by using the OHI Coverage Type Code in the OHI inquiry sent to

DEERS, or for a specific insurance carrier by using the HIC Name. If a requestor is unsure about a specific OHI Policy, a time period should be specified for the inquiry to return the OHI Policy information in effect.

1.7.1.4. Information Returned In The OHI Inquiry Response

The DEERS response returns all OHI policies in effect during the specified time period for the beneficiary. OHI policies that are inactive or deactivated are returned if the OHI policies were in effect for any portion of the OHI inquiry period. If a specific coverage type is selected in the inquiry, only policies having that coverage are included in the DEERS response.

The OHI/SIT web application will return OHI for a requested beneficiary or a sponsor and family. OHI is displayed one person at a time.

If DEERS cannot find OHI information, DEERS does not return any OHI policies for the requested OHI inquiry period. When the Patient ID is included in the OHI inquiry, the Patient ID is returned in the response.

1.7.2. OHI Policy Add

DEERS allows the MHS and contractor systems to add an OHI policy for a person when documented information is presented to the MHS clinical personnel or to the contractor. An OHI Inquiry should be done prior to updating an OHI policy. This ensures that updates are performed with the most current information. Following the OHI Inquiry, the OHI data can be added as necessary. OHI data can be added during an enrollment via the DOES application. OHI can be updated any time after enrollment though the Web application provided by DEERS, or through the system to system interface. The presence of an OHI Policy discovered during routine claims processing shall be entered on DEERS within two business days. Within 15 business days, the contractor shall provide all OHI data not initially entered.

The fields required to add an OHI policy for a person are:

- Patient ID
- HIC Name or HIC ID
- OHI Policy ID
- OHI Effective Calendar Date
- HIPAA Insurance Type Code
- HIPAA Person Association Code
- OHI Claims Filing Code
- OHI Policy Coverage Effective Date
- OHI Policy Coverage Precedence Code
- HIC Coverage Type Code
- HIC Coverage Payer Type Code
- OHI Coverage Type Code
- OHI Carrier Coverage Payer Type Code

When the MHS organization enters the HIC Name, DEERS will check it against the SIT for validation of the HIC information. If the HIC Name is not on the SIT, the MHS organization may add a new HIC and Coverage. If the insurance carrier is not known, enter the carrier "Placeholder HIC ID", which is the placeholder entry on the SIT. The single placeholder entry on the SIT can be used to indicate that an OHI policy exists for a beneficiary. Additional fields required to complete the OHI record are at Addendum D, Table X. This HIC of "Placeholder HIC ID" has an assigned HIC ID of UNKVA0001 with a coverage type of "XM". For "Placeholder HIC ID" OHI policies the default coverage indicator is "comprehensive medical"; however, any coverage indicator can be assigned to it. The enrolling entity or updating system is responsible for obtaining the complete OHI information and updating the placeholder OHI policy in DEERS within 15 work days.

Then the OHI can be added to the person as an indication that OHI exists. More information on the SIT is contained in paragraph 1.8.

A person can have multiple types of OHI coverage for one policy. For example, to add an OHI policy that covers medical and vision, two OHI coverage types, one for medical coverage and one for vision coverage, would be sent to DEERS.

A person can have multiple OHI policies. Multiple OHI policies may have the same or different HICs, and/or the same or different OHI policy effective periods. For example, two OHI policies would be sent to DEERS, one OHI Policy ID covers medical and a second OHI Policy ID, with a different HIC and the same dates, covers dental.

The HIC ID, OHI Policy ID, and OHI Effective Date cannot be updated once an OHI policy has been added to DEERS. These attributes, along with the person identification, uniquely associate an OHI Policy to a person.

All messages sent to DEERS are acknowledged as either accepted or rejected.

1.7.3. OHI Policy Update

DEERS allows the MHS systems to update existing OHI policy and coverage information for a person when policy change information is presented. Policy and coverage updates include modifications to existing policy and coverage information. Updates can also be used to terminate an existing policy or coverage, that is when the policy or coverage no longer applies to the person. An OHI Inquiry must be done prior to updating an OHI policy. Following the OHI Inquiry, the OHI data can be updated as necessary. OHI data can be updated during an enrollment via the DOES application.

If OHI is identified during routine claims processing or other contract activities, the contractor shall send the OHI information to DEERS within two business days.

1.7.4. OHI Policy Cancellation

NOTE: Cancellation of an OHI policy is used to remove a policy that was erroneously associated to a person. **The OHI Policy Cancellation is not used to terminate an existing policy (see OHI Policy Update above).** An OHI policy cancellation completely removes the

policy. DEERS verifies that the cancellation is performed by the entity that added or last updated the OHI policy.

NOTE: Terminations do not remove the policy from a person's record.

When canceling an OHI policy, an OHI Policy Inquiry must be done to verify the information necessary to perform a cancellation. Canceling an OHI policy requires the following data elements:

- Patient ID
- HIC ID
- OHI Policy ID
- OHI Effective Calendar Date
- OHI Expiration Calendar Date
- OHI End Reason Code

1.8. SIT

The SIT program supports the MHS billing and collection process. The requirements for the SIT are validated by the TMA UBO through the DoD VPOC. DEERS is the system of record for SIT information, but not OHI information. The VPOC at TMA maintains the SIT in DEERS. The MHS personnel use the SIT to obtain other payer information in a standardized format. The SIT provides uniform billing information for reimbursement of medical care costs covered through commercial policies held by the DoD beneficiary population.

The HIC ID is the key used for associating a person's OHI policy with a commercial insurance company on the SIT. The HIC ID consists of the first three characters of the insurance company name, the two-letter standard state or country abbreviation, and a four-character identifier assigned by the DMDC. Once a standard national health plan identifier is adopted by the Secretary, Health and Human Services (HHS), DEERS and trading partners will migrate to that identifier.

All systems identified as trading partners will request an initial full SIT subscription from DEERS. See the "Technical Specifications for the Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (OHI)" for subscription procedures. The holders of the SIT shall subscribe to DEERS daily in order to receive subsequent updates of the SIT. These updates may result from a user request or may be additions or updates made directly by the DoD VPOC.

Field users perform five actions with the SIT:

- Inquiry actions can be performed on the OHI/SIT web application or through their local SIT file
- An add action to report a new SIT entry for validation by the DoD VPOC
- An update action to report an updated SIT entry for validation by the DoD VPOC
- The cancellation of a carrier add sent to the SIT for verification by the DoD VPOC

NOTE: Only the organization requesting a carrier be added can cancel the request.

- The deactivation of a verified HIC sent to the SIT for verification by the DoD VPOC.

1.8.1. SIT Inquiry

Local holders of the SIT cannot perform inquiries against the central SIT maintained on DEERS. All actions against the SIT on DEERS will be defined in paragraphs 1.8.2. through 1.8.6.

1.8.2. SIT Add

When the MHS personnel add a complete OHI record to a person or patient, they will need the HIC ID that matches an entry in the SIT. The HIC ID represents the identifier assigned to insurance carriers in the SIT provided by DEERS. The HIC ID Status Code identifies the ID as standard or temporary. See the "Technical Specifications for the Health Insurance Carrier (HIC) Standard Insurance Table (SIT) and the Other Health Insurance (OHI)" for detailed information about the data elements required for the SIT add process.

When a HIC is not on the SIT, the user may send a request to add it to the SIT on DEERS. If the DoD VPOC rejects the request to add the HIC, all OHI Policies associated with the HIC are automatically cancelled. DEERS responds with a HIC ID a HIC Status Code with the designation of "temporary" and a HIC Verification Status Code of "unverified". Unverified carriers are made available to all local holders of the SIT through the daily subscription process to prevent duplicate requests requiring VPOC validation. When the DoD VPOC validates the SIT, the HIC Verification Status Code will be changed from "unverified" to "verified." DEERS will make updates available with the appropriate HIC information to all local holders of the SIT through the daily subscription process.

1.8.3. SIT Update

For updates to an existing SIT record, the existing HIC ID is sent with the update. These updates are sent to all subscribers thought the daily subscription process. Without the HIC ID, DEERS is not able to report a validation or a rejection of the SIT update. Returning all the insurer information in the update assists in the rapid validation of the SIT by the DoD VPOC. Rejection of SIT updates by the DoD VPOC is reported to all local holders of the SIT.

DEERS does not allow an update to a HIC when the HIC has a Verification Status Code of "unverified."

1.8.4. SIT Add Cancellation

The MHS personnel may need to cancel a previously submitted "add" to the SIT. A cancel can only be done by the system that submitted the "add" and only if the "add" has not yet been verified by the DoD VPOC.

DEERS cancels any OHI policy on the DEERS database associated with the cancelled "unverified" HIC. After the "add" request is cancelled, DEERS will provide the cancellations to all local holders of the SIT through the daily subscription process.

1.8.5. Validation Of HIC Information

DEERS, provides the TMA UBO an application that allows the DoD VPOC to validate SIT.

Validation of a SIT update includes verifying the name, mailing address, and telephone number information for the HIC. In addition, the DoD VPOC assigns the HIC Status Code of "Standard" to validated HICs. If the DoD VPOC determines that the requested update is not correct, the DoD VPOC assigns a HIC Status Code of "rejected". Rejected updates are returned to all local holders of the SIT.

If a SIT "add" or "update" request is rejected by the DoD VPOC, DEERS cancels any OHI policy on the DEERS database associated with the rejected HIC. All SIT additions and updates that are validated by the DoD VPOC are made available to all systems identified to DEERS as authorized holders of a local copy of the SIT.

1.8.6. Deactivation of a HIC

MHS organizations can request the DoD VPOC to deactivate any HIC on the SIT. DEERS does not allow a deactivation of a HIC with a HIC Status Code of "temporary" and/ or a HIC Verification Status Code of "unverified", until validated by the DoD VPOC. DEERS deactivates any OHI policy on the DEERS database associated with the deactivated HIC. DEERS reports the deactivation of the HIC to all local holders of the SIT.

1.9. Medicare Data

DEERS performs a match with Centers for Medicare and Medicaid Services (CMS) to obtain Medicare data and incorporates the Medicare data into the DEERS database as OGP entitlement information. This information includes both Medicare A and Medicare B eligibility along with the effective dates. The match includes beneficiaries who are either over or under 65 on the DEERS.

DEERS sends the Medicare information to the TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC). The TDEFIC sends the information to the CMS Fiscal Intermediaries for identification of Medicare eligibles during claims adjudication.

DEERS sends the TDEFIC three types of files based on the population of beneficiaries being sent:

- A monthly file of beneficiaries who will turn 65 years old within the next 60 to 90 days and beneficiaries over age 65 that did not have Medicare on DEERS within the preceding month.
- A quarterly file of all beneficiaries under age 65 that CMS identified as having Medicare.
- Every six months, DEERS sends the TDEFIC a file of all beneficiaries over age 65 with Medicare reported on DEERS.

1.10. Resource Utilization

1.10.1. Performance Characteristics

DEERS response times provided in this section are based on internal system response time. Internal system response time is defined as the interval of time from the receipt of the last bit of the incoming transaction to DEERS' communications system until the first bit of the response leaves DEERS' communications system. Communications time is not included in these estimates.

DEERS average response times for online data updates (data push) from socket to socket connections is seven seconds, and for online data queries (data pull) from socket to socket is five to eight seconds.

Average online response time in the current version of DOES is four to six seconds.

Batch transaction response time varies with the batch volume and overall concurrent batches processed.

X12 or HL7 transactions are beyond the scope of these estimates, but are expected to run slower than the batch response times due to the overhead of the translation.