CHAPTER 3
SECTION 1.5

DEERS FUNCTIONS

1.0. As the centralized data repository of 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 information, Other Health Insurance (OHI) and the Standard Insurance Table (SIT). The expected data stores for the MCSC are illustrated in Figure 3-1.5-1. Deviation from the intended concept of operations between the MCSC 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 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 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 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., DOB, Name) "to resend the inquiry."

1.2. Health Care Delivery Program 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 MCSC or the Designated Provider has the most current information.

A beneficiary who is considered eligible for DoD benefits, according to 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

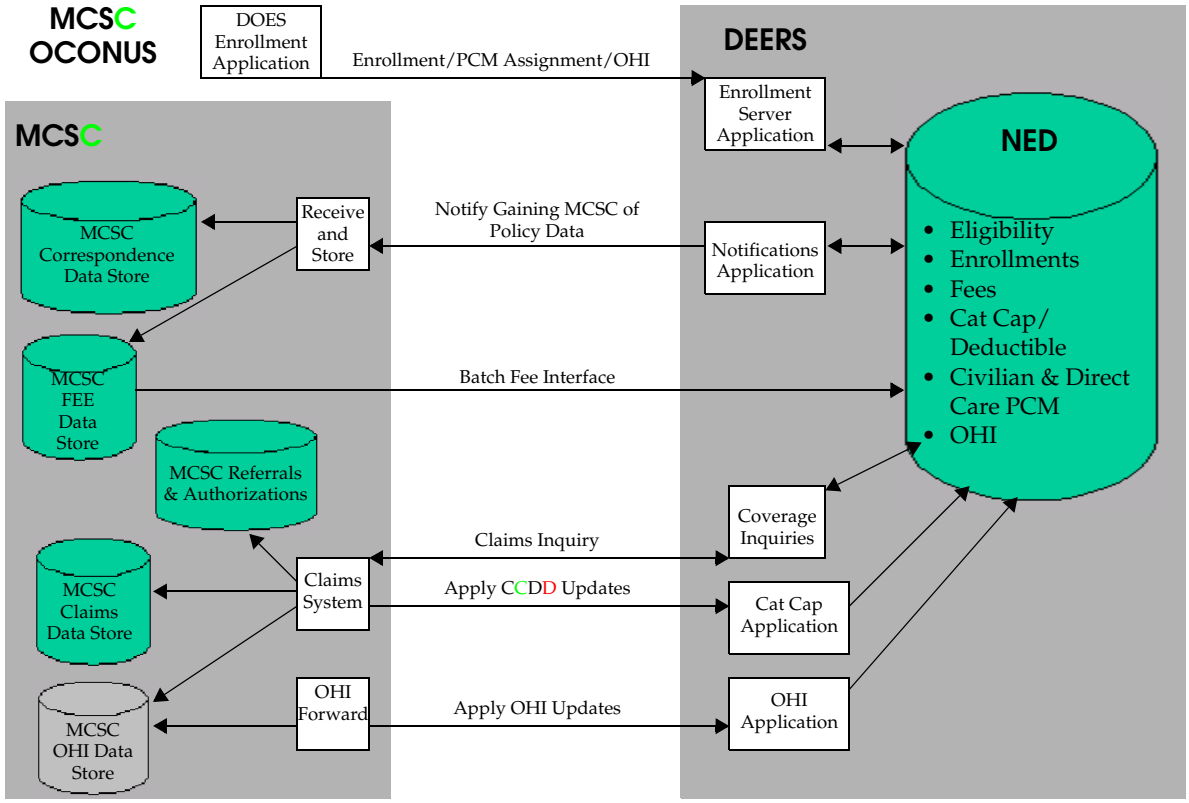
Enrollment related business events include:

- 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 other health insurance (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 enrollment fee history transaction 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 GFE application developed by 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. MCSCs and USFHP providers 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 Payment
- Enrollment Fee Waiver Update for an Individual
- Beneficiary Update
- Other Health Insurance (OHI) Add

The DOES application meets HIPAA guidelines for a direct data-entry application, and is data-content compliant for enrollment and disenrollment functions.

Refer to Chapter 3, Addendum F for the National Enrollment Database DOES Training document for examples of screens for DOES.

1.2.3. Beneficiary Self-Service

The Government will provide a web application for the beneficiary to perform enrollment-related activities. This application will serve all TRICARE eligible beneficiaries. The web application will be made available upon the completion of the transition from seven regional managed care support contracts to three regional managed care support contracts. It is expected that the web application will interface with the MCSC systems for the purposes of accommodating on-line payment of enrollment fees.

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 a PCM change, address update, transfer of enrollment, disenrollment, limited cancellation events, request a new enrollment card, and submit an initial enrollment application. 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 MCSC for accuracy and compliance with established Regional requirements, and that they will receive further notice from the MCSC as to any need for additional information. DEERS will send the MCSC or USFHP provider a Policy Notification, informing the MCSC or USFHP provider that a pending enrollment exists for

the beneficiary. Using DOES, the MCSC or USFHP provider 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 four calendar days of receipt of the information. DEERS will perform a daily process to finalize pending enrollment actions after four dates of no action by the MCSC/DP. DEERS will send a policy notification indicating that the MCSC/DP has approved the enrollment action in DOES. Additionally, within four calendar days of the submission, the MCSC or USFHP Provider shall contact the beneficiary to resolve discrepancies in the web-submitted application (if necessary). If the application is not accepted, the MCSC or USFHP provider shall send the beneficiary an explanatory letter within five calendar days. The MCSC or USFHP provider shall also cancel the enrollment using DOES. The MCSCs and USFHP providers 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 MCSC web applications that perform any enrollment-related functions.

DEERS will produce a daily report of all web-based pending enrollments that are greater than four calendar days old. Reports listing pending enrollments not processed will be distributed by DEERS to the Contracting Officers (COs) and Contracting Officers Representatives (CORs), Lead Agents and Managed Care Support Services (MCSS) MCSCs or USFHP providers.

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

1.2.4. Eligibility For Enrollment

The DoD provides assigned health care delivery programs 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 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 sponsor and family members are added to DEERS:

- A sponsor is assigned a Direct Care for Active Duty Sponsors plan in which he or she is the subscriber and the insured with Direct Care 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 assigned plan. The sponsor is not insured under this coverage plan.
- Eligible family members are assigned a TRICARE Standard for Active Duty Family Members plan as insured with both Direct Care 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. 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 automatically switches enrollment plans from individual to family upon the enrollment of a second family member; however, DEERS does not make automatic adjustments from family to individual plans upon the disenrollment of all but one family member. It is the MCSC's or USFHP provider'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 plans that a family may have.

The MCSC or USFHP provider 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.

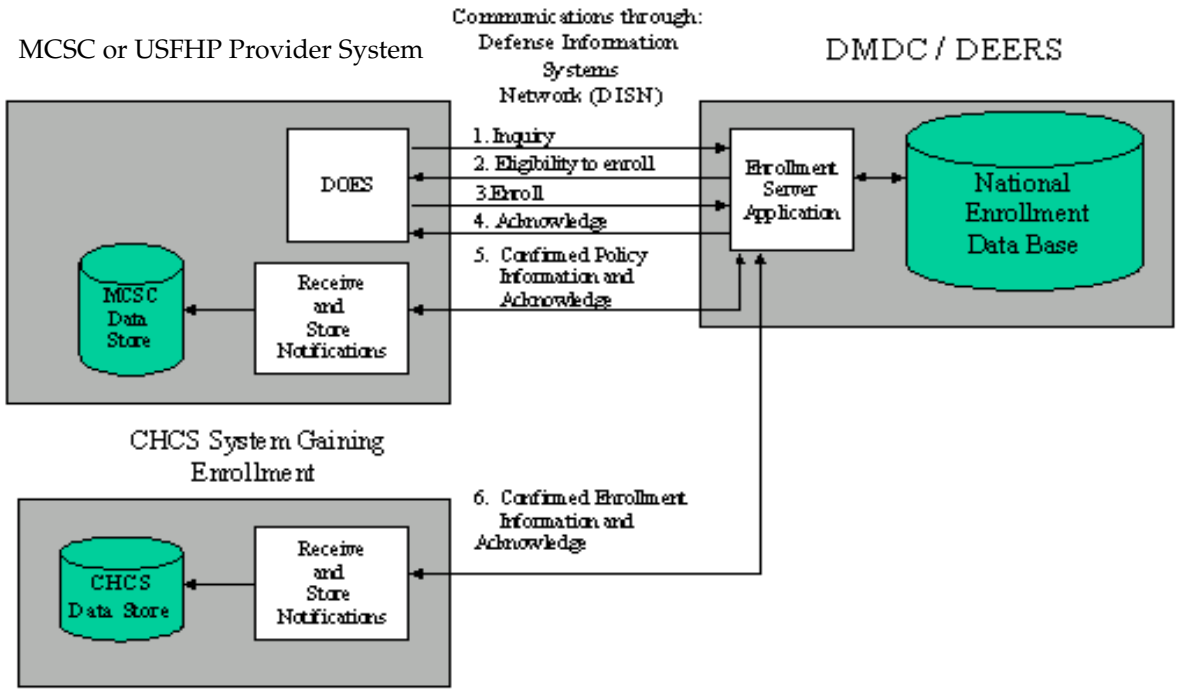
Enrollment anniversary dates for all enrollees are being transitioned to a fiscal year basis, i.e., October 1 through September 30. To accomplish this, on new enrollments or when a policy is up for renewal, the MCSC shall only establish the policy and prorate the enrollment fees as described below. At the end of that fiscal year, the MCSC 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 enrollees that pay fees on an annual basis, the MCSC shall collect the entire prorated fee covering the period through September 30 of the current fiscal year. For enrollees that pay fees on a quarterly basis, the MCSC 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), MCSCs 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. If during the transition from enrollment year to fiscal year, the first three-month payment crosses into the next fiscal year, the MCSC 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.

For example, if a beneficiary's enrollment anniversary date is August 1 and they wish to pay by monthly allotment or EFT, the MCSC 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 1.2.8.1. MCSCs 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.

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 MCSC to an incoming MCSC region, DEERS will provide the incoming MCSC with a "Gold File" that contains enrollment information for enrollees being transitioned to the incoming MCSC.

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 MCSC or DP. 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 MCSC or DP (prior to the start of health care delivery of the incoming MCSC or DP) 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 '04) and the contract transition is April 2004 (FY '04), the FY '04 re-enrollment was performed by the outgoing MCSC or DP; 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 MCS contractor or DP effective on or after the start of health care delivery, DEERS will not alter the enrollment policy end date. The incoming MCSC or DP, 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 '03) and the contractor transition is April 2004 (FY '04), the FY '04 re-enrollment will be performed by the incoming MCS contractor or DP; therefore DEERS will not alter the enrollment policy end date.

The incoming MCS contractor or DP will receive from the outgoing MCSC or DP at transition, the MCSC's or DP's fee information which will show the "paid through" dates. The incoming MCSC or DP 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 MCSC or DP that are effective prior to the start of health care delivery of the incoming MCSC or DP, 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 MCSC or DP 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 MCSC or DP 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 MCSC or DP performed a re-enrollment effective November 1 and the enrollee is paying on a quarterly basis (and the incoming MCSC or DP start of health care delivery is April 1), the outgoing MCSC or DP fee information will show a "paid through" date of April 30. In this case, the enrollee paid the outgoing MCSC or DP two quarterly payments, November 1 - January 31 and February 1 - April 30. The incoming MCSC or DP 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 MCSC or DP in the current fiscal year but prior to the start of health care delivery of the incoming MCSC or DP (April 1).

For enrollments performed by the outgoing MCSC or DP in the current fiscal year but prior to the start of health care delivery of the incoming MCSC or DP, 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 MCSC or DP fee information will show the

"paid through" date to be what the outgoing MCSC or DP had established. In this case, when the incoming MCSC or DP 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 MCSC or DP fee information. For example, if the outgoing MCSC or DP 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 MCSC or DP 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 MCSC or DP 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 or when policies that have not been aligned to the fiscal year are renewed, the MCSC or DP shall establish abbreviated policies ending September 30 and prorate the enrollment fees on a monthly basis. The monthly prorated enrollment fee for individual policies is 1/12 of the annual individual enrollment fee (currently $230/year). For family policies, the monthly prorated enrollment fee shall be 1/12 of the annual family enrollment fee (currently $460/year). At the end of the abbreviated enrollment (end of the current fiscal year), the MCSC or DP 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 MCSC or DP shall collect the entire prorated fee covering the period from the new or re-enrollment effective date through September 30 of the current fiscal year. For enrollees that pay fees on a quarterly basis, the MCSC or DP 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 Electronic Funds Transfer (EFT) or by monthly allotments), the MCSC or DP 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. If during the transition from enrollment year to fiscal year, the first three month payment crosses into the next fiscal year, the MCSC or DP 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 a request for a monthly allotment or EFT is 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.

For example, if a beneficiary's enrollment policy anniversary date is August 1 and they request to pay by monthly allotment or EFT, the MCSC or DP 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 MCSC or DP 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). MCS contractors or DPs 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.**

1.2.5.1.4. Prorated Catastrophic Cap Amounts

TRICARE Prime enrollees who are other than Active Duty (AD) or Active Duty Family Members (ADFM), (e.g., Retirees and Retiree Family Members), are entitled to an enrollment year catastrophic cap of $3,000. 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 or re-enrollment of a policy that has not yet been aligned to the fiscal year. The monthly prorated catastrophic cap credit for non-AD and non-ADFMs will be 1/12 of the $3,000 annual catastrophic cap limit or $250 per month.

For new enrollments or re-enrollments performed by the outgoing MCSC with effective dates prior to the start of health care delivery of the incoming MCSC, DEERS will show the enrollment end date on the "Gold File" to be September 30. For these enrollments that involve non-AD and non-ADFMs, DEERS will also apply a prorated catastrophic cap credit covering the period from October 1 through the end of the original enrollment end date.

For example, if the outgoing MCSC performed a re-enrollment for a retiree with an effective date of December 1, the Gold File will show the end date for this enrollment as September 30. DEERS will also have applied a prorated catastrophic cap credit covering the remaining two months of the original enrollment year (October 1 through November 30).

For new enrollments or re-enrollments performed by the incoming MCSC with effective dates on or after the start of health care delivery of the incoming MCSC, the DEERS Gold File will not change the enrollment end date to September 30. Instead, the MCSC shall perform the new enrollment or re-enrollment and set the enrollment end date to be September 30. For new enrollments or re-enrollments of non-AD and non-ADFMs, DEERS shall also apply a prorated catastrophic cap credit covering the period from the next October 1 through the date the new enrollment or re-enrollment would have ended (12 months later) had no fiscal year alignment been performed.

For example, if the MCSC start of health care delivery is April 1, 2004, and the MCSC performs a re-enrollment of a retiree effective May 1, 2004, the MCSC shall create an

abbreviated enrollment covering May 1 through September 30. This aligns the enrollment dates to the fiscal year. The enrollee is, however, entitled to a 12 month enrollment year in which to meet the catastrophic cap. To align the catastrophic cap amount, DEERS shall first calculate the number of months the enrollment has been abbreviated, in this case October 1, 2004 through April 30, 2005, or 7 months. Second, DEERS shall multiply the number of months the enrollment has been abbreviated by $250 ($3,000/12 months = $250/month) to arrive at a catastrophic cap credit amount of $1,750 (7 months X $250) for a retiree or their family members. **DEERS will automatically apply the credit.** By applying the credit, the enrollee has the opportunity to reach the 12 month enrollment year catastrophic cap amount within the 5 month abbreviated enrollment period from May 1, 2004, through September 30, 2004. On October 1, 2004, when the MCSC re-enrolls this person, the enrollment period will be from October 1, 2004, through September 30, 2005, the full annual enrollment fees may be collected through annual, quarterly, or monthly payments, and no catastrophic cap credits will be applied since the enrollment year will be the same as the fiscal year.

Catastrophic cap credits are always applied to the fiscal year in which the abbreviated enrollment occurs. In the previous example, the credit of $1,750 would be applied to FY 04. 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. The only enrollments that will not receive a one-time enrollment year catastrophic cap credit are Active Duty and Active Duty Family Members, since their out-of-pocket expenses accrue only to the fiscal year catastrophic cap limit, and those enrollments that have a full 12 months to achieve the enrollment year catastrophic cap amount, i.e., those enrollments with an effective date of October 1. Otherwise, all enrollments will receive a one-time enrollment year catastrophic cap credit.

Catastrophic cap credit amounts will be reported **by DEERS** to the DEERS Catastrophic Cap and Deductible Database (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.

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 MCSC 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 deductibles and cost-shares will continue to be paid by the individual or family even though the catastrophic cap limits have been reached.

1.2.5.1.5. Alignment of the enrollment year to the fiscal year must also be performed for enrollees of the Uniformed Services Family Health Plan (USFHP). The process, as described for the MCSCs 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 managed care support contractors and the USFHP.

1.2.5.2. PCM Assignment Within The DOES Application

DEERS has a centralized PCM file containing all MCSCs' civilian network PCMs and PCMs for the Direct Care and USFHP provider systems. Additions and modifications of PCMs are performed in the MCSC provider system and the Designated Provider system. The MCSCs and USFHP providers shall provide daily additions and modifications on their provider files for retrieval by DEERS. If an MCSC or USFHP provider 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. MCSCs and USFHP providers 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. Direct Care PCM Assignment

The MCSC shall perform Direct Care PCM assignment at the time of enrollment in the DOES application. The MCSC 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, if the enrollment form has a UIC specified and the MTF has established a default provider for the UIC, the MCSC should use the default. If the enrollment form contains a specialty or gender preference, the MCSC 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 MCSC shall use the search criteria in DOES to select a PCM. DOES will only display PCMs with available capacity in the selected DMIS-ID. The MCSC 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 Direct Care facility, the MCSC shall assign the beneficiary to the civilian network.

1.2.5.4. Civilian PCM Assignment (MCSC And Designated Provider)

The MCSC shall perform Civilian PCM assignment at the time of enrollment in the DOES application. The MCSC shall use the PCM preference indicated on the enrollment form. If the enrollment form contains a specialty or gender preference, the MCSC shall use the preference filters available in DOES to select a PCM. DOES has 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 3 digits only)
- PCM City, PCM State
- PCM Specialty, PCM ZIP Code (entire ZIP Code or the first 3 digits only)
- PCM Specialty, PCM City, PCM State
- PCM Gender, PCM Zip Code (entire ZIP Code or the first 3 digits only)
- PCM Gender, PCM City, PCM State
- DMIS ID (for Direct Care PCMs)

1.2.5.5. PCM Batch Reassignment Access Through TRICARE Online (TOL)

The Direct Care PCM Batch Reassignment application is located on the TOL platform and access to TOL will be required. MCSCs that use the Direct Care PCM Batch Reassignment application will be given specific privileges within TOL that will allow them to access the application and perform contract required functions.

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 MCSC or the DP 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 MCSC or the DP at the time of enrollment. The MCSC/DP 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 active duty service members 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 MCSC or USFHP provider must reconcile their fee payment system against the fee totals in DEERS. Once the MCSC 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 MCSC, 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 MCSC 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 MCSCs and USFHP providers to perform mass reassignments of a PCM's enrollees. Within a MCSC or a USFHP provider, a MCSC or USFHP provider may move a Civilian PCM's entire panel to a new Civilian PCM.

The reassignments selected by the MCSC 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 Direct

Care PCM panel reassignments, please refer to paragraph 1.2.5.3. and the TRICARE Operations Manual, Chapter 6, Section 1, paragraph 3.1.

1.2.7.3. Direct Care 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 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 Direct Care 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 Direct Care 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.

Each MCSC required to use the Direct Care PCM Batch Reassignment application shall identify a primary and a backup "MCSC Administrator for TOL." Contractors shall coordinate with the TOL Program Office to complete administrative requirements necessary to establish the TOL Administrator roles.

MCSC Administrators will have the authority to authenticate the contractor personnel who need access to functionality on TOL to perform their work. MCSC Administrator's will have the authority to assign appropriate permissions to each user. MCSC Administrators shall also activate and deactivate contractor personnel's TOL user accounts.

Contractors shall ensure that all user names and passwords associated with TOL are secure and maintained in accordance with all government security requirements.

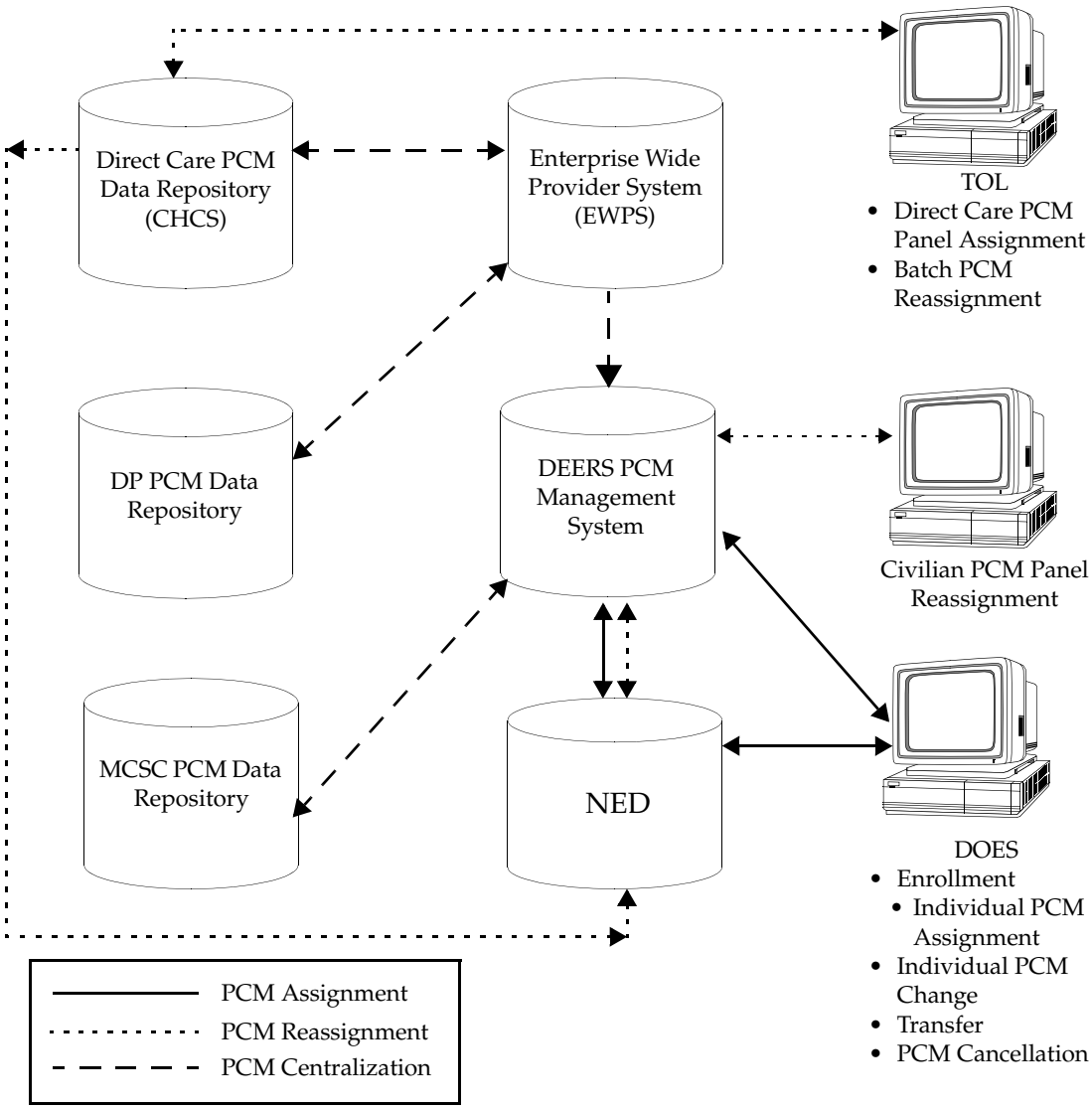
Should TOL or the Direct Care PCM Batch Reassignment Application go down, contractors should contact the TOL Tier 2 Help Desk at: 1-800-501-8662. If there are planned system maintenance or downtime, the TOL Tier 2 Help Desk will notify the contractors of the consequent nonavailability of the system. All contractors using TOL and the Direct Care PCM Batch Reassignment application shall identify and provide the TOL Program Office and the TOL Tier 2 Help Desk with names, telephone numbers, and e-mail addresses of contractor points of contact (POC) who can be notified by the TOL Tier 2 Help Desk of system problems or planned maintenance. Contractors shall provide the TOL Tier 2 Help Desk with POC updates on a quarterly basis or more frequently should contractor POCs change.

Contractor users of the PCM Batch Reassignment application shall complete all required TOL web-based training courses as defined by the TOL Program Office.

MCSC Administrators shall populate and maintain the list of MTF's in TOL for their respective contractual area.

Batch changes for Direct Care 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 MCSC. The MCSC shall enter the PCM change criteria in a government-provided web application. These PCM changes will be forwarded to DEERS by CHCS. (See the TRICARE Operations Manual, Chapter 6, Section 1, paragraph 3.1. for additional details). Batch changes of DMIS IDs where the PCM assignment does not change must be coordinated with the MTF, MCSC and DEERS. DEERS will effect the change in DMIS ID. If the PCM assignment must be changed in addition to the DMIS ID, the MCSC must enter each PCM change transaction into the DOES application. Changes in DMIS IDs across CHCS platforms also must be performed individually by the MCSC in DOES. In all cases, upon acceptance of the PCM change, DEERS will send a Policy Notification to the MCSC and a PCM Change Letter to the beneficiary.

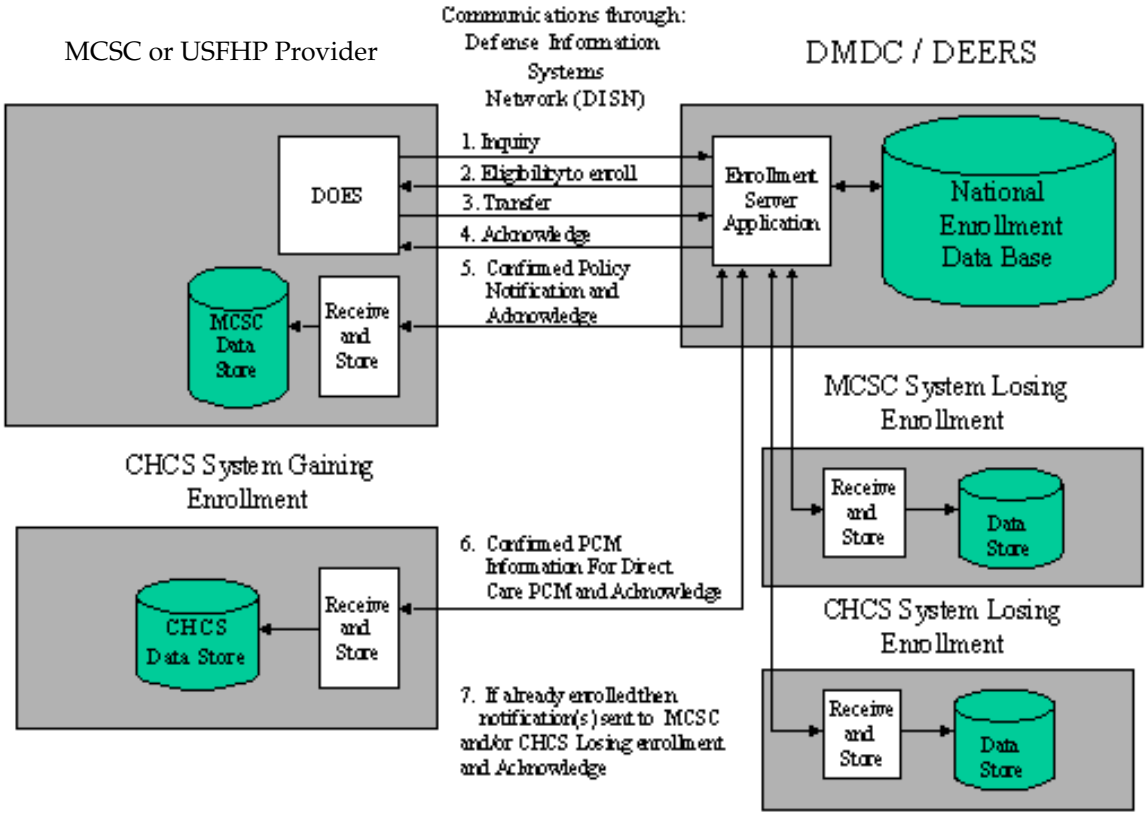
FIGURE 3-1.5-3 PCM ASSIGNMENT PROCESS



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 And Enrollment Fee Waivers

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

For Enrollment Fee Payment Research, DEERS provides a web-based application.

1.2.8.1. Enrollment Fee Payment

Enrollment fees may be paid periodically (e.g., monthly, quarterly, or annually). The beneficiary specifies this payment option during enrollment and the MCSC or DP may enter the fee information in DOES or the batch fee interface as part of the enrollment transaction. To send DEERS fee information separate from the enrollment, MCSC's and

Designated Providers Integrator (DPI) should use the batch enrollment fee payment process. If this information is entered into DOES, DEERS includes it on the notification to the MCSC or DP. MCSCs and DPs also update DEERS with subsequent enrollment fee payments for a policy when the quarterly or monthly option is selected, or to update a fee paid-through date or fee payment exception reason. The MCSC and DPI shall send all fee payment updates to DEERS within one business day. 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.

For monthly EFT or monthly allotments, MCSCs and DPs 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 TRICARE Operations Manual, Chapter 6, Section 1, paragraph 8.1., "Monthly Payment Fee Option"). Regardless of the date the MCSC or DP 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 applicable enrollment fee "paid through" date.

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 MCSC or DP.

NOTE: Enrolling organizations may indicate a "paid through" date that crosses 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.

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.

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.

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

1.2.8.2. Split Enrollments And Enrollment Fee Payment

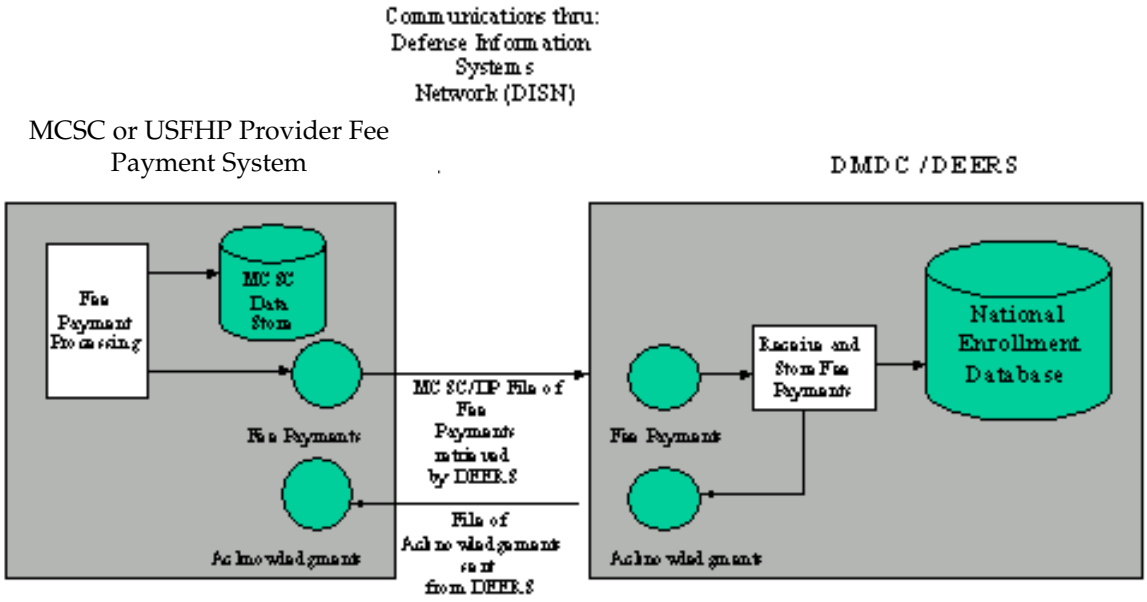
Split policies are an artifact of prior managed care support contracts. Split policies will exist until all policies have been transitioned to the new MCSC regional contracts or DPs and the DEERS performs the final consolidation of policies. Split enrollments occur when all family members are covered under the same type of coverage but do not reside in the same contract region causing the enrollments to be administered under multiple contracts. Split policies will exist until all seven MCS contracts are transitioned to the new three-regional MCSCs or DPs. Once the transitions are complete, a final consolidation of split enrollments will occur. Once consolidated, a family will share a single policy regardless of the region in which individual family members reside. Until all enrollments are migrated to the three new regional contracts or DPs, and consolidated, more than one policy may exist for a family where individual family members are enrolled under multiple MCSC contracts or DPs. DEERS will consolidate all split policies that are within the new regional contracts and communicate this information to the incoming MCSC Regional contracts or DPs via an initial load file. This will occur at each contract transition. If needed, the incoming MCSC or DP shall communicate to the beneficiaries whose policies have been consolidated and apply any fee payment overage to the next fee obligation. Any fee payment overage shall be applied first to the new fee obligation within the existing policy period. If there is additional overage, it shall then be applied to the new policy period when the policy is established on DEERS (i.e., 45 days prior to the expiration of the current policy). Such overages may be sent to DEERS with a fee payment action code indicating that the payment should be applied to the next policy period. DEERS will automatically apply these amounts when the new policy is created. If an enrollment transfer occurs after the new MCSC or DP receives the initial load file, the same procedure is used except DEERS will notify the contractor of the policy changes and fees through a Policy Notification Transaction (see Chapter 3, Addendum D, Business Rule O). In addition, enrollment fees may be collected from several locations for policies in a split enrollment situation. DEERS accepts and stores enrollment fee payments from multiple MCSCs or DPs. DEERS does not determine the entity or location responsible for collecting and reporting enrollment fee payments. The MCSCs and DPs are responsible for ensuring that the total fees received collectively for a policy involving split enrollments do not exceed the applicable enrollment fee amount.

1.2.8.3. Batch Fee Payments

In addition to sending enrollment fee payment information to DEERS through DOES, the MCSC may also send the information to DEERS in batch format. The batch fee payment updates include new payments, payment adjustments, and updates to enrollment fee payment exception reason codes, or paid-through dates. MCSCs and DPIs must correct and resubmit enrollment fee payments rejected by DEERS or research, correct and resubmit fee payments for which DEERS has provided a warning.

The following figure illustrates the process for sending batch fee payment updates to DEERS:

FIGURE 3-1.5-5 BATCH FEE PAYMENT PROCESS



1.2.9. Enrollment Attribute Updates

The DOES application supports the entry of additional enrollment-related information to support MCSC and DP 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 MCSC or DP reflecting the update.

1.2.9.1. Enrollment Fee Waiver Update For An Individual

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 MCSC or DP. 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 MCSC or DP 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.

1.2.9.2. Work ZIP Code

A work ZIP Code is supported for TRICARE Prime Remote plan determinations. TRICARE Prime Remote 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 MCSC or DP 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 MCSC or DP of the new policy end date. See "Enrollment" (paragraph 1.2.5.) and "Split Enrollment and Enrollment Fee Payments" (paragraph 1.2.8.2.) for more details on the migration of enrollment year to fiscal year basis.

1.3. Address And Telephone Number Updates

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.

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

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 MCSC or DP. The home e-mail address is updated through the DOES application.

1.4. Notifications

Notifications are sent to MCSCs and DPI for various reasons, and reflect the most current policy information for a beneficiary. The MCSC or DPI 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 MCSC or DP does not have

the information contained in the notification, the MCSC or DPI shall add it to their system. If the MCSC or DP already has enrollment information for the beneficiary, the MCSC or DP shall apply all information contained in the notification to their system. The MCSC or DP shall use the DEERS ID to match the notification to the correct beneficiary in their system. There are also circumstances where a MCSC or DP may receive a notification that does not appear to be updating the information that the MCSC or DP already has for the enrollee. Such notifications shall not be treated as errors by the MCSC or DP system and must be applied. The MCSC or DP 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 MCSC or DPI.

1.4.1. Notifications Resulting From Enrollment Actions

DEERS sends notifications to MCSCs and DP detailing any policy or PCM update performed in the DOES application. This includes address updates made for enrollees. Additionally, DOES supports a feature for the MCSC or DPI to request a notification to be sent without updating any address or enrollment information. The purpose of this request is to re-sync the MCSC or DP system with the latest DEERS policy data.

1.4.2. Unsolicited Notifications

These types of notifications are unsolicited to the MCSC or DP and result from updates to a sponsor or family member's information made by an entity other than the enrolling MCSC or DP. Unsolicited notifications may result from various types of updates made in DEERS:

- 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 MCSC or DP 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 date of birth changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or date of birth are communicated via unsolicited notification to the MCSC or DP.
- 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 MCSC or DP.
- Data corrections made by DSO or the DOES Help Desk. If a MCSC or DP requests the DSO to make a data correction for a current or future enrollment that the MCSC or DP cannot make themselves, notification detailing the update is sent to the MCSC or DP, and to CHCS, if appropriate.

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 MCSCs and DPs. The MCSC 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 MCSC or DP 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.

1.5. Enrollment Cards And Letter Production

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 and TRICARE Remote coverage plans. Enrollment cards are not produced for enrollments with DPs.

New enrollment cards are automatically sent upon a new enrollment or an enrollment transfer to a new MCSC, 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.

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

Along with the enrollment card, DEERS sends a letter to the beneficiary indicating their PCM selection as entered in DOES.

The MCSC 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 MCSC due to a bad address, the MCSC 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 MCSC shall query DEERS to determine eligibility and/or enrollment status for a given period of time. The MCSC shall use DEERS as the database of record for:

- Person Identification
- Eligibility
- Enrollment and PCM information

- Enrollment/Fiscal year to date totals for catastrophic cap and deductible amounts
- Other Government Program (OGP)

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

Although DEERS is not the database of record for OHI, it is a centralized database 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 Other Health Insurance 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 MCSC 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 MCSC shall send the updated or additional OHI information to DEERS using the system to system process or other mechanisms identified in the Other Health Insurance section of this document.

DEERS stores enrollment/fiscal year catastrophic cap and deductible data in a central repository. DEERS stores the current and the two prior enrollment/fiscal year catastrophic cap and deductible totals. The purpose of the DEERS Catastrophic Cap and Deductible Database (CCDD) repository is to maintain and provide accurate catastrophic cap and deductible 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 MCSCs and DEERS, associated with CCDD transactions.

The main events to support processing this information include:

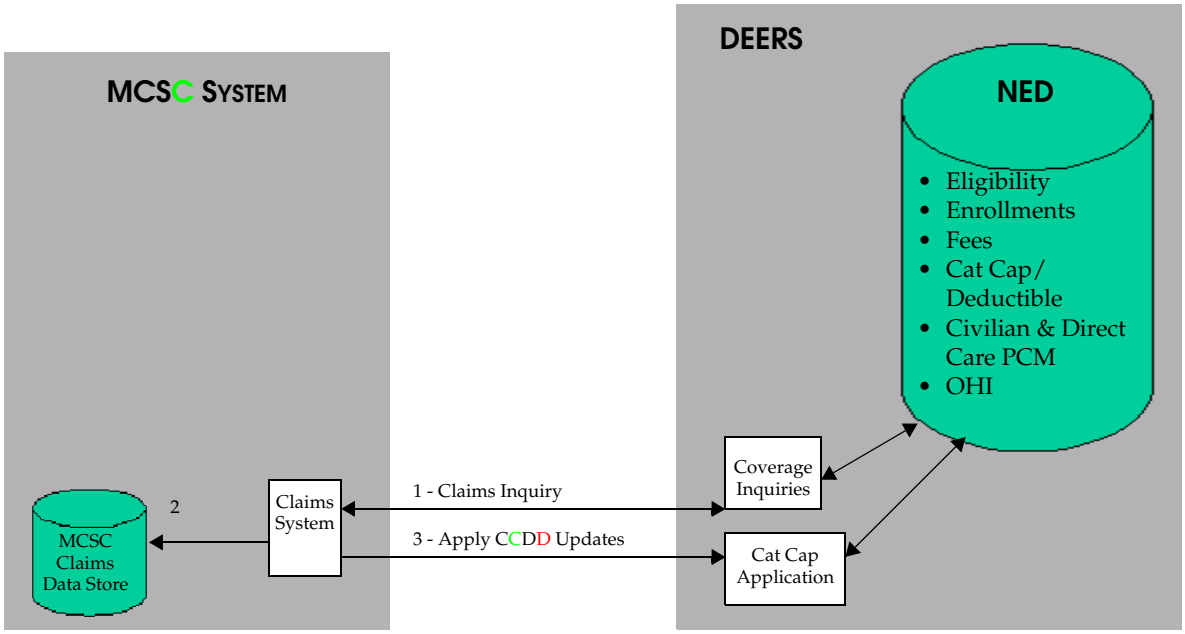
- Health Care Coverage Inquiry for Claims
- CCDD Totals Inquiry
- CCDD Amounts Update
- CCDD Transaction History Request

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 MCSC must use the eligibility, enrollment, OHI, Other Government Programs (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 TRICARE Policy or TRICARE Operations Manual.

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.

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 SPN_INQ_PN_ID_TYP_CD SPN_PN_LST_NM SPN_PN_1ST_NM SPN_PN_BRTH_DT INQUIRY PERSON INFO SECTION*: INQ-PN_ID INQ-PN_ID_TYP_CD and/or PN-LST-NM PN-1ST_NM PN_BRTH_DT	 R R O O O S S NA S 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: INQUIRY PERSON INFO SECTION: INQ_PN_ID INQ_PN_ID_TYP_CD PN_LST_NM PN_1ST_NM PN_BRTH_DT	NA R R O O 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 SPN_NQ_PN_ID_TYP_CD SPN_PN_LST_NM SPN_PN_1ST_NM SPN_PN_BRTH_DT INQUIRY PERSON INFO SECTION:	 R R O O O 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 MCSC 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 MCSC is required to store the Patient ID. The Patient ID provides uniform person identification and patient identification across the MHS. The MCSC 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

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 MCSC shall not use this information for claims processing. This information is intended to be used for the TED only.
- Primary care manager 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.
- Other Health Insurance: Limited OHI information is returned.
- Other Government Programs: 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 active duty.

The Health Care Coverage Copayment Factor Code is determined by DEERS and is returned on a claims inquiry. The MCSC 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 TRICARE Operations Manual and TRICARE Policy Manual.

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	MCSC 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)		
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 response, see Return Code section 10.0.

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

CONDITION	RESPONSE	MCSC ACTION
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 response, see Return Code section 10.0.
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 response, see Return Code section 10.0.

If the contractor is unable to select a patient from the family listing provided by DEERS, the contractor shall check the patient's date of birth. If the date of birth 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 date of birth 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 DMDC Support Office (DSO) personnel and the Joint Uniformed Services Personnel and Medical Advisory Committee Members is provided at the TMA web site at http://www.tricare.osd.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 MCSC 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 MCSC 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 Beneficiaries Not On DEERS

A catastrophic cap record is not required for beneficiaries 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 beneficiaries 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 in the past. Future dates are not valid.

1.6.1.4.1.4. Lock Indicator

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

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.

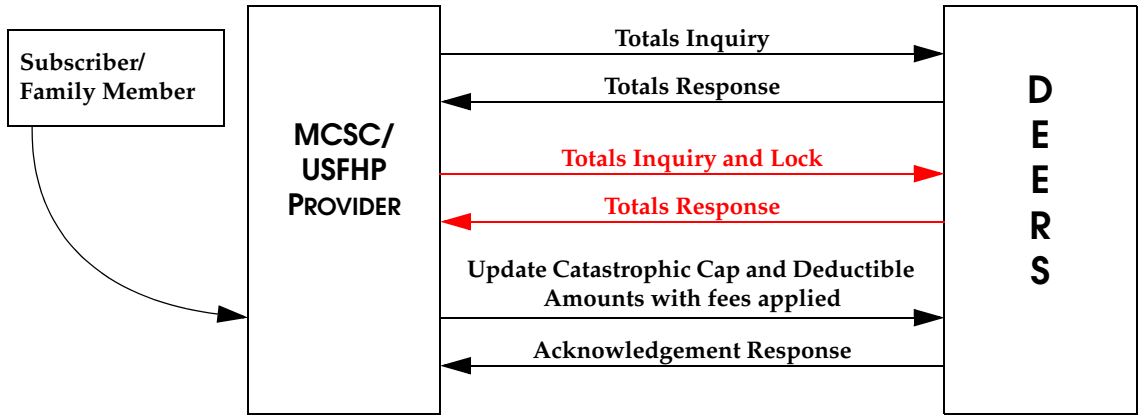
If the inquiry period spans fiscal or enrollment years, the CCDD totals would repeat multiple times. For example, if the inquiry dates are September 1, 2003 through October 25, 2003, there would be two sets of fiscal year totals, one for FY 2003 and one for FY 2004.

1.6.1.4.1.7. Lock Information

If an MCSC or DP 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 an MCSC inquires for totals with a lock and the totals were not presently locked, DEERS would return the accumulated totals and that MCSC's lock information, including their lock organization, lock date, and lock time. If an MCSC 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 CATASTROPHIC CAP AND DEDUCTIBLE 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 bullet: A non-split claim extension identifier 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 MCSC 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., PFPWD). See the TRICARE Policy Manual.

CCDD updates should be posted to DEERS even if the limit has been met.

1.6.1.5.1. Information Required To Update CCDD Amounts

The MCSC 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 dollar amount

The MCSC 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 MCSC 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.

- Adds

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

- Adjustments

The MCSC 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, an MCSC must provide the same information for updating a claim as outlined in the previous section. For example, an MCSC 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 MCSC 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.

- Canceling a catastrophic cap or deductible amount

The MCSC 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, an MCSC 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 MCSC would then update the insured's deductible with an amount of -$120. This would zero out the previous amount applied for that claim.

- The 48-hour rule

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

- Removing a lock

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

- 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' or 'O'. The 'Y' code indicates that a newborn is to be added. If DEERS returns an error code on a newborn

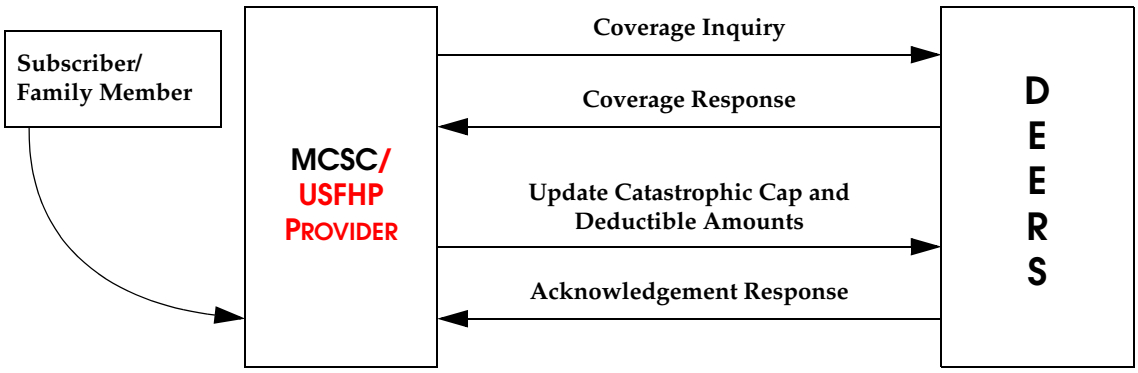
add that the person is already on the database, then the contractor should query to determine if this is the same person. If so, then use the return information to apply the CCDD. If no, then use the 'O' code to override the DEERS edits and add the newborn anyway.

Newborn information within the transfer record is populated as well as 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'.

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 Fiscal Year 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 regional contractor during transition. It is the responsibility of the new Regional contractor to ensure DEERS reflects the correct TRICARE Prime Point of Service deductible total for all FYs stored on DEERS. This data will be migrated from the CDCF to the DEERS CCDD repository via initial load.

TRICARE Prime Point of Service deductible data has been maintained separately by MCSC's. TRICARE Prime Point of Service 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. 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, 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.

1.7. Other Health Insurance

Other Health Insurance (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, deactivating, 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 MCSC will determine the existence of OHI. The MCSC can add or update minimal OHI data through the DOES application used by the MCSC to enter enrollments into DEERS. Other MHS systems can add or update the OHI through the Web application provided by DEERS. In addition, DEERS will accept OHI updates from the 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

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) Carriers 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 MCSC, the MCSC is required to fully develop for the remaining OHI data necessary to complete the OHI record within 15 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) Carriers. Health Insurance Carrier information is validated

against the Standard Insurance Table (SIT) which maintains the valid insurance carrier information on DEERS.

DEERS requires the MCSC to perform a coverage inquiry or 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. Performing a coverage inquiry or 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:

- 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 Medical Coverage unless another of the above coverages is selected. DEERS reports which coverages are included within the OHI policy. 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 health insurance carrier on the SIT. Refer to the SIT section for more information. DEERS retains OHI policy data for three 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 done to obtain it.

1.7.1.2. OHI Person Inquiry

The OHI data is by person and the OHI inquiry is only for individual person requests. DEERS allows multiple OHI policies for each person. DEERS does not support an inquiry that shows all insureds 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 can specify a time period (begin and end date) or through combinations of the time period, the Health Insurance Carrier ID or the Health Insurance Carrier Name, the OHI Policy ID and the OHI Coverage Type Code.

The Health Insurance Carrier 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 Health Insurance Carrier 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.

If DEERS cannot find the OHI policies for the specific coverage indicator, 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 MCSC systems to add an OHI policy for a person when documented information is presented to the MHS clinical personnel or to the MCSC. A coverage inquiry or an OHI Policy Inquiry should be done prior to adding an OHI policy. This ensures that updates are performed with the most current information. Following the coverage inquiry or the OHI Policy Inquiry, the OHI data can be added as necessary. OHI data can be added during an enrollment via the DOES application. OHI can be added 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 days, the MCSC shall provide all OHI data not initially entered.

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

- Patient ID
- Health Insurance Carrier Name
- OHI Policy ID
- OHI Effective Calendar Date
- OHI Policy Coverage Effective Date
- OHI Policy Coverage Precedence Code
- OHI Coverage Type Code
- OHI Carrier Coverage Payer Type Code

When the MHS organization enters the Health Insurance Carrier Name DEERS will check it against the SIT for validation of the Health Insurance Carrier information. If the Health Insurance Carrier Name is not on the SIT, the MHS organization may enter the carrier name as "Unknown", using the placeholder entry on the SIT. The placeholder entry on the SIT has a value of "Unknown" and can be used to indicate that an OHI policy exists for a beneficiary. The presence of a placeholder on the SIT is an indicator that OHI exists. Additional fields required to complete the OHI record are at Addendum D, Table X. This health insurance carrier of "Unknown" has an assigned Health Insurance Carrier Identifier (ID). For "Unknown" OHI policies the default coverage indicator is "medical"; however, any coverage indicator can be assigned to it. Monthly, DEERS provides the TMA Uniform Business Office (UBO) and the entity that provided the policy a report of the persons with an "Unknown" OHI policy. The report details the persons' information and the systems that entered the "Unknown" policy. The enrolling entity or updating system is responsible for obtaining the complete OHI information. NOTE: MCSCs may request the electronic copies of the report by submitting their request to the Contracting Officer along with the electronic address to where the report should be sent.

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.

The Health Insurance Carrier ID, Other Health Insurance 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 identify an OHI Policy to a person.

All messages sent to DEERS receive an acceptance or rejection acknowledgement.

1.7.3. OHI Policy Update

DEERS allows the MHS systems to update existing OHI policy information for a person when documented information is presented. Policy updates include modifications to existing policy 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 Policy Inquiry must be done prior to updating an OHI policy. This ensures that updates are performed with the most current information. Following the OHI Policy Inquiry, the OHI data can be updated as necessary. OHI data can be updated during an enrollment via the DOES application. OHI can also be updated any time after enrollment though the Web application provided by DEERS, or through the system to system interface.

If OHI is identified during routine claims processing or other contract activities, the MCSC 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 cancel. Canceling an OHI policy requires the following data elements:

- Patient ID
- Health Insurance Carrier ID
- OHI Policy ID
- OHI Effective Calendar Date
- OHI Expiration Calendar Date
- OHI End Reason Code

1.8. Standard Insurance Table

The Standardized Insurance Table (SIT) program supports the MHS billing and collection process. The requirements for the SIT are validated by the TMA Uniform Business Office (UBO) through the DoD Verification Point of Contact (VPOC). DEERS is the central repository of the SIT information for the use by the MHS organizations. 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 Health Insurance Carrier ID is the key used for associating a person's OHI policy with a commercial insurance company on the SIT. During the initial deployment of the SIT on DEERS, the Health Insurance Carrier ID will consist of the first three letters of the insurance company name, the two-letter standard state abbreviation, and a four-character identifier assigned by the DoD VPOC. 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 be provided the initial SIT from DEERS. 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 that is validated by the DoD VPOC, or may be additions or updates directly from the DoD VPOC.

Field users perform five actions with the SIT:

- An inquiry action to verify the information in the table for assignment of an OHI policy or to verify billing information

- 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
- The deactivation of a verified Health Insurance Carrier 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 Health Insurance Carrier ID that matches an entry in the SIT. The Health Insurance Carrier ID represents the identifier assigned to insurance carriers in the SIT provided by the DoD VPOC to DEERS. The Health Insurance Carrier 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) Carriers" for detailed information about the data elements required for the SIT add process.

When a Health Insurance Carrier is not on the SIT, the user may send a request to add it to the SIT on DEERS. DEERS responds with a Health Insurance Carrier ID a Health Insurance Carrier Status Code with the designation of "temporary" and a Health Insurance Carrier 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 Health Insurance Carrier Verification Status Code will be changed from "unverified" to "verified." DEERS will make updates available with the appropriate health insurance carrier 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 Health Insurance Carrier ID is sent with the update. Without the Health Insurance Carrier 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 health insurance carrier when the Health Insurance Carrier has a Status Code of "temporary" and is "unverified." See the SIT Add Cancellation section for more information.

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 temporary health insurance carrier. 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 Health Insurance Carrier 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 health insurance carrier. In addition, the DoD VPOC assigns the Health Insurance Carrier Status Code of "Standard" to validated health insurance carriers. If the DoD VPOC determines that the requested update is not correct, the DoD VPOC assigns a Health Insurance Carrier Status Code of "rejected". Rejected updates are returned to all local holders of the SIT.

If a health insurance carrier "add" request is rejected by the DoD VPOC, DEERS cancels any OHI policy on the DEERS database associated with the rejected health insurance carrier. 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 Health Insurance Carrier

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

1.9. Medicare Data

DEERS performs a match with CMS to obtain Medicare data and incorporates the Medicare data into the DEERS database as OTHER GOVERNMENT PROGRAMS (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 Centers for

Medicare and Medicaid Services (CMS) Fiscal Intermediaries for identification of Medicare eligibles during claims adjudication.

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

- A monthly file including all beneficiaries who will turn 65 within the next 60-90 days and all under 65 beneficiaries declaring Medicare on DEERS within the preceding month.
- Every six months, DEERS sends the TDEFIC a file of all beneficiaries with Medicare 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 (7) seconds, and for online data queries (data pull) from socket to socket is five (5) to eight (8) seconds.

Average online response time in the current version of DOES is four (4) to six (6) 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.