AWARD/CONTRACT

11. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 700) | !RATING DO-C9 | IPAGE 1 OF PAGES 73

2. CONTRACT (Proc. Inst. /dent.) NO. HT9402-13-C-0006

13. EFFECTIVE DATE ri | REQUISITION/PURCHASE REQUEST/PROJECT NO. See Block 20C13-CDBX-0003

5. ISSUED BY | GODE i HT9402

DEPARTMENT OF DEFENSE
TRICARE MANAGEMENT ACTIVITY COD-AB
16401 E CENTRETECH PARKWAY
AURORA CO 80011-9066

6. ADMINISTERED BY (If other than Item 5) | GODE i HT9402

DEPARTMENT OF DEFENSE
TRICARE MANAGEMENT ACTIVITY COD-AB
16401 E CENTRETECH PARKWAY
AURORA CO 80011-9066

7. NAME AND ADDRESS OF CONTRACTOR (No., Street, City, Country, State and ZIP Code)

DELTA DENTAL OF CALIFORNIA
100 lST ST STE 400
SAN FRANCISCO CA 941052634

CODE | FACILITY CODE

8. DELIVERY
FOB ORIGIN '8J OTHER (See below)

9. DISCOUNT FOR PROMPT PAYMENT
Net 30

10. SUBMIT INVOICES (4 copies unless otherwise specified) TO THE ADDRESS SHOWN IN | ITEM

11. SHIP TO/MARK FOR | CODE

Multiple Destinations

12. PAYMENT WILL BE MADE BY | CODE

13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION:
10 U.S.C. 2304 (c) ( ) 41 U.S.C. 253 (c) ( )

14. ACCOUNTING AND APPROPRIATION DATA
See Schedule

15A. ITEM NO	15B. SUPPLIES/SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
	Continued				

15G. TOTAL AMOUNT OF CONTRACT $0.00

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X	B	SUPPLIES OR SERVICES AND PRICES/COSTS	2-30			PART III - LIST OF DOCUMENTS, EXHIBITS AND OTHER ATIACH.	
X	C	DESCRIPTION/SPECS./WORK STATEMENT	31-55	X	J	LIST OF ATIACHMENTS	73-73
X	D	PACKAGING AND MARKING	56-56			PART IV - REPRESENTATIONS AND INSTRUCTIONS	
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CONTRACTING OFFICER WILL COMPLETE ITEM 17 (SEALED-BID OR NEGOTIATED PROCUREMENT) OR 18 (SEALED-BID PROCUREMENT) AS APPLICABLE

17. CONTRACTOR'S NEGOTIATED AGREEMENT (Contractor is required to sign this document and return 1 copies to issuing office.) Contractor agrees to **furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and** obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)

18. SEALED-BID AWARD (Contractor is not required to sign this document.) Your bid on **Solicitation Number** HT9402-11-R-0001 including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any continuation **sheets. This award consummates the contract which consists of the following** documents: (a) the Government's solicitation and your bid, and (b) this award/contract. No further contractual document is necessary. (Block 18 should be checked only when awarding a sealed-bid contract.)

19A. NAME AND TITLE OF SIGNER (Type or11rint)
P.T. Henry, Sr_ Vice resident

20A. NAME OF CONTRACTING OFFICER
Bruce M ttere r 303.676.3812
bruce.mitterer@tma.osd.mil

198. NAME OF CONTRACTOR

"(M--0' /:;r

19C. DATE SIGNED
2/03/2012

208. UNITED STATES OF AMERICA
BY
ISianature Ofthe Contractina Officer)

20C. DATE SIGNED

AUTHORIZED FOR LOCAL REPRODUCTION
Previous edition is NOT usable

STANDARD FORM 26 (Rev.5/2011)
Prescribed by GSA
FAR (48 CFR) 53.214(a)

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	No Government Funds on Contract. All funds are collected from beneficiaries to the contractor through premium payments.				
	BASE PERIOD January 2, 2013 through December 31, 2013.				
0001	Transition-In Obligated Amount: $0.00	1	LT		0.00
	Accounting Info: Funded: $0.00				
0002	Data prepared and delivered in accordance with Sections C, F and J. (Not Separately Priced)	1	LT	NSP	NSP
	Accounting Info: Funded: $0.00				
	OPTION PERIOD 1 January 1, 2014 through December 31, 2014.				
1001	BASIC PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 13,300 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
1001AA	Region 1 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
1001AB	Region 2 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
1001AC	Region 3 (Option Line Item)		EA		0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
1001AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1001AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1002	BASIC PROGRAM - TWO PARTY ENROLLMENT (Note: The estimate for this CLIN is 21,500 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
1002AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1002AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1002AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1002AD	Region 4 (Option Line Item)		EA	[redacted]	0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
1002AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1003	BASIC PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 3,500 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
1003AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1003AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1003AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1003AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1003AE	Region 5 (Option Line Item) Continued ...		EA	[redacted]	0.00

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
1004	ENHANCED PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 217,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
1004AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1004AB	Region 2 (Option Line Item)		EA	(b)(4)	0.00
	Accounting Info: Funded: $0.00				
1004AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1004AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1004AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1005	ENHANCED PROGRAM - TWO-PARTY ENROLLMENT (Note: The estimate for this CLIN is 297,000 Continued ...				

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
1005AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1005AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1005AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1005AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1005AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
1006	ENHANCED PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 128,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
1006AA	Region 1		EA	[redacted]	0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Option Line Item) Accounting Info: Funded: $0.00				
1006AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
1006AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
1006AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
1006AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
1007	Data prepared and delivered in accordance with Sections C, F and J. (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00
1008	Phase-Out (NOTE: Only one Option Period Phase-Out CLIN will be exercised during the life of the contract.) (Option Line Item) (Not Separately Priced) Accounting Info: Continued ...	1	LT	NSP	0.00

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Funded: $0.00				
	OPTION PERIOD 2 January 1, 2015 through December 31, 2015.				
2001	BASIC PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 12,500 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
2001AA	Region 1 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
2001AB	Region 2 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
2001AC	Region 3 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
2001AD	Region 4 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
2001AE	Region 5 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
2002	BASIC PROGRAM - TWO PARTY ENROLLMENT Continued ...				

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Note: The estimate for this CLIN is 20,400 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
2002AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
2002AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
2002AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
2002AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
2002AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
2003	BASIC PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 2,600 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2003AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA		0.00
2003AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2003AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2003AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2003AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2004	ENHANCED PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 222,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
2004AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA		0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2004AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
2004AC	Region 3 (Option Line Item)		EA	(b)(4)	0.00
	Accounting Info: Funded: $0.00				
2004AD	Region 4 (Option Line Item)		EA	(b)(4)	0.00
	Accounting Info: Funded: $0.00				
2004AE	Region 5 (Option Line Item)		EA	(b)(4)	0.00
	Accounting Info: Funded: $0.00				
2005	ENHANCED PROGRAM - TWO-PARTY ENROLLMENT (Note: The estimate for this CLIN is 302,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
2005AA	Region 1 (Option Line Item)		EA	(b)(4)	0.00
	Accounting Info: Funded: $0.00				
2005AB	Region 2 (Option Line Item)		EA	(b)(4)	0.00
	Accounting Info: Funded: $0.00				

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2005AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2005AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA		0.00
2005AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2006	ENHANCED PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 131,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
2006AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2006AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2006AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2006AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2006AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
2007	Data prepared and delivered in accordance with Sections C, F and J. (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00
2008	Phase-Out (NOTE: Only one Option Period Phase-Out CLIN will be exercised during the life of the contract.) (Option Line Item) (Not Separately Priced) Accounting Info: Funded: $0.00	1	LT	NSP	0.00
	OPTION PERIOD 3 January 1, 2016 through December 31, 2016.				
3001	BASIC PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 11,700 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
3001AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA		0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
3001AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3001AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
3001AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
3001AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
3002	BASIC PROGRAM - TWO PARTY ENROLLMENT (Note: The estimate for this CLIN is 19,300 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
3002AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA	(b)(4)	0.00
3002AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00 Continued ...		EA	(b)(4)	0.00

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
3002AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3002AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3002AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3003	BASIC PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 2,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
3003AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3003AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3003AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00 Continued ...		EA	[redacted]	0.00

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
3003AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3003AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3004	ENHANCED PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 227,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
3004AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3004AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3004AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3004AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00 Continued ...		EA	[redacted]	0.00

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
3004AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3005	ENHANCED PROGRAM - TWO-PARTY ENROLLMENT (Note: The estimate for this CLIN is 307,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
3005AA	Region 1 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3005AB	Region 2 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3005AC	Region 3 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3005AD	Region 4 (Option Line Item) Accounting Info: Funded: $0.00		EA	[redacted]	0.00
3005AE	Region 5 (Option Line Item) Accounting Info: Funded: $0.00 Continued ...		EA	[redacted]	0.00

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
3006	ENHANCED PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 134,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
3006AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
3006AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
3006AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
3006AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
3006AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
3007	Data prepared and delivered in accordance with Sections C, F and J. (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
3008	Phase-Out (NOTE: Only one Option Period Phase-Out CLIN will be exercised during the life of the contract.) (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00
	Accounting Info: Funded: $0.00				
	OPTION PERIOD 4 January 1, 2017 through December 31, 2017.				
4001	BASIC PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 10,900 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
4001AA	Region 1 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4001AB	Region 2 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4001AC	Region 3 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4001AD	Region 4 (Option Line Item)		EA		0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
4001AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4002	BASIC PROGRAM - TWO PARTY ENROLLMENT (Note: The estimate for this CLIN is 18,200 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
4002AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4002AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4002AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4002AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4002AE	Region 5 (Option Line Item)		EA	[redacted]	0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
4003	BASIC PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 1,700 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
4003AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4003AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4003AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4003AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4003AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4004	ENHANCED PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 232,000 plans/policies per month which is multiplied by Continued ...				

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ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
4004AA	Region 1 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4004AB	Region 2 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4004AC	Region 3 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4004AD	Region 4 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4004AE	Region 5 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
4005	ENHANCED PROGRAM - TWO-PARTY ENROLLMENT (Note: The estimate for this CLIN is 312,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
4005AA	Region 1 (Option Line Item)		EA		0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
4005AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4005AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4005AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4005AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4006	ENHANCED PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 137,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
4006AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4006AB	Region 2 (Option Line Item)		EA	[redacted]	0.00

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Accounting Info: Funded: $0.00				
4006AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4006AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4006AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
4007	Data prepared and delivered in accordance with Sections C, F and J. (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00
	Accounting Info: Funded: $0.00				
4008	Phase-Out (NOTE: Only one Option Period Phase-Out CLIN will be exercised during the life of the contract.) (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00
	Accounting Info: Funded: $0.00				
	OPTION PERIOD 5 January 1, 2018 through December 31, 2018				
5001	BASIC PROGRAM - SINGLE ENROLLMENT Continued ...				

NAME OF OFFEROR OR CONTRACTOR
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ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Note: The estimate for this CLIN is 10,100 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
5001AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5001AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5001AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5001AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5001AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5001AF	Region 6 (Option Line Item)		EA	0.00	0.00
	Accounting Info: Funded: $0.00				

Continued ...

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
5002	BASIC PROGRAM - TWO PARTY ENROLLMENT (Note: The estimate for this CLIN is 17,100 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
5002AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5002AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5002AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5002AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5002AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5003	BASIC PROGRAM - FAMILY ENROLLMENT (Note: The estimate for this CLIN is 1,500 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item) Continued ...				

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
5003AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5003AB	Region 2 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5003AC	Region 3 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5003AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5003AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5004	ENHANCED PROGRAM - SINGLE ENROLLMENT (Note: The estimate for this CLIN is 237,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
5004AA	Region 1 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Continued ...				

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Funded: $0.00				
5004AB	Region 2 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5004AC	Region 3 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5004AD	Region 4 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5004AE	Region 5 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5005	ENHANCED PROGRAM - TWO-PARTY ENROLLMENT (Note: The estimate for this CLIN is 317,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
5005AA	Region 1 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5005AB	Region 2 (Option Line Item)		EA		0.00
	Accounting Info: Continued ...				

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Funded: $0.00				
5005AC	Region 3 (Option Line Item)		EA	(b)(4)	0.00
	Accounting Info: Funded: $0.00				
5005AD	Region 4 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5005AE	Region 5 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5006	ENHANCED PROGRAM - TWO-PARTY ENROLLMENT (Note: The estimate for this CLIN is 317,000 plans/policies per month which is multiplied by 12 to arrive at the number of premium payments for the Option Period.) (Option Line Item)				
5006AA	Region 1 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5006AB	Region 2 (Option Line Item)		EA		0.00
	Accounting Info: Funded: $0.00				
5006AC	Region 3 (Option Line Item)		EA		0.00
	Accounting Info: Continued ...				

NAME OF OFFEROR OR CONTRACTOR
DELTA DENTAL OF CALIFORNIA

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Funded: $0.00				
5006AD	Region 4 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5006AE	Region 5 (Option Line Item)		EA	[redacted]	0.00
	Accounting Info: Funded: $0.00				
5007	Data prepared and delivered in accordance with Sections C, F and J. (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00
5008	Phase-Out (NOTE: Only one Option Period Phase-Out CLIN will be exercised during the life of the contract.) (Option Line Item) (Not Separately Priced)	1	LT	NSP	0.00

SECTION C
DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

C.1. GENERAL. The Department of Defense (DoD) through the TRICARE Management Activity (TMA) offers TRICARE Retiree Dental Program (TRDP) coverage to all eligible personnel retired from the Uniformed Services, unremarried surviving spouses, eligible dependents, former members of the armed forces who are Medal of Honor recipients and their eligible dependents (See 32 CFR 199.22(d)(1) for a complete description of eligibility coverage).

C.1.1. The TRDP has two programs: The Basic program which is closed to new enrollments (with the exception of adding a family member (see C.7.2)) and the Enhanced program to which all new TRDP enrollees shall be enrolled. Enrollment in the TRDP is voluntary. All premium costs are paid by the enrollee.

C.1.2. The TRDP Basic program offers coverage for dental services rendered in the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands**,** and Canada. The TRDP Enhanced program benefits are offered worldwide.

C.2. STATEMENT OF OBJECTIVES. The statement of objectives represents the desired outcomes of this contract. The objectives are supported by technical requirements stated throughout Section C. The objectives are as follows:

C.2.1. Sustain or increase TRDP enrollment.

C.2.2. Increase enrolled members' utilization of diagnostic and preventive services.

C.2.3. Establish and maintain high levels of enrollee and provider satisfaction.

C.2.4. Promote preventive dental services among enrolled diabetics.

C.3. DOCUMENTS. The following documents are incorporated by reference. These documents form an integral part of this contract and have the same force and effect as if set forth in full text. The TRICARE Manuals provide instruction, guidance and responsibilities in addition to the requirements set forth in the incorporated federal statutes and regulations. If there is a conflict the order of precedence is – TRICARE Policy Manual (TPM), TRICARE Systems Manual (TSM) then the TRICARE Operations Manual (TOM). The Manuals and TMA version of CFR 199 are located at http://manuals.tricare.osd.mil/.

C.3.1. Title 10, United States Code (U.S.C.), Chapter 55, Section 1076c.

C.3.2. Title 32 Code of Federal Regulations (CFR) 199.3, 199.6, 199.10 and 199.22.

C.3.3. Title 36 CFR 1222 (data created or received and maintained for the Government by Contractors).

C.3.4. Title 45 CFR Parts 160, 162 and 164 (the Health Insurance Portability and Accountability Act of 1996 [HIPAA] security and privacy standards, transaction and code set standards, National Provider Identifier [NPI] requirements and implementation specifications).

C.3.5. National Institute of Standards and Technology (NIST) special publications (SP) 800-53 and 800-53A.

C.3.6. TRICARE Policy Manual (TPM) 6010.57-M, February 1, 2008 (through Change 73). The requirements in the following TPM chapters apply to the TRDP Contractor:

- Chapter 8, Section 13.1 Adjunctive Dental Care
- Chapter 8, Section 13.2 Dental Anesthesia
- Chapter 10, Section 5.1 - Transitional Assistance Management Program

C.3.7. TRICARE Operations Manual (TOM) 6010.56-M, February 1, 2008 (through Change 81). The requirements in the following TOM chapters apply to the TRDP Contractor:

- Chapter 1, Section 1 – Organization of the TRICARE Management Activity(TMA)
  Section 2 – Contract Administration and Instructions
  Section 5 – Compliance with Federal Statutes
  Section 6 – Legal Matters
- Chapter 2, Records Management (For Chapter 2, see draft Section J Attachment J-9, which is the prevailing version for the purposes of this solicitation until such time that the manual is updated.)
- Chapter 11, Section 9 – Grievances and Grievance Processing
  Addendum A - TRICARE Logo
- Chapter 12, Appeals and Hearings
- Chapter 14, Section 2 – Reports and Plans
- Chapter 19, Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Appendix A, Acronyms and Abbreviations
- Appendix B, Definitions

C.3.8. TRICARE Systems Manual (TSM) 7950.2-M, February 1, 2008 (through Change 40). The requirements in the following TSM chapters apply to the TDP Contractor:

- Chapter 1, General Automated Data Processing (ADP) Requirements (For Chapter 1, Section 1.1, see draft Section J Attachment J-8a, which is the prevailing version for the purposes of this solicitation until such time that the manual is updated.)
- Chapter 3 - Defense Enrollment Eligibility Reporting System (DEERS) (For Chapter 3, Sections 1.2, 1.3 and 1.5, see draft Section J Attachments J-8b, J-8c and J-8d, which are the prevailing versions for the purposes of this solicitation until such time that the manual is updated.) Sections 1.4 and 1.6 do not apply to this contract.

C.4. DEFINITIONS. Definitions are included in 32 CFR 199.2, the TOM's Appendix B, and Section J Attachment J-1.

C.5. GOVERNMENT INFORMATION AND APPLICATIONS.

C.5.1. The Government will furnish an electronic file listing of the names and addresses of all known retirees for the Contractor's use as a list of potential enrollees in the TRDP. The listing

will be provided no later than the date initial education materials are approved. The Contractor must comply with the required certification and validation for safeguarding unclassified DoD sensitive information prior to receiving the data. Thereafter, a new listing of all known retirees will be furnished every contract quarter.

C.5.2. The official TRICARE logo which must be incorporated in all education materials, may be found at TOM Chapter 11, Addendum A.

C.5.3. The Government will furnish the Contractor with access to the Defense Manpower Data Center's (DMDC) Defense Eligibility Enrollment Reporting System (DEERS) to perform eligibility inquiries and enrollments. DEERS is the database of record for the TRDP. The Government will furnish access to DEERS only after the Contractor's staff and all subcontractors' staff that utilize systems which access and maintain TRDP data are compliant with the enhanced safeguarding methods for unclassified DoD information, personnel security, and clearance requirements. The Contractor and its subcontractors must be in compliance with Section C.9, no later than 120 days before the contract start work date.

C.6. CONTRACTOR-FURNISHED ITEMS.

The Contractor shall furnish all necessary items for the satisfactory performance of this contract, unless the contract specifically states that the Government will be providing such item.

C.7. TECHNICAL REQUIREMENTS.

C.7.1. Benefits, Exclusions, and Limitations.

C.7.1.1. Covered benefits for the TRDP are determined by the DoD and are based upon generally accepted dental practice standards. The Contractor shall be compliant with the most current version of the Code on Dental Procedures and Nomenclature (Code) published in the American Dental Association's (ADA) Current Dental Terminology (CDT) manual throughout the life of the contract. (Note: For the purposes of this solicitation, the list of covered services in TRDP Benefits, Exclusions, and Limitations, Section J Attachment J-3, conforms to the ADA's CDT- 2011/2012 manual.)

C.7.1.2. The Contractor shall promptly notify the Contracting Officer whenever a new version of the ADA CDT manual is published. Within 30 calendar days of the release of the new version, the Contractor shall provide the Contracting Officer with a synopsis of the changes the Contractor recommends be made to TRDP Benefits, Exclusions, and Limitations, Section J Attachment J-3. Within 45 calendar days of the release of the new version, the Contractor and TMA shall initiate discussions regarding those recommended changes. Subsequently, based upon these discussions, the Contractor shall provide the Contracting Officer with a written description of all the changes that need to be made to Section J Attachment J-3 in order for them to conform to the new version of the ADA CDT manual and Code. The Contracting Officer will review the proposed changes and if warranted, issue a contract modification to implement the changes.

C.7.1.2.1. When the proposed changes to TRDP Benefits, Exclusions, and Limitations have been reviewed and approved by the Contracting Officer, in the form of a modification to the contract, the Contractor shall notify all current enrollees and all network providers via an update to the TRDP Web site as required by Section C.7.16.2.3. In addition the Contractor shall update any Contractor provided literature.

C.7.1.2.2. The Contractor shall, with no increase in premiums, update their Information Technology (IT) and other related business systems required to accommodate the approved changes/modifications to the TRDP Benefits, Exclusions, and Limitations.

C.7.1.3. In certain circumstances, some TRDP covered services may be unavailable from overseas dental providers due to that country's standards of dental practice. In these cases, the Contractor shall accommodate unusual circumstances relevant to the practice and delivery of dental services in the overseas service area and determine what reasonable payment will be made by the Contractor to the provider based upon the treatment information provided. It is not expected that overseas dental providers will utilize ADA CDT coding or a standard bill when submitting claims. The Contractor shall utilize all available information submitted with the overseas bill and claim to cross reference services to the ADA CDT coding scheme.

C.7.2. Enrollment.

C.7.2.1. New enrollments for the TRDP Basic program are closed, with the exception being when an existing plan under the Basic program adds a family member. The 12-month enrollment commitment for the primary enrollee starts over again with the family member's coverage effective date and must be satisfied by the primary enrollee before voluntary disenrollment can be considered (see C.7.3). The Contractor shall offer continuous open enrollment to all TRDP eligibles for the TRDP Enhanced program. Surviving family members of the non-mobilized Individual Ready Reserve (IRR) are not eligible for TRDP. Enrollment in the TRDP is voluntary and shall be portable if there are multiple regions (see Section C.7.5). The Contractor shall maintain an enrollment file to reflect new enrollments, continuing enrollments, and disenrollments.

C.7.2.2. Enrollment Effective Date. New enrollments and changes to enrollment are effective the first of the month following the month in which the request was received by the Contractor. Premiums will not be pro-rated. The Contractor may allow retroactive changes to enrollments up to 18 months in the past or prospective changes up to 90 days in the future with the effective date being the first of the month.

C.7.2.3. The Contractor shall record all enrollments, re-enrollments, disenrollments, and correct enrollment discrepancies on the Defense Enrollment Eligibility Reporting System (DEERS), as specified in Section J Attachment J-8d, TSM Chapter 3, Section 1.5. DEERS is the sole source for verifying eligibility and enrollment for the TRDP. The Contractor shall interface directly with DEERS through the Government provided on-line enrollment software in accordance with Section J Attachment J-8d, TSM Chapter 3, Section 1.5. All eligibility information, to include all eligible retirees, family members and coverage plans in which they are eligible to be enrolled, will be provided to the Contractor through this Government provided on-line enrollment system

and all voluntary enrollments/terminations will be performed using this web based system. Voluntary enrollment/termination information input by the Contractor, using the Government system, will be applied to the DEERS database and an enrollment transaction will be sent by DEERS to the Contractor who must be able to apply the enrollment information sent by DEERS to their system. Sensitive enrollment/eligibility information that is subject to the Privacy Act shall be maintained in the Contractor's owned and operated IT system during the period of contract performance.

(b)(4)

C.7.2.4. The Contractor shall use the TRDP Enrollment/Change Authorization developed in coordination with TMA to record enrollments.

C.7.2.4.1. The Contractor shall also accept and process TRDP enrollment applications via the Beneficiary Web Enrollment (BWE) process (see Section J Attachment J-8d, TSM, Chapter 3, Section 1.5).

C.7.2.4.2. Web DOES and BWE will require that a residential address be entered when a beneficiary is enrolled into the TRDP. This address will not be allowed to be removed as long as the beneficiary remains enrolled. This will facilitate tracking and recalculations of premiums.

C.7.2.4.3. The Defense Manpower Data Center (DMDC) shall print and mail the TRDP coverage cards directly to the enrollee at the residential mailing address specified on the enrollment application after the receipt of the enrollment record. DMDC will also provide written notification for new enrollments, plan type changes, disenrollments, and the replacement of the TRDP coverage card (see Section J Attachment J-8d, TSM, Chapter 3, Section 1.5). The return address on the envelope mailed by DMDC will be that of the TRDP Contractor and will also include the statement: “Address Service Requested” (Note: the Contractor will be responsible for paying the U.S. Postal Service for this service). In the case of receiving returned mail, the TRDP Contractor shall develop a process to ensure delivery to the enrollee.

C.7.2.5. Types of Enrollment. Enrollment options shall be structured as single (e.g., sponsor only or unremarried surviving spouse only), two-party and family (three or more).

C.7.3. Lock-In and Lock-Out Periods. All new enrollees will incur a 12-month lock-in period. There is a 12-month enrollment lock-out if the enrollee fails to pay premiums during the 12-month lock-in period or disenrolls for other than valid reasons as specified in 32 CFR 199.22(d)(5)(ii)(A) and (B). Following a lock-out period, an eligible enrollee may re-enroll at any time, with another 12-month lock-in.

C.7.4. Voluntary Disenrollment. An enrollee may submit to the Contractor a request for voluntary termination of TRDP coverage before the completion of the customary initial enrollment period. The Contractor shall then make a formal determination on whether the enrollee qualifies to be disenrolled under any of the following exceptions.

C.7.4.1. Enrollment Grace Period. Regardless of the reason, TRDP coverage shall be cancelled upon request from an enrollee, if the request is received by the Contractor within 30 calendar days following the enrollment effective date and if there has been no use of TRDP benefits under the enrollment. If such is the case, the enrollment shall be voided and all premium payments refunded. However, any use of TRDP benefits during this 30-day enrollment grace period shall constitute acceptance by the enrollee of the enrollment and the enrollment period commitment. In this case, a request for termination of enrollment will not be honored, and premiums will not be refunded.

C.7.4.2. Extenuating Circumstances. Under limited circumstances, TRDP enrollees shall be disenrolled by the Contractor upon request by an enrollee, before the completion of the enrollment period commitment, if the enrollee submits written, factual documentation that independently verifies that one of the following extenuating circumstances occurred during the enrollment period. In general, the circumstances must have been unforeseen and be long-term, and must have originated after the effective date of TRDP coverage.

C.7.4.2.1. The enrollee is prevented by a serious medical condition from being able to utilize TRDP benefits,

C.7.4.2.2. The enrollee would suffer severe financial hardship by continuing enrollment in TRDP, or

C.7.4.2.3. The enrollee is recalled to active duty.

C.7.4.3. Effective Date of Voluntary Termination. For cases determined to qualify for disenrollment under the grace period provisions, enrollment is completely nullified effective from the beginning date of coverage. For cases determined to qualify for disenrollment under the extenuating circumstances provisions, the effective date of disenrollment is the first of the month following the Contractor's initial determination on the disenrollment request or the first of the month following the last use of TRDP benefits under the enrollment, whichever is later.

C.7.4.4. An enrollee has the right to appeal to TMA the Contractor's determination that a disenrollment request does not qualify under the preceding paragraphs. The enrollee may appeal that determination by submitting a written request to TMA’s Dental Program Office with a copy of the Contractor's determination notice and relevant documentation supporting the

disenrollment request. This appeal must be received by TMA within 60 days of the date on the Contractor's determination notice. The burden of proof is on the enrollee to establish affirmatively by substantial evidence that the enrollee qualifies to be disenrolled. TMA will issue written notification to the enrollee and the Contractor of its appeal determination within 60 days from the date of receipt of the appeal request. The decision of TMA is final.

C.7.5. Benefit Portability. If there is more than one region, the Contractor shall ensure that the TRDP benefit is portable to those enrollees with multiple residences, traveling enrollees and families whose members reside in different regions.

C.7.6. Premium Payments. Premiums for each premium region shall be structured on the three enrollment options (see Section C.7.2.4). Enrollees must submit a payment equivalent to two months' premium with their enrollment application. Ongoing premium collection activity shall be initiated by the Contractor and sent to the Uniformed Services finance centers for collection of premiums from those individuals who enroll in the TRDP, who receive retired pay and who receive sufficient funds in their retired pay at the time of collection. The Contractor shall interface with the Uniformed Services Finance Centers through the MHS B2B Gateway and shall follow the payroll allotment process as described in Section J Attachment J-8a, TSM Chapter 1, Section 1.1. The Contractor's Uniformed Services Finance Center interfaces shall be ready to begin testing approximately 30 days following certification of its compliance with Section C.9.

C.7.6.1. Contractor Direct Billing. The Contractor shall collect premiums directly from all enrollees who do not receive retired pay from the Defense Finance and Accounting Service-Cleveland Center (DFAS-Cleveland), from the National Oceanic and Atmospheric Administration (NOAA), Coast Guard (USCG), or from the U.S. Public Health Service (PHS), or whose retired pay is insufficient to pay the entire monthly dental premiums. The Contractor shall allow for payment by the enrollee on a monthly basis (i.e., with the exception of the initial premium payment due upon enrollment, enrollees may not be required to pay more than one month's premium in a single payment). The Contractor shall employ its standard business practices for collection of past due premiums. The Contractor shall refund overpayments within 30 calendar days of identifying the overpayment.

C.7.6.2. Regional Premium Breakout. The Contractor shall provide a file to DMDC that maps the zip codes to the regional codes. In addition the Contractor shall provide any updates to the zip codes and/or premiums each Option Period (see Section J Attachment J-6, CDRL AR040)

C.7.6.3. Recalculated Premium. There will be no premium changes mid-month. The effective date of the recalculated premium paid period will be the first of the month following the date of the change requiring the recalculation (e.g., the Contractor notifies DEERS of a residential address change mid-month; the recalculated premium period will be effective the first of the following month). The premium amount and premium paid period is based on the sponsor's residential address unless the sponsor is not enrolled. If the sponsor is not enrolled (or disenrolls/enrollment is terminated) DEERS will use an established hierarchy of family members for determining the premium paid period (e.g., spouse, oldest child, etc.) DEERS will notify the Contractor of a new premium paid period whenever the premium paid period (based on the

policy begin date and premium records on file for that policy) is recalculated. The premium paid period is recalculated automatically when any of the following events occur:

- The premium amount changes and a policy is paid beyond the effective date of that premium increase (e.g., if an enrollee paid out months in the future and DEERS hadn't received the premium rate).
- Two or more policies are merged into one and all premium entries are moved to one policy.
- The policy begin date is adjusted.
- If a zip code within a pricing region gets added/changed
- When the person whose address determines the premium is no longer enrolled (e.g., disenrolls, dies) and the next person in the hierarchy for determining premiums has a different address.

C.7.7. Waiting Periods. Under the provisions of Section J Attachment J-3A, certain procedures shall be covered only after the completion of the 12 months waiting period.

C.7.7.1. . Credit for the 12 months benefit waiting period shall be granted to individuals newly covered under enrollments in the TRDP, if their enrollment takes place within four months after the sponsor's retirement from the Uniformed Services. Procedures otherwise scheduled to become covered after 12 months continuous enrollment shall be available to these enrollees immediately.

C.7.7.2. Credit for the 12 months benefit waiting period shall be applied to a surviving spouse whose enrollment in the TRDP takes place within four months of the termination of survivors' coverage under the TRICARE Dental Program (TDP).

C.7.7.3. For those individuals already enrolled in the TRDP Enhanced program at the beginning of this contract, credit for waiting periods shall be granted in an amount no less than the period of Enhanced enrollment already completed (see Section J Attachment J-3A). The Contractor may at its option deem all waiting periods to have been met for these individuals at the commencement of coverage under this contract.

C.7.7.4. If a Basic program enrollee elects to enroll in the Enhanced program, the Contractor shall transfer the enrollment with no break in coverage. Credit for waiting periods shall be granted in an amount no less than the period of Basic enrollment already completed (see Section J Attachment J-3A). The Contractor may at its option deem all waiting periods to have been met for these individuals at the commencement of coverage under this contract.

C.7.8. Maximum Benefit Payment.

C.7.8.1 Annual Benefit Maximum and Annual Deductible. With the exception of the diagnostic and preventive services indicated in Section J Attachments J-3A and J-3B, the Enhanced program's annual benefit maximum is $1,300.00 and the Basic program's annual benefit maximum is $1,000.00, of paid allowable charges, per enrollee per contract year. For both the Enhanced and Basic programs the annual deductible is $50.00 per person, not to exceed $150.00

per family, per contract year. The entire annual maximum and deductible amounts apply beginning on the TRDP enrollment effective date, regardless of when during the year an individual enrolls. Subsequently new annual maximum and deductible amounts begin again at the start of each contract year.

C.7.8.2 Dental Accident Coverage. The Enhanced Program provides a separate annual benefit maximum of $1,200.00 per enrollee for dental accident coverage. The annual deductible will not apply. The Contractor shall pay claims in accordance with the benefit limitations and cost shares stated in Section J Attachment J-3a, for dental accident treatment defined as follows:

C.7.8.2.1. Covered services for this program, excluding orthodontics, are subject to all applicable general policies and exclusions, when provided for conditions caused directly by external and accidental means.

C.7.8.2.2. Dental accident benefits shall be limited to services provided to an eligible person within 180 days following the date of the accident, and shall not include any services for conditions caused by an accident occurring before the enrollee's eligibility date.

C.7.8.2.3. Once the $1,200 accident maximum is reached, benefits will be paid up to the annual $1,300 maximum, with applicable benefit limitations and cost share amounts.

C.7.8.3. Orthodontic Lifetime Maximum. A separate lifetime maximum benefit of $1,750.00 per enrollee shall apply to orthodontic services and the annual deductible shall not apply. In the case of those individuals who had previously accumulated all or part of the $1,500.00 orthodontic services lifetime maximum applicable under the predecessor contract, additional coverage of orthodontic services shall be made available up to a cumulative total of $1,750.00. The enrollee must be in active orthodontic treatment to receive the additional benefit.

C.7.8.4. Overseas Locations. In overseas locations (i.e. other than the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands**,** and Canada), the allowable charges used to reach the annual benefit maximum shall be calculated based on the Contractor's approved provider fee schedule. The Contractor shall base its allowable charge schedule on the ninety-fifth (95th) percentile of undiscounted charge data obtained from the Contractor's most current District of Columbia region provider billed charge data. Determination of the overseas fee schedule will not include any discounted charge data and can only be determined using undiscounted, billed charge data. Network provider fee schedules will not be used in the determination of the overseas fee schedule. This fee schedule shall be updated by the Contractor on an annual basis to coincide with the start date of the next contract option period. The Contractor shall pay overseas claims (i.e. that is other than claims received from the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands**,** and Canada) for covered services at the lesser of:

C.7.8.4.1. Billed charges, less applicable cost shares, or

C.7.8.4.2. The ninety-fifth (95th) percentile of the Contractor's most current provider fee schedule for the District of Columbia region, less applicable cost shares.

C.7.8.5. Exceptions to Maximum Benefit Payment. The following paragraphs contain guidance on application of exceptions to maximums for overseas locations (other than those locations stated in C.7.8.4) under various Enhanced program enrollee situations.

C.7.8.5.1. If an enrollee resides overseas and returns to seek care in the United States, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, Northern Marianna Islands or Canada, then the Contractor shall revert to the procedures used for these locations for processing claims against maximums. For care received in these locations, the Contractor shall utilize the Contractor's current applicable fee schedule as the basis for calculating the allowable charge against billed charges and the enrollee will be fully responsible for reimbursing the provider for applicable cost shares.

C.7.8.5.2. Enhanced program enrollees enrolled in the United States, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, Northern Marianna Islands or Canada that visit overseas countries, are entitled to only receive care for emergency services. Claims for emergency services will be subject to overseas computations and all other overseas service area provisions. The enrollee will be fully responsible for reimbursing the provider for applicable cost shares.

C.7.9. Access to Dental Care Providers.

C.7.9.1. The Contractor shall make the TRDP available throughout the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands**,** Canada and all other overseas locations.

C.7.9.2. Network Provider Access. The Contractor shall establish provider networks for the delivery of dental services in the United States, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. (b)(4) percent of enrollees shall have access to a general dentistry network provider within 35 driving miles (b)(4) (b)(4) of their primary residence, and be able to obtain an appointment with 21 calendar days of requesting an appointment. (b)(4) (b)(4) (b)(4) The Contractor shall ensure that the network provider access standard is met at the start of dental care delivery and continuously maintained thereafter. (b)(4) The Contractor shall provide a stable, high-quality network or networks of general and specialty dental care providers that are available to all enrollees. Enrollees shall not be restricted as to their choice of a network or non-network provider.

C.7.9.3. Network Adequacy. The Contractor shall provide the Contracting Officer with written notification of any instances of provider network inadequacy relative to the access standard

specified in C.7.9.2, by five digit ZIP code, and shall submit a corrective action plan with each notice of an instance of provider network inadequacy. Provider network inadequacy is defined as any failure to meet the access standard. This information shall be included in the Monthly Provider Network Access Report (see Section J Attachment J-6).

C.7.9.3.1. When more than 25% percent or more than 200 enrollees in a specific five digit ZIP code area are unable to obtain a periodic or initial (non-emergency) dental examination appointment with a network provider within the access standard specified in C.7.9.2, then TMA will designate that area as non-compliant with the network access standard. Once an area is designated as non-compliant, the Contractor shall reimburse the non-network providers in that area (or a subset of the area or nearby ZIP codes in other five digit ZIP code areas as determined by TMA) at the level of the provider's usual fees less applicable enrollee cost-shares. Enrollee cost-shares shall be based on the Contractor's fee schedule for that geographic area rather than the provider's usual fees. The Contractor shall notify enrollees residing in a non-compliant area that they can use any provider and that their claims will be reimbursed as if they were receiving care from a network provider. TMA shall determine when such areas become compliant with the access standards. When determined compliant, the Contractor shall notify the enrollees by mail that network dentists are now available and normal reimbursements will take effect 30 calendar days from the date of the notification.

C.7.9.4. Listing of Network Providers. The Contractor shall maintain an accurate, up-to-date list of network providers that includes their name, specialty, gender, address, fax number, telephone number for each service area, and whether or not they are accepting new enrollees. The Contractor shall provide easy access to this list, to include making it available upon request, for all enrollees, providers, and Government representatives. The Contractor shall also post the list on its Web site. The Contractor shall maintain this list in a manner that maximizes ease of access and allows for electronic sorting of the providers. The information contained on all electronic lists shall be current with changes (b)(4) (b)(4)

C.7.9.5. Network Provider Reimbursement.

C.7.9.5.1. TRDP network providers shall file all claims on behalf of the enrollee and shall agree not to balance bill the enrollee for the difference between the billed amount and the allowed amount.

C.7.9.5.2. The Contractor shall ensure that enrollees continue to receive the benefit of discounted network provider rates for examinations, radiographs, prophylaxis and periodontal maintenance when the enrollee has exceeded their frequency limitation for that contract year/period (see C.7.10 for preemption of state laws).

C.7.9.5.3. Network providers shall be reimbursed in accordance with the Contractor’s network agreements, less any cost-share amount due for authorized services.

C.7.9.6. Hold Harmless Provision. A network provider may not require payment from the enrollee for any excluded or excludable services that the enrollee received from the network provider, i.e., the enrollee will be held harmless except as follows:

C.7.9.6.1. If the enrollee did not inform the provider that he or she was a TRICARE enrollee, the provider may bill the enrollee for services provided.

C.7.9.6.2. If the enrollee was informed that the services were excluded or excludable and he/she agreed in advance to pay for the services, the provider may bill the enrollee. An agreement to pay must be evidenced by written records and the enrollee's signature. If the enrollee is a minor, then the agreement to pay must be signed by the sponsor, custodial parent or guardian. Written records include for example: 1) provider notes written prior to receipt of the services demonstrating that the enrollee was informed that the services were excluded or excludable and the enrollee agreed to pay for them and a signed acknowledgement by the enrollee; 2) a statement or letter written by the enrollee prior to receipt of the services, acknowledging that the services were excluded or excludable and agreeing to pay for them; or 3) statements written by both the enrollee and provider following receipt of the services that the enrollee, prior to receipt of the services, agreed to pay for them, knowing that the services were excluded or excludable. General agreement to pay, such as those signed by the enrollee at the time of admission, are not evidence that the enrollee knew specific services were excluded or excludable.

C.7.9.6.3. The enrollee will be entitled to a full refund of any amount paid by the enrollee for the excluded services, including any deductible and cost-share amounts, provided the enrollee informed the network provider that he or she was a TRICARE enrollee, and did not agree in advance to pay for the services after having been informed that the services were excluded or excludable. In order to obtain a refund, the enrollee is not required to ask the provider to return the payments the enrollee has made for excluded services. Instead, the enrollee will be refunded by the Contractor for any payments made by the enrollee or by another party on behalf of the enrollee (excluding an insurer or provider) for the excluded services. The enrollee, or other party making payment on behalf of the enrollee, must request a refund in writing from the Contractor by the end of the sixth month following the month in which payment was made to the provider or by the end of the sixth month following the month in which TMA advised the enrollee that he or she was not liable for the excludable services. The time limit may be extended where good cause is shown. Good cause is defined as follows:

C.7.9.6.3.1. Administrative error, such as, misrepresentation or mistake, by an officer or employee of TMA, if performing functions under TRICARE and acting within the scope of the officer's or employee's authority.

C.7.9.6.3.2. Mental incompetence of the enrollee or, in the case of a minor child, mental incompetence of his or her guardian, parent, or sponsor.

C.7.9.6.3.3. Adjudication delays by other health insurance, when not attributable to the enrollee.

C.7.9.7. Non-Network Provider Reimbursement. Enrollees may be balance billed for the balance of the provider's fee. Non-network provider claims filed by the enrollee shall be paid to

the enrollee in U.S. Dollars, unless the enrollee assigns payment to the provider in which case the payment shall be made in local currency.

C.7.9.7.1. For all enrollees enrolled in the United States, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, Northern Marianna Islands or Canada, the Contractor shall pay the claims generated when enrollees use non-network providers (minus the appropriate cost-share) at the lesser of: (1) billed charges; or (2) prevailing charges at the 50th percentile for that geographic area as listed in the most current version available of the Prevailing Health Care Charges System®, from FAIR Health at http://www.fairhealthus.org/, at the time the claim is adjudicated.

C.7.9.8. Provider Standards.

C.7.9.8.1. Prior to the payment of any claim for dental services, the Contractor shall ensure that the provider has complied with the licensure requirements established by the 32 CFR 199.6 and the locality (e.g., state, country, territory, etc.) in which the services were rendered, including national and/or lower level requirements as appropriate. Claims for services rendered by providers who do not meet applicable licensure requirements shall be denied.

C.7.9.8.2. The Contractor is responsible for determining the standard dental malpractice coverage required in the state (including state risk pools if applicable) for each network provider (both professional and institutional). In the absence of a state law requirement for dental malpractice insurance coverage, the Contractor is responsible for determining the local community standard for dental malpractice coverage, and the Contractor must maintain the documentation evidencing both the standard and compliance by network providers. In those cases where there are no state and/or community requirements, the Contractor shall use its corporate/commercial network provider dental malpractice insurance requirements for dental malpractice insurance coverage.

C.7.9.8.3. Each network provider agreement must indicate the required coverage and the provider's compliance with the requirements.

C.7.9.8.4. Evidence documenting the required coverage of each network provider under the contract shall be provided to the Contracting Officer upon request. The Contracting Officer retains the authority to determine whether state and/or local requirements for dental malpractice coverage have been met by a network provider and whether the evidence documenting the required coverage complies with contract requirements.

C.7.9.8.5. The Contractor shall be solely liable for and expressly agrees to indemnify the Government with respect to any liability producing acts or omissions by it or by its employees or agents. Further, the Contractor agrees to be liable for and expressly agrees to indemnify the Government for any liability resulting from services provided under the contract to eligible beneficiaries for care provided by Contractor network providers, or, in the alternative, the Contractor agrees that all network provider agreements used by the Contractor shall contain a requirement, directly or indirectly by reference to applicable regulations or TMA policies, that the provider agrees to indemnify the Government from any liabilities arising from any acts or

omissions in the provision of services by the provider to eligible beneficiaries for care provided under this contract.

C.7.10. Preemption of State Laws. Pursuant to 10 U.S.C. 1103(a), the preemption of U.S. state and local law applies to this program. There will, however be no preemption of Canadian or other overseas (i.e., non-U.S. territories) laws or regulations. See 32 CFR 199.22(l).

C.7.11. Claims Processing

C.7.11.1. The Contractor shall process dental care claims to completion (payment or denial) in an accurate and timely manner (as defined in C.7.17.2). If a non-network provider submits the claim and requests that the payment be made to the enrollee, then the Contractor shall forward the payment to the enrollee. If an enrollee submits the claim and states that payment should be made directly to the non- network provider, the enrollee must sign the portion of the claim form that assigns benefits to the provider. If the Contractor is unable to determine which party forwarded the claim, payment shall be made to the provider. The Contractor shall retain all claims that contain sufficient information to allow processing and all claims for which missing information may be developed from in-house sources, including DEERS and Contractor-operated or maintained electronic, paper, or film files.

(b)(4)

C.7.11.2. Non-Network Provider Claim Form. The Contractor shall accept any American Dental Association (ADA) approved claim form from enrollees using non-network providers. The Contractor shall stock and distribute ADA approved claim forms that enrollees may use for non-network provider claims. The Contractor shall maintain at least one ADA approved form on its Web site allowing enrollees to complete the form online and then download for submittal.

C.7.11.3. Coordination of Benefits. The Contractor shall follow coordination of benefits rules in accordance with general industry standards and guidance set forth by the National Association of Insurance Commissioners. Where TRICARE is secondary payer, the Contractor shall reimburse the enrollee (or provider as applicable) for the full billed amount remaining following payment by the primary payer, up to the amount the TRDP would have paid had the TRDP been primary.

C.7.11.4. Contractor Self-Audit for Claims Payment and Coding Accuracy. The Contractor shall implement a method for auditing processed claims data on a monthly basis to assure that the contract standards for claims payment and coding accuracy are met or exceeded. The Contractor shall provide a detailed description of their claims auditing methodology in their Quality Management/Quality Improvement program (see Section C.7.15.2).

C.7.12. Dental Explanation of Benefits (DEOB).

C.7.12.1. The Contractor shall provide each enrollee and provider with a Dental Explanation of Benefits (DEOB). The Contractor shall offer each household and provider a choice of receiving a DEOB by U.S. mail or electronically. The DEOB must clearly describe the action taken on the claim or claims and provide information regarding appeal rights, to include the address and instructions for filing an appeal. The DEOB must also provide information on the annual maximum, out-of-pocket costs, as well as sufficient information to allow an enrollee to file a claim with a supplemental insurance carrier. Providers shall receive DEOBs at their service address for all care rendered even if the provider uses a Third Party Administrator. Drafts/checks may be mailed separately to a provider billing address. The Contractor shall provide a duplicate DEOB at an enrollee's request, without charge to the enrollee and within 5 calendar days of receiving a request (written, verbal, or electronic), regardless of their status.

C.7.12.2. The Contractor shall match (e.g. the DEERS ID number) drafts/checks with DEOBs prior to mailing. For provider submitted claims, the Contractor shall forward the draft/check to the provider and a DEOB to both the provider and the enrollee. The Contractor may issue summary DEOBs for multiple episodes of care to the same provider as long as the summary DEOB is matched to the draft/check that is issued.

C.7.12.3. All DEOBs shall be written in English. DEOBs shall include the Contractor's commercial telephone numbers and the business operating hours including the time zone.

C.7.12.4. There is no requirement to include the enrollees SSN on the DEOBs sent to enrollees; however, if the SSN is used, the DEOB shall only include the last four digits of the enrollee's Social Security Number.

C.7.12.5. All DEOBs shall include a statement advising recipients to notify the Contractor if the care identified on the DEOB was not actually received.

C.7.13. Appeals. The Contractor's appeals process shall comply with 32 CFR 199.22(k) (with cross-references to 32 CFR 199.10), the instructions in the TOM, Chapter 12 and the standards stated in C.7.17.3.

C.7.14. Grievances. The Contractor shall operate a grievance process, separate and apart from the appeals process in accordance with the TOM, Chapter 11, Section 9 and the standards stated in C.7.17.4..

C.7.15. Management.

C.7.15.1. The Contractor shall establish and maintain effective management strategies, staff education and training programs, lines of authority and reporting and coordination interfaces with the Government. The Contractor shall comply with the management guidance in the TOM, Chapter 1, Sections 1, 2, 5 and 6.

C.7.15.2. Quality Management/Quality Improvement Program (QM/QI). The Contractor shall establish and continuously operate an internal quality management/quality improvement (QM/QI) program that will provide the Contractor's management with effective and efficient processes for identifying and correcting problems throughout the duration of the contract. At a minimum, the QM/QI program shall include the following:

- Quality Practices
- Claims Processing
- Internal Controls
- Utilization Review, Claims Review, and Utilization Management Processes
- Credentialing and Re-credentialing Activities
- Access to Care Monitoring Procedures
- Member Communications Activities and Satisfaction Monitoring Procedures
- Delegated Activities Oversight Management
- Disease Prevention and Health Promotion Initiatives
- Appeals and Grievances Procedures
- Quality Management Plan

C.7.15.3. Quality Assurance Surveillance Plan (QASP). The role of the Government is to design, implement and conduct adequate contract surveillance and quality assurance to ensure contract requirements and standards are satisfactorily performed. The Government will be utilizing the Section J Attachment J-5 QASP to ensure that the Contractor satisfactorily performs the contract requirements, that the Government receives the quality of services defined in the contract and applicable TRICARE Management Activity (TMA) manuals, and to provide a planned process for assessing the Contractor's performance in a systematic manner across TMA.

C.7.15.4. Compliance with Statutory Requirements. The Contractor shall document and employ procedures to assure confidentiality of all enrollee and provider information. This includes the protection of rights of the individual in accordance with the provisions of the Privacy Act (5 U.S.C. 552(a)); the Freedom of Information Act (5 U.S.C. 552); the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act (42 U.S.C. 290dd-2) (see the TOM, Chapter 1, Section 5). The Contractor shall also prevent unauthorized use of files. The Contractor must also comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 including DoD Health Information Privacy Regulation – DoD 6025.18-R (as amended) and the TOM, Chapter 19 as applicable to dental care services.

C.7.15.4.1. Pursuant to FAR Part 24 the requirements of the Privacy Act (5 U.S.C. 552a) and the Department of Defense Privacy Program (DoD 5400.11-R) are applicable to this contract and the systems of records operated and maintained by the Contractor on behalf of the TMA. These systems of records are found at 65 Federal Register 30966 (Health Benefits Authorization Files, Medical/Dental Care and Claims Inquiry Files, Medical/Dental Claim History Files), 60 Federal Register 43775 (USTF Managed Care System), 69 Federal Register 50171 and 71 Federal Register 16127 (Military Health Information System), and 64 Federal Register 22837 (Health Affairs Survey Data Base). The records systems operated and maintained by the Contractor are

records systems operated and maintained by a DoD Component (TMA). (See TOM, Chapter 1, Section 5, Chapter 2, Section 1, and Chapter 2, Section 2).

C.7.15.5. Legal Matters. See the TOM, Chapter 1, Section 6.

C.7.15.6. Records Management. All Contractor records generated under this contract shall be maintained in accordance with 36 CFR 1222 and the TOM, Chapter 2 (see Section J Attachment J-9). The Contractor shall identify its Records Manager to the Contracting Officer within 10 calendar days of award. Following contract award, the Contractor shall schedule its Records Manager to attend the next available TMA records management class (a five day course) presented in Aurora, Colorado. The Contractor's Records Manager shall continue to attend the records management course annually thereafter. Contractor travel shall be at the Contractor's expense. Enrollee records may not be used for any other purpose not directly related to the contract.

C.7.15.7. Dissemination of Information. There shall be no dissemination or publication, except within and between the Contractor, subcontractors, and TMA of information developed under this contract or contained in the reports to be furnished pursuant to this contract without prior written approval from the Contracting Officer.

C.7.16. Beneficiary and Provider Services.

C.7.16.1. Education Requirements. The education of the TRDP beneficiaries and providers will be accomplished through a collaborative effort between the TRDP Contractor, TMA Dental Program Office and the TMA Beneficiary Education and Support (BE&S) Directorate. The Contractor is responsible for providing the content of the educational materials, printing and distribution of them.

C.7.16.1.1. Education Plan. The Contractor shall submit an annual education plan to inform and educate TRICARE beneficiaries and providers on all aspects of the TRDP. The TMA Dental Care Branch will review the plan and provide concurrence or appropriate feedback for recommended changes.

C.7.16.1.2. Interface Requirements. The Contractor shall forward all proposed education materials to the TRDP Contracting Officer's Representative (COR) for review and approval. The Contractor shall allow no less than 30 calendar days for Government review. The initial submission shall be no later than 120 days prior to start of dental care delivery. Subsequent submissions due to updates or changes to the program shall be submitted no later than 60 days prior to release. No materials shall be utilized until they have been approved by the Government.

C.7.16.1.3. The Contractor shall use the Government's national suite of TRICARE educational materials pertaining to specific aspects of the TRICARE benefit and programs. The Contractor shall use the Government's mandatory formats to ensure "one look and feel" of all educational material. The educational materials must cite the Web site www.tricare.mil/dental. This Web site will direct the beneficiary and provider to the correct dental site.

C.7.16.1.4. The Contractor shall participate in monthly TRICARE beneficiary and provider workgroup meetings, comprised of the TRICARE Dental Program (TDP) marketing representative, the TRICARE Regional Offices (TROs) marketing representative, overseas marketing representatives and the TRICARE Beneficiary Publications Office/BE&S. As an advisor, the Contractor shall provide unique perspectives, ideas, and recommendations regarding the development and maintenance of TRICARE educational materials to the group. The Contractor shall provide a primary and alternate representative for attendance and participation in the monthly meetings, to be held approximately 12 times per contract year in the Washington, DC area. Meetings may be attended via teleconference, video telecommunications, or in person.

C.7.16.1.5. Printed Mass Communication Materials. The Contractor shall post all current versions of approved mass communications materials on its Web site.

C.7.16.1.5.1. The Contractor shall offer each household and provider a choice in the manner in which to receive communication materials. Methods of distributing materials may include, but are not limited to: (1) TRDP Web site, (2) CD, (3) email as a PDF, or (4) U.S. mail.

C.7.16.1.5.2. The Contractor shall inform enrollees and providers 60 calendar days prior to the start of Option Periods 2, 3, 4 and 5, of information identifying any changes to the program for the next option period, including any premium changes.

C.7.16.1.6. TRDP Benefits Booklet. The Contractor shall develop, update, print and distribute a comprehensive Benefits Booklet for the TRDP. The Benefits Booklet shall clearly explain the operational procedures under the TRDP to facilitate maximum use of program benefits by enrollees. The Contractor shall distribute one copy of the TRDP Benefits Booklet to each household with current TRDP enrollees no later than 30 calendar days prior to the start of dental care delivery (see Section C.7.16.1.5.1).

C.7.16.1.6.1. The Contractor shall distribute a copy of the TRDP Benefits Booklet to new enrollees within 15 calendar days of receipt of the new enrollee's premium payment.

C.7.16.1.6.2. The Contractor shall coordinate proposed changes with the COR for approval, no later than 90 days prior to the intended release date. Updated versions, or at a minimum the updated page, will be distributed to each household with TRDP enrollees.

C.7.16.1.7. TRDP Benefits Brochure. The Contractor shall develop, update, print and distribute a TRDP Benefits Brochure to be used as a supplement and/or quick reference guide to the Benefits Booklet. The TRDP Benefits Brochure shall provide a condensed overview of the TRDP benefit. The condensed version should include summary information about eligibility, enrollment, premiums, cost shares, claim filing, and policy benefits and limitations. The Contractor shall distribute one copy of the TRDP Benefits Brochure to each household with current TRDP enrollees no later than 90 calendar days prior to the start of dental care delivery. Thereafter, the Contractor shall distribute a copy of the TRDP Benefits Brochure to new eligibles identified on the quarterly file received from DMDC.

C.7.16.1.8. Copyrighted Material. The Contractor may claim any copyright interest in any education materials solely produced or developed by the Contractor during contract performance, and will have commercial rights in that material. These materials may or may not be combined with or include information provided by the Government. The Government will have a royalty free right to use the material as well as any product with which it is delivered while performing this contract or any subsequent contracts, for any Government purpose.

C.7.16.2. Customer Service Program. The Contractor shall provide comprehensive, readily accessible customer services that include multiple, contemporary avenues of access such as telephonic, facsimile, written, e-mail and World Wide Web for TRDP beneficiaries and providers. Customer services shall be delivered in a manner that achieves the objectives and standards (see Sections C.2 and C.7.17) of this contract without charge to beneficiaries or providers.

C.7.16.2.1. Enrollees shall be provided long distance telephone access at no cost to call for general information, assistance in locating a provider, status of claims, or other TRDP related issues. If the Contractor uses an Automated Response Unit (ARU) to answer incoming telephone calls, the initial listing of menu choices shall offer the caller the opportunity to immediately speak with a Customer Service Representative (CSR). The Contractor's customer service center shall be able to communicate with non-English speaking enrollees or providers.

C.7.16.2.2. The Contractor shall provide prompt responses to written correspondence received either via hardcopy or electronic media. Priority correspondence is that correspondence received from Members of Congress, DoD leadership and/or TMA leadership.

C.7.16.2.3. The Contractor shall provide a Web site that will provide information to beneficiaries and enrollees that will include, at a minimum, an explanation of the TRDP benefit, a listing of network providers accepting new patients searchable by zip code, and Contractor contact information. This contact information shall include phone numbers, mailing, and email address(es). The Web site shall also provide online access to the TRDP Dental Benefits Booklet, an ADA approved Provider Claim Form for use by enrollees under the TRDP, and a link to TMA's main TRICARE Web site at http://www.TRICARE.osd.mil. The Web site design and content shall be subject to review and approval by the Contracting Officer prior to activation.

C.7.17. Standards.

C.7.17.1. Predetermination processing standards shall be as follows:

CATEGORY	STANDARD
Predeterminations Processed to Completion	95% within 14 calendar days 98% within 30 calendar days [redacted] within [redacted] calendar days

C.7.17.2. Claims processing standards shall be as follows:

CATEGORY	STANDARD

Process Claim to Completion	90% within (b)(4) calendar days of receipt 98% within (b)(4) calendar days of receipt 99.9% within (b)(4) calendar days of receipt 100% within (b)(4) days of receipt
Claim Payment Accuracy	98%
Coding Accuracy	98%

C.7.17.2.1. For purposes of computing claims processing cycle times, the date of claim receipt and date of completion shall be computed as defined in the TOM, Appendix B (see definitions for: Processed to Completion, Receipt of Claim, Correspondence or Appeal).

C.7.17.3. Appeals Processing Timelines. The following standards will be measured on a monthly basis:

CATEGORY	STANDARD
Process Expedited Preadmission/Preprocedure Reconsiderations to Completion	99.9% within 3 business days of receipt unless the reconsideration is rescheduled at the written request of the appealing party.
Process Nonexpedited Medical Necessity Reconsiderations to Completion	85% within 30 calendar days of receipt 95% within 60 calendar days of receipt 99.9% within 90 calendar days of receipt
Process Nonexpedited Factual Reconsiderations to Completion	95% within 60 calendar days of receipt 99.9% within 90 calendar days of receipt
Process Determinations Reversed by Appeals Process to Completion	99.9% within 21 calendar days of receipt

C.7.17.3.1. Expedited preadmission/preprocedure requests are those requests filed by the enrollee within three calendar days after the enrollee's receipt of the initial denial determination.

C.7.17.3.2. The date of completion is considered to be the date the determination is mailed to the appropriate parties.

C.7.17.4. Grievance Processing Timelines. The following standards will be measured on a monthly basis:

CATEGORY	STANDARD
Process Grievances to Completion	95% within 60 calendar days of receipt

C.7.17.4.1. All written grievances shall be stamped with the actual date of receipt within three business days of receipt by the Contractor. The Contractor shall provide interim written response within 30 calendar days after receipt for all grievances not processed to completion by that date. The interim response shall include an explanation for the delay and an estimated date of completion.

C.7.17.5. Telephone response and correspondence processing shall meet the following standards:

CATEGORY	STANDARD
Telephone Call Blockage Rate	5% or less at all times measured, at a minimum, hourly
Telephone Answered by CSR	80% within 30 seconds
Telephone Answered by ARU	98% within 20 seconds
Telephone Calls Completed	80% within the initial call 99.9% within three business days
Priority Written and E-mail Correspondence	95% within 7 business days 99.9% within 20 business days
Routine Written and E-mail Correspondence	85% within 10 business days 99.9% within 25 business days

C.7.17.5.1. For purposes of computing telephone call processing cycle times, the date of completion shall be computed as defined in the TOM, Appendix B.

C.7.17.5.2. For purposes of computing correspondence processing cycle times, the date of receipt and date of completion shall be computed as defined in the TOM, Appendix B.

C.7.17.5.3. Any correspondence or written material sent to the enrollee by the Contractor that includes the enrollee's Social Security Number shall only include the last four digits of the number.

C.7.17.6. Network Provider Access. (b)(4) of enrollees living with the United States, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands, shall have access to a network general dentistry provider within 35 driving miles (b)(4) (b)(4) of their primary residence, and be able to obtain an appointment within 21 calendar days of requesting a routine appointment. (b)(4) (b)(4)

(b)(4)

(b)(4)

C.8. DATA REQUIRED.

C.8.1. The Contractor shall provide the Government with access to the full TRDP data set. The data shall include, but are not limited to, data concerning the network providers, non-network providers, enrollment information, authorizations, claims processing, claims payment, enrollee care and service data.

C.8.2. During the contract transition-in period, the Contractor shall fully describe to the Government the complete set of data that the Contractor shall maintain to support the requirements of the TRDP. The Government will review the data elements available and notify the Contractor as to what additional data elements the Government wants added to the above mentioned reports. Subsequently, the Contractor shall work with the Government to fully describe the format/data elements (i.e., field descriptions, field lengths, list of allowed entries for each field) to be used for each report and to build/test the reports to be forwarded to the Government. During the term of the contract the Government may require additional changes to the makeup of these reports (e.g., add or delete data elements or change the format) and the Contractor shall implement these changes at no additional cost to the Government.

C.8.3. The Contractor shall cooperate and work with the Contracting Officer and TMA Defense Health Services Systems (DHSS) in developing a TRDP Interface Control Document (ICD) describing the data exchange to the Military Health System Data Repository (MDR). The purpose of the TRDP ICD document is to describe the interface that provides the TRDP records from the Contractor's automated information systems in support of the TRDP.

C.8.3.1. The TRDP Contractor shall submit the claims data on a monthly basis via secure File Transfer Protocol (FTP) reflecting previous month's claim activity (see Section J Attachment J-4). DHSS receives the claims data on the Feed Nodes of the MDR. The main host of the MDR is an IBM RS/6000SP multi-node computing platform located at the Defense Enterprise Computing Center – Denver (DECC) located in Aurora, Colorado. The data is then sent to the Tivoli Storage Manager node where the data is copied and stored for back-up purposes. The MDR pulls the raw TRDP files and processes the data to yield two files.

C.8.3.2. The Contractor shall protect the data in accordance with the C2-level protection standards mandated for all "Sensitive Unclassified Systems" as required in the DoD Directive 5200.28 since the data exchanged in this interface contains protected patient level identifiable information and the aggregate data being transmitted by DHSS becomes part of a database that contains sensitive data.

C.8.3.3. The Contractor shall perform validation checks such as record counts, file formats, source stamps, and date-time stamps on data transferred from the Contractor to the MDR and will be defined in a design documentation. When errors are discovered in the data exchange, the Contractor will be notified immediately by DHSS operations personnel. If there are systemic problems, Interface Working Group (IWG) counterparts will be contacted by DHSS to work the issues.

C.9. SYSTEM SECURITY.

C.9.1. The Contractor shall acquire, develop and maintain processes for safeguarding unclassified sensitive DoD information on all Contractor/subcontractor systems/networks that store, process or access Government sensitive information (SI) in accordance with Section J Attachment J-8a, TSM, Chapter 1, Section 1.1 and Section H.4. The Contractor shall implement a minimum level of enhanced safeguarding for unclassified DoD information as defined in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53 and 53A, Privacy Act Program Requirements (DoD 5400.11-R), and the Personnel Security Program (DoD 5200.2-R). Government acknowledgement of the Contractor's Annual Checklist and Certification for Minimum Level of Enhanced Safeguarding for Unclassified DoD Information (also known as the "Checklist") is required prior to accessing DoD data or interconnectivity with the Government system and testing (see Section J Attachment J-6 CDRL AP040).

C.9.2. Health Insurance Portability and Accountability Act (HIPAA Security Rule). The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically, the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS), the DoD Health Information Privacy regulation (DoD 6025.18-R), the Health Insurance Portability and Accountability Act Security Compliance Memorandum (HA Policy 60-010), the Security Standards for the Protection of Electronic Protected Health Information and the requirements of the TOM, Chapter 19, Section 1 and the TSM, Chapter 1.

C.9.2.1. The Contractor shall enter into a Data Use Agreement (DUA) for data obtained from DoD Systems and applications and comply with DoD 6025.18-R, DoD Health Information Privacy Regulation, HIPAA Privacy Rule, and DoD 5400.11-R DoD Privacy Program, by submitting a DUA to the Privacy Office annually or until their contract is no longer in effect as required in the TSM, Chapter 1 and the TOM, Chapter 19.

C.9.2.2. The Contractor shall ensure its subcontractors and/or their agents who require the use of or access to individually identifiable information or protected health information under the provisions of this contract comply with DoD regulations and the TRICARE Systems Manual.

C.9.3. Physical Security. The Contractor shall employ physical security safeguards for IS/networks involved in the operation of the TRDP program systems of records to prevent the unauthorized access, disclosure, modification, destruction, use, etc., of sensitive information. The Contractor's safeguards shall be in accordance with the physical security requirements of the NIST SP 800-53 and 53A (see Section C.9.1).

C.9.4. Information Systems (IS)/Networks Personnel Security. The Contractor shall meet the requirements of DoD 5200.2-R "Personnel Security Program", January 1987, and the Personnel Security ADP/IT requirements as outlined in the TSM, Chapter 1. The requirements apply to employees and subcontractor employees who require access to Government information technology (IT) systems or access to Contractor/subcontractor IT systems that process DoD sensitive but unclassified (SBU) information and are directly connected to Government IT systems. Personnel to be assigned to positions that require an Automated Data Processing / Information Technology (ADP/IT) – I or II designation shall undergo a successful security screening before being granted access to DoD IT systems and/or all DoD/TMA data that contain sensitive information. DoD/TMA data includes all information (e.g., test or production data) provided to the contractor for the purposes of determining eligibility, enrollment, disenrollment, fees, claims, maximum allowances, patient health information, protected as defined by DoD 6025.18-R or any other information for which the source is the Government. Any information received by a contractor or other functionary or system(s), whether Government owned or Contractor owned, in the course of performing Government business is also DoD/TMA data. DoD/TMA data means any information, regardless of form or the media on which it may be recorded.

C.10. Reports and Plans. The contractor shall provide all reports and plans that are specified in Section J, Attachment J-6.

C.10.1. The contractor shall provide the capability to develop up to four ad hoc reports per contract year, at the request of the Contracting Officer. All ad hoc reports are due to the Contracting Officer no later than 14 calendar days after the date of the Government request. These reports shall be produced at the Contractor's own expense.

C.11. DISASTER ACTION PLAN. The Contractor shall develop a Disaster Action Plan to be implemented when the President of the United States declares an area of the United States or any U.S. territory with a provider network to be a "National Disaster Area" (see Section J Attachment J-6, CDRL SP060).

C.12. CONTINUITY OF OPERATIONS PLAN (COOP). The Contractor shall provide a plan for continuation of operations on an annual basis. The plan shall address all areas specified in the TSM, Chapter 1. The COOP shall be validated annually through disaster recovery testing (see Section J Attachment J-6 CDRL AP030).

C.13. GOVERNMENT AND CONTRACTOR VISITS/MEETINGS AND FOCUSED REVIEWS. The Contractor shall participate in up to four meetings with Government representatives per contract year. Attendance at these meetings shall be at no cost to the Government. Generally, a 14 calendar day notice will be provided for all meetings hosted by TMA. The Contractor may be invited to additional meetings by the Contracting Officer. All costs associated with the additional meetings shall be the responsibility of the Contractor. (NOTE: The meetings and travel required in this paragraph are exclusive of those specifically identified elsewhere in the contract.)

C.14. MISDIRECTED COMMUNICATIONS. The Contractor shall forward, within three working days of identification, all out-of-jurisdiction claims to the appropriate Contractor (e.g., regional Managed Care Support Contractor or Retail Pharmacy Contractor). All out-of-jurisdiction correspondence and appeals received from the Government, private providers and the public shall be returned to the sender within three working days of receipt. Out-of-jurisdiction communications include correspondence, appeals, emails, faxes, and phone messages.

C.15. ENGLISH LANGUAGE. All documentation and deliverables submitted to the Government, shall be written in the English language.

C.16. CONTRACT TRANSITIONS. For purposes of transition, the incumbent Contractor shall be designated the outgoing Contractor and the successor Contractor shall be designated the incoming Contractor. All transition-related Contractor travel costs shall be at the expense of the respective traveling party. The start-up and phase-out of this contract shall be conducted according to the requirements listed in Section J Attachment J-2.

SECTION D
PACKAGING AND MARKING

D.1. PACKAGING

Preservation, packaging, and packing for shipment or mailing of all work delivered hereunder, by other than electronic means, shall be in accordance with good commercial practice and adequate to insure acceptance by common carrier and safe transportation at the most economical rate(s).

D.2. MARKING

Each package, report or other deliverable shall be accompanied by a letter or other document which:

D.2.1. Identifies the contract by number under which the item is being delivered.

D.2.2. Identifies the deliverable Item Number or Report Requirement which requires the delivered item(s).

D.2.3. Indicates whether the Contractor considers the delivered item to be a partial or full satisfaction of the requirement.

(End of Section)

SECTION E
INSPECTION AND ACCEPTANCE

E.1. 52.246-4 INSPECTION OF SERVICES--FIXED-PRICE (AUG 1996)

E.2. 252.246-7000 MATERIAL INSPECTION AND RECEIVING REPORT (MAR 2008)

E.3. INSPECTION AND ACCEPTANCE

The final acceptance authority for the government shall be:

Department of Defense
TRICARE Management Activity
Contracting Officer Representative (COR)
Dental Care Branch
16401 E. CentreTech Parkway
Aurora, CO 80011-9066

E.4. INSPECTION LOCATION

Inspections may be conducted electronically or by physical inspection. Inspections will be conducted either at TRICARE Management Activity (TMA), the contractor's and/or subcontractor's facilities, or other locations where work is performed. Inspection and acceptance of services provided hereunder shall be accomplished by the COR; or in the COR's absence the Contracting Officer. Inspections may include, but are not limited to, payment record audits, performance audits, program integrity audits, and Contractor/TMA quality assurance audits.

(End of Section)

SECTION F
DELIVERIES OR PERFORMANCE

F.1. 52.242-15 STOP-WORK ORDER (AUG 1989)

F.2. PERIOD OF PERFORMANCE

Transition-in Period (Date of Award to the start of dental care delivery): The Contractor shall begin transition-in activities and complete specific activities by the timelines specified in Section J, Attachment J-2. All transition-in activities shall be completed by the date specified in the contractor's Transition Plan. The transition-in period is 12 months in duration.

a. Base Period/Transition-In: 2 January 2013 through 31 December 2013

b. Options 1 through 5 (if exercised) will be:

Option Period 1:	1 January 2014 - 31 December 2014
Option Period 2:	1 January 2015 - 31 December 2015
Option Period 3:	1 January 2016 - 31 December 2016
Option Period 4:	1 January 2017 - 31 December 2017
Option Period 5:	1 January 2018 - 31 December 2018

F.3. PLACE OF DELIVERY AND PROCEDURES

a. All certified and overnight mail for TRICARE Management Activity (TMA) is to be delivered to: TRICARE Management Activity, 16401 E. CentreTech Parkway, Aurora, CO 80011-9066. TMA Normal Delivery Hours are 7:30 a.m. to 4:00 p.m. (local time), Monday through Friday, excluding Federal Holidays.

b. All mail directed to the Contracting Officer (CO) shall be addressed to the TRICARE Management Activity, Attention: Contracting Officer, TRICARE Retiree Dental Program, 16401 E. CentreTech Parkway, Aurora, CO 80011-9066. TMA Normal Delivery Hours are 7:30 a.m. to 4:00 p.m. (local time), Monday through Friday, excluding Federal Holidays.

c. All mail directed to the Contracting Officer Representative (COR) shall be addressed to the TRICARE Management Activity, Attention: COR, TRICARE Retiree Dental Program, 16401 E. CentreTech Parkway, Aurora, CO 80011-9066. TMA Normal Delivery Hours are 7:30 a.m. to 4:00 p.m. (local time), Monday through Friday, excluding Federal Holidays.

F.4. NOTICE REGARDING LATE DELIVERY

In the event the contractor anticipates difficulty in complying with the delivery schedule, the contractor shall immediately notify the Contracting Officer (CO) or the Contracting Officer Representative (COR), in writing, giving pertinent details, including the date by which it expects to make delivery.This notification shall be informational only in character and that receipt of it shall not be construed as a waiver by the Government of any contract delivery schedule, or any rights or remedies provided by law or under this contract.

SECTION F
DELIVERIES OR PERFORMANCE

F.5. REPORTS AND PLANS

a. Unless otherwise specified, contractors shall electronically submit all deliverables in a format approved by the Government to include Microsoft Office Excel, Word, PDF, or other specified format. Unless otherwise specified, all deliverables shall be submitted to TMA via the Ecommerce Extranet (htpps://tma-extranet.csd.disa.mil/logon/privacystatement.cfm). See the TOM, Chapter 14, Section 2 for report submission requirements).

b. The contractor is accountable for assuring that reports contain accurate and complete data. The contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. All reports must be supported with sufficient documentation and audit trails. The reports shall be titled as listed. The contractor shall submit a negative report if there is no data to report.

c. The contractor shall provide all reports and plans that are specified in Section J, Attachment J-6.

(End of Section)

SECTION G
CONTRACT ADMINISTRATION DATA

G.1. CONTRACT ADMINISTRATION

G.1.1. The Contracting Officer (CO) is responsible for the administration of this contract and is solely authorized to take action on behalf of the Government. Unless specified otherwise within this contract, the PCO is referred to as the Contracting Officer. The following address for this contract is:

TRDP Contracting Officer
Office of the Assistant Secretary of Defense for Health Affairs
TRICARE Management Activity
Contract Operations Division - Aurora
ATTN: TRICARE Retiree Dental Program
16401 E. CentreTech Parkway
Aurora, CO 80011-9066

G.1.2. Contracting Officer's Representative (COR): The CO will designate a Contracting Officer's Representative in writing and provide a copy of the designation letter to the Contractor. The designation letter will delineate the scope of authority of the COR to act on behalf of the Contracting Officer. The COR has no authority to make any commitments or changes that affect any term or condition of the contract.

G.1.3. Contractor Points of Contact Personnel: The names and addresses of the Contractor's primary and alternate point of contact (POC) for contract implementation and compliance are as follows:

Primary: (B)(4)
Company Name: (B)(4)
Address: (B)(4)
Telephone (B)(4)
FAX (B)(4)

Alternate: (B)(4)
Company Name (B)(4)
Address (B)(4)
Telephone (B)(4)
FAX (B)(4)

(End of Section)

SECTION H
SPECIAL CONTRACT REQUIREMENTS

H.1. PAYMENT OF FOREIGN TAXES

Foreign taxes are not preempted under the preemption language contained within 32 CFR 199.22 (l). There is the possibility that foreign governments or other individuals may separately bill the contractor for overseas claims payments or include foreign taxes in the billed charge.

H.2. WOUNDED WARRIOR PROGRAM

Contractors are strongly encouraged to utilize products and/or services offered through Wounded Warrior to Work program. Credit for utilizing these products and/or services cannot be offered toward meeting small business subcontracting goals. However, when the contractor has demonstrated use of the products and/or services to the Contracting Officer, the contractor will receive appropriate consideration in the annual Contractor performance Assessment Reporting System (CPARS). Information about the Wounded Warrior to Work Program may be accessed at http://www.woundedwarriorproject.org .

H.3. NO GOVERNMENT LIABILITY

Funds available for payment for dental care to enrollees are from enrollee premiums only. The Government is providing no funding for this contract. The legal liability for any changes or modifications to the contract of any type of any nature that result in any cost can only be reimbursed through adjustment to the premiums for the following option period or periods.

H.4. REQUIREMENTS FOR MINIMUM LEVEL OF ENHANCED SAFEGUARDING FOR UNCLASSIFIED DOD INFORMATION

H.4.1. The Contractor shall implement and maintain information security in its project, enterprise, or company-wide unclassified information technology system(s) in accordance with the requirements set forth in DOD Directive-Type Memorandum (DTM) 08-027, *Security of Unclassified DoD Information on Non-DoD Information Systems*, July 31, 2009 (incorporating Change 2, September 2, 2011). The Contractor shall, at a minimum, comply with the specified National Institute of Standards and Technology (NIST) Special Publication (SP) 800–53 security controls. If a control is not implemented, the Contractor shall prepare a written determination that explains how either the required security control is not applicable or how an alternative control or protective measure is used to achieve equivalent protection.

H.4.2. In connection with the Enhanced Safeguarding requirements, the Contractor shall annually provide the completed checklist and certification described in Attachment J-6, CDRL AP040, *Checklist and Certification for Minimum Level of Enhanced Safeguarding for Unclassified DoD Information*. The Contractor shall use a current, dated copy of the prescribed Checklist and Certification Form (TMA Form Aug 2011), to be provided to the contractor by the Contracting Officer's Representative (COR) no later than 30 days prior to the date on which the completed and signed form must be submitted to the Government.

SECTION H
SPECIAL CONTRACT REQUIREMENTS

H.5. PERFORMANCE GUARANTEES

H.5.1. The performance guarantee described in this provision is the contractor's guarantee that the contractor's performance will not be less than the performance standards described below. The rights of the Government and remedies described in the Performance Guarantee provision are in accordance with, and in addition to all other rights and remedies of the Government.

H.5.2. Based on the contractor's Network Provider Access report, a disincentive shall be applied if the contractor fails to meet the minimum network access standard over a one-year period. The first one-year period will include the last four months of the first Option Period and the first eight months of the second Option Period. The second one-year period will include the last four months of the second Option Period and the first eight months of the third Option Period and so. If the contractor fails to meet the 95% access standard, the disincentive will require the contractor to reduce the premiums, for the following Option Period, in the amount specified in the schedule below. Compliance with this standard will be determined annually based upon the cumulative percentage of all enrollees not having access to a network provider for the current one-year period as indicated on the contractor's Network Provider Access report (Section J, Attachment J-6). Premium cost for this standard is defined as the total annual cost of the premium.

H.5.2.1. Network Provider Access Standard (C.7.9.3)

Standard: (b)(4) of enrollees, living within the United States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands, shall have access to a network general dentistry participating provider located within 35 driving miles (b)(4) (b)(4) of their primary residence, and be able to obtain an appointment within 21 calendar days of requesting a routine appointment.

Standard	Premium Reduction
If less than and more than or equal to	.1% of the premium cost for the next Option Period
If less than and more than or equal to	.2% of the premium cost for the next Option Period
If less than and more than or equal to	.3% of the premium cost for the next Option Period
If less than	.5% of the premium cost for the next Option Period

(End of Section)

SECTION I
CONTRACT CLAUSES

FEDERAL ACQUISITION REGULATION CLAUSES

I.1. 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address:

http://farsite.hill.af.mil

(End of Clause)

52.202-1 DEFINITIONS (Jan 2012)

52.203-3 GRATUITIES (APR 1984)

52.203-5 COVENANT AGAINST CONTINGENT FEES (APR 1984)

52.203-6 RESTRICTIONS ON SUBCONTRACTOR SALES TO THE GOVERNMENT (SEP 2006)

52.203-7 ANTI-KICKBACK PROCEDURES (OCT 2010)

52.203-8 CANCELLATION, RESCISSION, AND RECOVERY OF FUNDS FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)

52.203-10 PRICE OR FEE ADJUSTMENT FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)

52.203-12 LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (OCT 2010)

52.203-13 CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (APR 2010)

52.204-4 PRINTED OR COPIED DOUBLE-SIDED ON POST CONSUMER FIBER CONTENT PAPER (MAY 2011)

52.204-9 PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL (JAN 2011)

52.204-10 REPORTING EXECUTIVE COMPENSATION AND FIRST-TIER SUBCONTRACT AWARDS (AUG 2012))

52.204-99 SYSTEM FOR AWARD MANAGEMENT REGISTRATION (August 2012) (DEVIATION)

(a) *Definitions.* As used in this clause-

"Central Contractor Registration (CCR) database" means the retired primary Government repository for Contractor information required for the conduct of business with the Government. "Commercial and Government Entity (CAGE) code" means-

(1) A code assigned by the Defense Logistics Agency (DLA) Logistics Information Service to identify a commercial or Government entity; or

(2) A code assigned by a member of the North Atlantic Treaty Organization that DLA records and maintains in the CAGE master file. This type of code is known as an "NCAGE code."

"Data Universal Numbering System (DUNS) number" means the 9-digit number assigned by Dun and Bradstreet, Inc. (D&B) to identify unique business entities.

"Data Universal Numbering System+4 (DUNS+4) number" means the DUNS number means the number assigned by D&B plus a 4-character suffix that may be assigned by a business concern. (D&B has no affiliation with this 4-character suffix.) This 4-character suffix may be assigned at the discretion of the business concern to establish additional SAM records for identifying alternative Electronic Funds Transfer (EFT) accounts (see the FAR at Subpart 32.11) for the same concern.

"Registered in the SAM database" means that-

(1) The Contractor has entered all mandatory information, including the DUNS number or the DUNS+4 number, into the SAM database;

(2) The Contractor's CAGE code is in the SAM database; and

(3) The Government has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS), and has marked the record "Active". The Contractor will be required to provide consent for TIN Attachment, Page 1 of 4 validation to the Government as a part of the SAM registration process.

"System for Award Management (SAM)" means the primary Government repository for prospective federal awardee information and the centralized Government system for certain contracting, grants, and other assistance related processes. It includes-

(1) Data collected from prospective federal awardees required for the conduct of business with the Government;

(2) Prospective contractor submitted annual representations and certifications in accordance with FAR Subpart 4.12; and

(3) The list of all parties suspended, proposed for debarment, debarred, declared ineligible, or excluded or disqualified under the nonprocurement common rule by agencies, Government corporations , or by the Government Accountability Office.

(b)

(1) The Contractor shall be registered in the SAM database prior to submitting an invoice and through final payment of any contract, basic agreement, basic ordering agreement, or blanket purchasing agreement resulting from this solicitation.

(2) The SAM registration shall be for the same name and address identified on the contract, with its associated CAGE code and DUNS or DUNS+4.

(3) If indicated by the Government during performance, registration in an alternate system may be required in lieu of SAM.

(c) If the Contractor does not have a DUNS number, it should contact Dun and Bradstreet directly to obtain one.

(1) A contractor may obtain a DUNS number-

(i) Via the internet at http://fedgov.dnb.com/webform or if the contractor does not have internet access, it may call Dun and Bradstreet at 1-866-705-5711 if located within the United States; or

(ii) If located outside the United States, by contacting the local Dun and Bradstreet office. The contractor should indicate that it is a contractor for a U.S. Government contract when contacting the local Dun and Bradstreet office.

(2) The Contractor should be prepared to provide the following information:

(i) Company legal business name.

(ii) Tradestyle, doing business, or other name by which your entity is commonly recognized.

(iii) Company physical street address, city, state and Zip Code.

(iv) Company mailing address, city, state and Zip Code (if separate from physical).

(v) Company telephone number.

(vi) Date the company was started.

(vii) Number of employees at your location.

(viii) Chief executive officer/key manager.

(ix) Line of business (industry).

(x) Company Headquarters name and address (reporting relationship within your entity).

(d) Reserved.

(e) Processing time for registration in SAM, which normally takes five business days, should be taken into consideration when registering. Contractors who are not already registered should consider applying for registration at least two weeks prior to invoicing.

(f) The Contractor is responsible for the accuracy and completeness of the data within the SAM database, and for any liability resulting from the Government's reliance on inaccurate or incomplete data. To remain registered in the SAM database after the initial registration, the Contractor is required to review and update on an annual basis from the date of initial registration or subsequent updates its information in the SAM database to ensure it is current, accurate and complete. Updating information in the SAM does not alter the terms and conditions of this contract and is not a substitute for a properly executed contractual document.

(g)

(1)

(i) If a Contractor has legally changed its business name, "doing business as" name, or division name (whichever is shown on the contract), or has transferred the assets used in performing the contract, but has not completed the necessary requirements regarding novation and change-of-name agreements in Subpart 42.12, the Contractor shall provide the responsible Contracting Officer

sufficient documentation to support the legally changed name with a minimum of one business day's written notification of its intention to-

(A) Change the name in the SAM database;

(B) Comply with the requirements of subpart 42.12 of the FAR; and

(C) Agree in writing to the timeline and procedures specified by the responsible Contracting Officer.

(ii) If the Contractor fails to comply with the requirements of paragraph (g) (1) (i) of this clause, or fails to perform the agreement at paragraph (g) (1) (i) (C) of this clause, and, in the absence of a properly executed novation or change-of-name agreement, the SAM information that shows the Contractor to be other than the Contractor indicated in the contract will be considered to be incorrect information within the meaning of the "Suspension of Payment" paragraph of the electronic funds transfer (EFT) clause of this contract.

(2) The Contractor shall not change the name or address for EFT payments or manual payments, as appropriate, in the SAM record to reflect an assignee for the purpose of assignment of claims (see FAR Subpart 32.8, Assignment of Claims). Assignees shall be separately registered in the SAM database. Information provided to the Contractor's SAM record that indicates payments, including those made by EFT, to an ultimate recipient other than that Contractor will be considered to be incorrect information within the meaning of the "Suspension of payment" paragraph of the EFT clause of this contract.

(h) Contractors may obtain information on registration and annual confirmation requirements via the SAM accessed through https://www.acquisition.gov or by calling 866-606-8220, or 334-206-7828 for international calls.
(End of Clause)

52.209-6 PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT (DEC 2010)

52.209-9 UPDATES OF PUBLICLY AVAILABLE INFORMATION REGARDING RESPONSIBILITY MATTERS (FEB 2012)

52.210-1 MARKET RESEARCH. (APR 2011)

52.211-15..DEFENSE PRIORITY AND ALLOCATION REQUIREMENT (APR 2008)

52.215-2 AUDIT AND RECORDS--NEGOTIATION (OCT 2010)

52.215-8 ORDER OF PRECEDENCE--UNIFORM CONTRACT FORMAT (OCT 1997)

52.215-11 PRICE REDUCTION FOR DEFECTIVE CERTIFIED COST OR PRICING DATA--MODIFICATIONS (AUG 2011)

52.215-13 SUBCONTRACTOR CERTIFIED COST OR PRICING DATA--MODIFICATIONS (OCT 2010)

52.215-21 REQUIREMENTS FOR CERTIFIED COST OR PRICING DATA AND DATA OTHER THAN CERTIFIED COST OR PRICING DATA--MODIFICATIONS (OCT 2010)

52.215-21 ALT III - REQUIREMENTS FOR CERTIFIED COST OR PRICING DATA AND DATA OTHER THAN CERTIFIED COST OR PRICING DATA--MODIFICATIONS (OCT 1997)

(c) Submit the cost portion of the proposal via the following electronic media: *EXCEL (Microsoft)*

52.217-8 OPTION TO EXTEND SERVICES (NOV 1999)

The Government may require continued performance of any services within the limits and at the rates specified in the contract. These rates may be adjusted only as a result of revisions to prevailing labor rates provided by the Secretary of Labor. The option provision may be exercised more than once, but the total extension of performance hereunder shall not exceed 6 months. The Contracting Officer may exercise the option by written notice to the Contractor within 90 calendar days of contact expiration.

(End of Clause)

52.217-9 OPTION TO EXTEND THE TERM OF THE CONTRACT (MAR 2000)

(a) The Government may extend the term of this contract by written notice to the Contractor within 30 calendar days before the contract expires, provided that the Government gives the Contractor a preliminary written notice of its intent to extend at least 60 days before the contract expires. The preliminary notice does not commit the Government to an extension.
(b) If the Government exercises this option, the extended contract shall be considered to include this option clause.
(c) The total duration of this contract, including the exercise of any options under this clause, shall not exceed 6 years.

(End of Clause)

52.219-8 UTILIZATION OF SMALL BUSINESS CONCERNS (JAN 2011)

52.219-9 SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2011) and ALT II (OCT 2001)

52.219-16 LIQUIDATED DAMAGES – SUBCONTRACTING PLAN (JAN 1999)
52.222-1 NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997)

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52.222-3 CONVICT LABOR (JUN 2003)

52.222-21 PROHIBITION OF SEGREGATED FACILITIES (FEB 1999)

52.222-26 EQUAL OPPORTUNITY (MAR 2007)

52.222-29 NOTIFICATION OF VISA DENIAL (JUNE 2003)

52.222-35 EQUAL OPPORTUNITY FOR VETERANS (SEP 2010)

52.222-36 AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES (OCT 2010)

52.222-37 EMPLOYMENT REPORTS VETERANS (SEP 2010)

52.222-40 NOTIFICATION OF EMPLOYEE RIGHTS UNDER THE NATIONAL LABOR RELATIONS ACT (DEC 2010)

52.222-41 SERVICE CONTRACT ACT OF 1965 (Nov 2007)

52.222-42 - STATEMENT OF EQUIVALENT RATES FOR FEDERAL HIRES (MAY 1989)

In compliance with the Service Contract Act of 1965, as amended, and the regulations of the Secretary of Labor (29 CFR Part 4), this clause identifies the classes of service employees expected to be employed under the contract and states the wages and fringe benefits payable to each if they were employed by the contracting agency subject to the provisions of 5 U.S.C. 5341 or 5332.

This Statement is for Information Only: It is not a Wage Determination

Employee Class	Monetary Wage -- FringeBenefits (Range)
Mail Clerk/Mail Assistant	$ 11.75 per hour $6,375 - $12,260
Data Entry Operator	$ 11.75 per hour $6,375 - $12,260
Claims Assistant	$ 13.14 per hour $7,130 - $13,710
Administrative Assistant	$ 14.65 per hour $7,950 - $15,290
Administrative Coordinator	$ 16.28 per hour $8,830 - $16,990
Data Entry Clerk	$ 9.59 per hour $5,250 - $10,110
Financial Technician	$ 14.65 per hour $7,950 - $15,290
Customer Service Associate	$ 16.28 per hour $8,830 - $16,990
Communication Coordinator	$ 24.10 per hour $13,075 - $25,140

(End of Clause)

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52.222-43 -- FAIR LABOR STANDARDS ACT AND SERVICE CONTRACT ACT -- PRICE ADJUSTMENT (MULTIPLE YEAR AND OPTION CONTRACTS). (SEP 2009)

52.222-50 COMBATING TRAFFICKING IN PERSONS (FEB 2009)

52.222-54 EMPLOYMENT ELIGIBILITY VERIFICATION (JUL 2012)

52.223-6 DRUG-FREE WORKPLACE (MAY 2001)

52.223-18 ENCOURAGING CONTRACTOR POLICIES TO BAN TEXT MESSAGING WHILE DRIVING (AUG 2011)

52.224-1 PRIVACY ACT NOTIFICATION (APR 1984)

52.224-2 PRIVACY ACT (APR 1984)

52.225-13 RESTRICTIONS ON CERTAIN FOREIGN PURCHASES (JUN 2008)

52.227-1 AUTHORIZATION AND CONSENT (DEC 2007)

52.227-3 PATENT INDEMNITY (APR 1984)

52.227-14 RIGHTS IN DATA--GENERAL (DEC 2007)

52.229-3 FEDERAL, STATE, AND LOCAL TAXES (APR 2003)

52.232-11 EXTRAS (APR 1984)

52.233-1 DISPUTES (JUL 2002)—ALTERNATE I (DEC 1991)

52.233-3 PROTEST AFTER AWARD (AUG 1996)

52.233-4 APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004)

52.237-3 CONTINUITY OF SERVICES (JAN 1991)

52.239-1 PRIVACY OR SECURITY SAFEGUARDS. (AUG 1996)

52.242-13 BANKRUPTCY (JUL 1995)

52.243-1 III CHANGES--FIXED-PRICE (AUG 1987)--ALTERNATE III (APR 1984)

52.243-7 NOTIFICATION OF CHANGES (APR 1984)

52.249-2 TERMINATION FOR CONVENIENCE OF THE GOVERNMENT (FIXED-PRICE) (APR 2012)

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52.249-8 DEFAULT (FIXED-PRICE SUPPLY AND SERVICE) (APR 1984)

52.253-1 COMPUTER GENERATED FORMS (JAN 1991)

DEFENSE FEDERAL ACQUISITION REGULATION (DFARS) CLAUSES

252.201-7000 CONTRACTING OFFICER'S REPRESENTATIVE (DEC 1991)

(a) "Definition. Contracting officer's representative" means an individual designated in accordance with subsection 201.602-2 of the Defense Federal Acquisition Regulation Supplement and authorized in writing by the contracting officer to perform specific technical or administrative functions.

(b) If the Contracting Officer designates a contracting officer's representative (COR), the Contractor will receive a copy of the written designation. It will specify the extent of the COR's authority to act on behalf of the contracting officer. The COR is not authorized to make any commitments or changes that will affect price, quality, quantity, delivery, or any other term or condition of the contract.

(End of clause)

252.203-7000 REQUIREMENTS RELATING TO COMPENSATION OF FORMER DOD OFFICIALS (SEP 2011)

252.203-7001 PROHIBITION ON PERSONS CONVICTED OF FRAUD OR OTHER DEFENSE-CONTRACT-RELATED FELONIES (DEC 2008)

252.203-7002 REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (JAN 2009)

252.203-7003 AGENCY OFFICE OF THE INSPECTOR GENERAL (APR 2012)

The agency office of the Inspector General referenced in paragraphs (c) and (d) of FAR clause 52.203-13, Contractor Code of Business Ethics and Conduct, is the DoD Office of Inspector General at the following address:

Department of Defense Office of Inspector General
Investigative Policy and Oversight
4800 Mark Center Drive, Suite 11H25
Alexandria, VA 22350-1500

Toll Free Telephone: 866-429-8011

(End of clause)

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252.203-7004 DISPLAY OF HOTLINE POSTER(S) (SEP 2011)

(a) *Definition*. "United States," as used in this clause, means the 50 States, the District of Columbia, and outlying areas.

(b) *Display of fraud hotline poster(s).*

(1) The Contractor shall display prominently in common work areas within business segments performing work in the United States under Department of Defense (DoD) contracts DoD fraud hotline posters prepared by the DoD Office of the Inspector General. DoD fraud hotline posters may be obtained from the DoD Inspector General, ATTN: Defense Hotline, 400 Army Navy Drive, Washington, DC 22202-2884.

(2) If the contract is funded, in whole or in part, by Department of Homeland Security (DHS) disaster relief funds, the DHS fraud hotline poster shall be displayed in addition to the DoD fraud hotline poster. If a display of a DHS fraud hotline poster is required, the Contractor may obtain such poster from: N/A

(3) Additionally, if the Contractor maintains a company website as a method of providing information to employees, the Contractor shall display an electronic version of the poster(s) at the website.

(c) *Subcontracts*. The Contractor shall include the substance of this clause, including this paragraph (c), in all subcontracts that exceed $5 million except when the subcontract—

(1) Is for the acquisition of a commercial item; or

(2) Is performed entirely outside the United States.

(End of clause)

252.204-7000 DISCLOSURE OF INFORMATION (DEC 1991)

252.204-7003 CONTROL OF GOVERNMENT PERSONNEL WORK PRODUCT (APR 1992)

252.205-7000 PROVISION OF INFORMATION TO COOPERATIVE AGREEMENT HOLDERS (DEC 1991)

252.209-7001 DISCLOSURE OF OWNERSHIP OR CONTROL BY THE GOVERNMENT OF A TERRORIST COUNTRY (JAN 2009)

252.209-7004 SUBCONTRACTING WITH FIRMS THAT ARE OWNED OR CONTROLLED BY THE GOVERNMENT OF A TERRORIST COUNTRY (DEC 2006)

252.215-7000 PRICING ADJUSTMENTS (DEC 1991)

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252.219-7003 SMALL BUSINESS SUBCONTRACTING PLAN (DOD CONTRACTS) (AUG 2012)

252.223-7004 DRUG-FREE WORK FORCE (SEP 1988)

252.225-7004 REPORT OF INTENDED PERFORMANCE OUTSIDE THE UNITED STATES AND CANADA -- SUBMISSION AFTER AWARD (OCT 2010)

252.225-7006 QUARTERLY REPORTING OF ACTUAL CONTRACT PERFORMANCE OUTSIDE THE UNITED STATES (OCT 2010)

252.243-7001 PRICING OF CONTRACT MODIFICATIONS (DEC 1991)

252.243-7002 REQUESTS FOR EQUITABLE ADJUSTMENT (MAR 1998)

(End of Section)

SECTION J
LIST OF ATTACHMENTS

The following attachments and documents form an integral part of this contract. Contractors are required to comply with the direction provided by this section. Documentation incorporated in this contract by reference has the same force and effect as if set forth in full.

J-1 Definitions

J-2 Transition Requirements

J-3 Benefits, Limitations, and Exclusions:
- A. Enhanced TRDP Program
- B. Basic TRDP Program

J-4 Data Submissions:
- A. TRDP Data Elements File
- B. TRDP Provider File Data Element Layout

J-5 Quality Assurance Surveillance Plan (QASP)

J-6 Contract Data Requirement List (CDRL), DD1423-1

J-7 RESERVED

J-8 Draft TRICARE Systems Manual (TSM):
- A. Draft TSM, Chapter 1, Section 1.1, General Automated Data Processing/Information Technology (ADP/IT) Requirements
- B. Draft TSM, Chapter 3, Section 1.2, DEERS Concepts and Definitions
- C. Draft TSM, Chapter 3, Section 1.3, Interface Overview
- D. Draft TSM, Chapter 3, Section 1.5, DEERS Functions in Support of the TRICARE Dental Program (TDP) and the TRICARE Retiree Dental Program (TRDP)

J-9 Draft TRICARE Operations Manual (TOM), Chapter 2, Records Management

J-10 Small Business Subcontract Plan submitted Sep 18, 2012

J-11 Collective Bargaining Agreements submitted Sep 18, 2012

(End of Section)

Attachment J-1
Definitions

As used throughout this contract, the following terms have the meanings set forth below:

Allowed Charge – Relative to network providers, the allowed charge for any procedure is the lower of: (1) the amount billed or (2) the amount under the network agreement that the network provider has agreed to accept as payment in full, inclusive of enrollee's share of the cost. The enrollee's share of the cost includes both the cost share percentage and amounts above the benefit maximums (annual/orthodontic).

Anesthesia Services - The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery. Anesthesia services do not include hypnosis or acupuncture.

Appealable Issue – Disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of TRDP benefits or approval as an authorized provider in accordance with this part. An appealable issue does not exist if no facts are in dispute, if no TRDP benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. See 32 CFR 199.10 for additional information concerning the determination of "appealable issue".

Appealing Party – Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of this part.

Assignment of Benefits - Acceptance by a non-network provider of payment directly from the insurer while reserving the right to charge the enrollee for any remaining amount of the fees for services which exceeds the prevailing fee allowance of the insurer. (Note: see definition of non-network provider.)

Authorized Provider - A dentist, dental hygienist, or certified and licensed anesthetist specifically authorized to provide benefits under the TRDP.

Average Allowed Charge – The average allowed charge is the mean across all procedures for a given code performed in a given three-digit zip code.

Balance Billing – A provider seeking any payment, other than any payment relating to applicable deductible and cost sharing amounts, from a beneficiary for TRDP covered services for any amount in excess of the applicable allowable charge.

Basic Program – coverage for dental services is rendered in the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada. Enrollment is closed to new enrollees. See Attachment J-3B for a complete listing of covered services.

Beneficiary - An individual who has been determined to be eligible for TRICARE benefits, as set forth in 32 CFR 199.3, but not enrolled in the plan.

Attachment J-1
Definitions

Billed Charge – The billed charge is equal to the undiscounted amount charged by a provider.

By Report - "By Report" or "Report Required" means dental procedures which are authorized as benefits only in unusual circumstances requiring justification of exceptional conditions related to otherwise authorized procedures.

Child – An unmarried child of a member or former member, who meets the criteria, including age requirements, in 32 CFR 199.3.

Consultation – A deliberation with a specialist physician or dentist requested by the attending physician primarily responsible for the medical care of the patient, with respect to the diagnosis or treatment in any particular case. A consulting physician or dentist may perform a limited examination of a given system or one requiring a complete diagnostic history and examination. To qualify as a consultation, a written report to the attending physician of the findings of the consultant is required.

Contracting Officer – A Government employee having authority vested by a Contracting Officer's Warrant to execute, administer, and terminate contracts and orders, and modifications thereto, which obligate Government funds and commit the Government to contractual terms and conditions.

Contracts – A single, single+1, or family enrollment (e.g., a family enrollment counts as one contract).

Cost-share - The amount of money for which the beneficiary is responsible in connection with otherwise covered dental services (other than disallowed amounts). A cost-share may also be referred to as a "co-payment."

Covered Benefit - Dental procedure included in a dental benefit plan subject to plan limitations.

Covered Life – An eligible beneficiary who is enrolled in the plan (see Enrollee).

Covered Lives – Total number of persons enrolled in the plan.

Covered Services - Dental procedure codes specified in a dental benefits plan.

Denied Benefit – Dental procedure denied based on a member's dental plan limitations.

Denied Service – Dental procedure not covered by a dental benefits plan.

Dental Care – Services relating to the teeth and their supporting structures.

Dental Explanation of Benefits (DEOB) - The document prepared by insurance carriers, health care organizations, and TRICARE provided to members and dentists explaining benefits determinations to include such things as: type of service received, the amount billed, the

allowable charge, the cost share amount, services denied (with denial reasons), and application of annual and life time maximums, etc.

Dental Hygienist - Practitioner in rendering complete oral prophylaxis services, applying medication, performing dental radiography, and providing dental education services with a certificate, associate degree, or bachelor's degree in the field, and licensed by an appropriate authority.

Dentist - Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Diagnostic Services - Category of dental services including clinical oral examinations, radiographic examinations, and diagnostic laboratory tests and examinations provided in connection with other dental procedures authorized as benefits of the TRDP.

DoD/TMA Data Information – For the purposes of this contract, DoD/TMA data includes all information (e.g., test or production data) provided to the contractor for the purposes of determining eligibility, enrollment, disenrollment, capitation, fees, patient health information, protected as defined by DoD 6025.18-R, or any other information for which the source is the Government. Any information received by a contractor other functionary or system(s), whether Government owned or contractor owned, in the course of performing Government business is also DoD/TMA data. DoD/TMA data means any information, regardless of form or the media on which it may be recorded.

Enhanced Program – coverage for dental services is rendered in the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada. Dental coverage is also provided overseas as stated in 32 CFR 199.22(b)(3)(ii). See Attachment J-4A for a complete listing of covered services.

Endodontics - The etiology, prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue.

Enrolled Member - An eligible beneficiary who is enrolled in the plan; also considered a covered life.

Enrollee - See Enrolled Member.

Enrollee Liability – The legal obligation of an enrollee, his or her estate, or responsible family member to pay for the costs of dental care or treatment received. Specifically, for the purposes of services and supplies covered by the TRDP, enrollee liability includes cost-sharing amounts or any amount above the prevailing fee determination by the contractor where the provider selected by the enrollee is not a network provider or a provider within an approved alternative delivery system. In cases where a non-network provider does not accept assignment of benefits, enrollees may have to pay the non-network provider in full at the time of treatment and seek reimbursement directly from the insurer for all or a portion of the non-network provider's fee.

Enrollee liability also includes any expenses for services and supplies not covered by the TRDP, less any available discount provided as a part of the insurer's agreement with an approved alternative delivery system.

Former Spouse - A former husband or wife of a Uniformed Service member or former member who meets the criteria as set forth in 32 CFR 199.3(b)(2)(ii).

Fraud – For purposes of the TRDP, fraud is defined as (1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRDP benefit to self or some other person, or some unauthorized payment, or (2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a TRDP claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is refutable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.

Non-network Provider – An individual or institutional provider who has no contractual relationship with the prime contractor to provide care to TRDP beneficiaries.

Oral and Maxillofacial Surgery - Surgical procedures performed in the oral cavity or maxillofacial region.

Oral Surgeon (D.D.S. or D.M.D.) - A person who has received a degree in dentistry and who limits his or her practice to oral surgery, that is, that branch of the healing arts that deals with the diagnosis and the surgical correction and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.

Orthodontics - The supervision, guidance, and correction of the growing or mature dentofacial structures; including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex.

Overseas Locations – For purposes of this contract, overseas locations is any location other than the United States, District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands and Canada.

Party to the Initial Determination - Includes a TRDP beneficiary and/or a network provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized TRDP provider is a party to the initial

determination, as is a provider who is suspended, excluded or terminated as an authorized provider, unless the provider is excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority.

Periodontics - The examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth.

Preventive Services - Traditional prophylaxis including scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth.

Prosthodontics - The diagnosis, planning, making, insertion, adjustment, refinement, and repair of artificial devices intended for the replacement of missing teeth and associated tissues.

Provider - A dentist, dental hygienist, or certified and licensed anesthetist, or other individual professional provider, or other provider of services or supplies as specified in 32 CFR 199.6. This term, when used in relation to overseas providers, may include other recognized professions authorized to furnish care under laws of that particular territory, possession or country.

Region – For the purposes of the TRDP contract, a region is the basis for a premium structure. Further, a region may be a country(ies), territory(ies), State(s), ZIP Code(s), rural or urban areas, geographic areas, or metropolitan areas.

Requirements and Standards –Requirements are those items in the contract which the contractor must perform. Standards are specific measurements associated with a requirement. Standards are a subset of requirements.

Restorative Services - Restoration of teeth including those procedures commonly described as amalgam restorations, resin restorations, pin retention, and stainless steel crowns for primary teeth.

Retained Claims – Claims retained by the contractor for processing to completion or development.

Routine Appointment – A routine appointment is care such as a 6-month or annual exam and preventive services (i.e. prophylaxis and application of fluoride).

Sealants - A material designed for application on specified teeth to seal the surface irregularities to prevent ingress of oral fluids, food, and debris in order to prevent tooth decay.

Specialty - A specialty is an area of dentistry that has been formally recognized by the American Dental Association (ADA) as meeting the specified requirements for recognition of Dental Specialists. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health.

Attachment J-1
Definitions

Specialty Dental Provider - The nine recognized ADA dental specialties are: Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics.

State - For purposes of the TRDP, any of the fifty States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands.

1.0 CONTRACT TRANSITION-IN

1.1. Transition-In Requirements. The incoming Contractor will have many time-critical tasks to perform during the twelve month transition-in period that must be accomplished before the Contractor can begin providing required TRDP services on the first day of Option Period One. Some of these tasks can be accomplished concurrently with others; however, certain tasks must be accomplished, and certified as complete, before the Contractor can proceed. These critical sequential tasks include:

- **Safeguarding Unclassified Sensitive DoD Information Certification**
  The incoming Contractor shall obtain certification of acceptable security risk for their system infrastructure via completion of the NIST Certification Process (see Section C.9 and TSM Chap 1, Section 1.1) and fulfill all system access requirements prior to accessing DoD data or interconnectivity with the Government system and/or initiation of integration testing.

- **Military Health System (MHS) B2B Gateway**
  After the Contractor has obtained certification of acceptable security risk for the system infrastructure, the Contractor will work with the Government to establish the B2B gateway required to interface with the Uniformed Services Finance Centers, MHS Data Repository (reference Section J Attachment J-4A and J-4B), and DMDC. The MHS B2B Gateway must be established and tested before the Contractor can begin testing the Uniformed Services Finance Center, MHS Data Repository and DMDC interfaces

- **Defense Manpower Data Center (DMDC) Interface**
  Once the MHS B2B Gateway is operational, the Contractor can begin interface testing with Government IT systems required to verify eligibility (reference C.5.3.), submit/receive monthly files required for withholding premiums from the enrollee's pay, submit provider and enrollee utilization data reports (reference Attachment J-4A and J-4B), etc.

1.2. Transition-In Plan. The incoming Contractor shall submit a comprehensive Transition-In Plan to the Contracting Officer no later than 10 calendar days following contract award. The plan shall address all events and milestones that need to occur for each functional area described in this contract to enable the start of dental service delivery under this contract. This plan shall include a timeline and key positions responsible for such areas as resource acquisition, staff training, file conversion and testing, eligibility verification, enrollment, interface with the Defense Manpower Data Center (DMDC) and Uniformed Service Finance Centers, marketing and public relations, support services, benefit policy and claims processing systems.

1.3. Post-Award Conference. Within 10 calendar days following contract award, the incoming Contractor shall attend a post-award conference with the Contracting Officer and other TMA representatives in a location determined by TMA. The Contracting Officer will notify all parties of the conference date.

1.4. Transition Specifications Meeting. Within 30 calendar days following contract award, the incoming Contractor shall attend a three day meeting with TMA at a location designated by TMA. Contractor representatives attending this meeting shall have the experience, expertise,

and authority to provide approvals and establish project commitments on behalf of their organization. The purpose of this meeting is to finalize the schedule of events associated with the incoming Contractor's assumption of responsibilities and receipt of files from the Government and outgoing Contractor and also the outgoing Contractor's phase-out of activities and workload. TMA and the Contractor will also agree on the format and submission dates for all recurring management reports. TMA will notify all parties of the meeting dates and provide a draft transition schedule to all parties prior to the meeting followed by a revised schedule within 10 calendar days after the meeting. The incoming Contractor shall incorporate all specifications of the final transition schedule into its Transition-In Plan and submit the revised plan within 15 calendar days or as agreed to by TMA. The final plan will be incorporated into the contract at no cost.

1.5. DMDC Interface Meeting. Within 60 calendar days following contract award, the incoming Contractor shall attend a three-day meeting with representatives of DMDC, and TMA in a location determined by TMA. TMA will notify all parties of the meeting dates. The purpose of this meeting is to discuss the implementation and testing of the DMDC interface applications. The incoming Contractor and the Government shall identify functions, technical details, other areas of the interface application, and telecommunications needs that require clarification. This meeting will also be used to determine a schedule of activities for a timely and successful implementation of the interfaces. Prior to the meeting, the incoming Contractor and the Government may participate in technical interchange discussions as needed. The incoming Contractor shall submit an agenda and list of questions to be addressed to TMA no later than five working days prior to the meeting. Within three working days following the meeting, the incoming Contractor shall submit minutes of the meeting to TMA for approval. The incoming Contractor shall incorporate all events and milestones established for the DMDC interfaces into its Transition-In Plan.

1.5.1. The Contractor is required to submit within 60 calendar days following contract award a file to DMDC that maps the zip codes to the regional codes (see Section J Attachment J-6, CDRL AR040). This submission may occur prior to the DMDC Interface Meeting so that DMDC can begin appropriate programming of their systems. Therefore technical interchange discussions between the Contractor and the Government may take place prior to the DMDC Interface Meeting.

1.6. Finance Interface Meeting. Within 10 calendar days following the DMDC Interface Meeting, the incoming contractor shall submit suggested dates for the Finance Interface Meeting. For this meeting the incoming Contractor shall attend a meeting with representatives of the Uniformed Service Finance Centers and TMA in a method determined by TMA. The meeting time and frequency will be mutually agreed upon by all parties. TMA will notify all parties of the meeting times. Participation at the meeting may be conducted telephonically. The purpose of this meeting is to discuss the Contractor's finance system interfaces for premium deductions from enrollees' retired military pay accounts. The incoming Contractor and the Government shall identify functions, technical details, other areas of the interface application, and telecommunications needs that require clarification. This meeting will also be used to determine a schedule of activities for a timely and successful implementation of the interfaces. Prior to the meeting, the incoming Contractor and the Government may participate in technical interchange

discussions as needed. The incoming Contractor shall submit an agenda and list of questions to be addressed to TMA no later than five working days prior to the initial meeting. Within three working days following each meeting, the incoming Contractor shall submit minutes of the meeting to TMA for approval. The incoming Contractor shall incorporate all events and milestones established for the Finance interfaces into its Transition-In Plan.

1.7. Outgoing/Incoming Transition Meeting. The incoming Contractor shall attend a meeting with TMA and the outgoing Contractor within 90 calendar days following contract award. Contractor representatives attending this meeting shall have the experience, expertise, and authority to provide approvals and establish project commitments on behalf of their organization. The purpose of this meeting is to finalize the schedule of events associated with the transfer of responsibilities and information to the incoming Contractor and the phase-out of activities and workload under the ending contract. TMA will notify all parties of the meeting date and provide a draft transition schedule to all parties prior to the meeting followed by a revised schedule within 10 calendar days after the meeting. The outgoing Contractor will incorporate the applicable specifications of the final transition schedule into its Phase-Out Plan.

2.1. START-UP REQUIREMENTS

Note: Time periods referenced in the remainder of this attachment are placeholders only. Dates to be determined during the Transition Specifications Meeting and will be dependant on the Government's acceptance of the Contractor's security assessment plan and report for safeguarding unclassified sensitive DoD information and the establishment of the B2B Gateway.

2.2. Contractor Weekly Status Reporting. Beginning the first month following contract award and continuing through the sixth month following the start of dental care delivery under this contract, the incoming Contractor shall submit weekly status reports of transition-in and operational activities to TMA. The Contracting Officer may revise this reporting schedule based on the status of the transition and other operational factors. These reports shall cover the status of all activities and milestones in the incoming Contractor's Transition-In Plan and the performance and inventory information required in the Weekly Management Reports described in Section J Attachment J-6.

2.3. Receipt of Files. The incoming Contractor will receive the files and information as indicated in the table below entitled, "Transition-In/Information Files Transfers" and complete any necessary conversion and testing as necessary to meet the schedule requirements established in the Transition Specifications, DMDC Interface, Finance Interface, and Outgoing/Incoming Transition meetings, and the incoming Contractor's Transition-In plan as approved by TMA. The listing in the table below is not all-inclusive or absolute. It is provided here as a guideline and may be revised by mutual agreement of the involved parties at the Transition Specifications Meeting. The details of the information and data to be transferred to the incoming Contractor will be determined at that meeting. To the extent possible, these files will be transmitted via electronic file transfer methods.

Transition-In/Information Files Transfers

File/ Information Type	Source	On or About Receipt Date	General Description
1st Eligibility Education and Communication Listing	DMDC	Thirty days post certification of meeting IA security requirements and at the beginning of each option period	Name and address information on each member eligible for the TRDP, but not enrolled, to supply the incoming Contractor with sufficient data for direct-mail educational activities.
Enrolled Population Initial Load File	Outgoing Contractor	90 days prior to start of dental care delivery	Existing enrollee file will be submitted to DMDC in order for DMDC to provide the Gold File to the incoming Contractor.
Enrolled Population (Gold File)	DMDC	NLT 45 days prior to start of dental care delivery	Information on each enrollee in the TRDP to supply the incoming Contractor with sufficient data for continuity of enrollment and benefits.
Enrollments made after Gold File has been sent	Outgoing Contractor	Within five business days of ceasing enrollment activity	'Delta' file sent to DMDC of all enrollments that had been entered since the initial Gold File was sent to the incoming Contractor.
Enrollments 'delta' Gold File	DMDC	10 days prior to start of dental care delivery	DMDC will provide an enrollment 'delta' Gold File to the incoming Contractor.
Processed Claims Histories	Outgoing Contractor	TBD at the Outgoing/Incoming Transition Meeting	Individual records of processed claims, both paid & denied, with enrollee and dental service detail.
Active Orthodontic Cases	Outgoing Contractor	TBD at the Outgoing/Incoming Transition Meeting	Ongoing orthodontic cases, which includes the amount paid towards the lifetime maximum and provider information.
Billed Enrollees	Outgoing Contractor	TBD at the Outgoing/Incoming Transition Meeting	Information (which includes enrollees names and addresses) needed by the incoming Contractor to continue collecting premiums directly from enrollees not paying through a payroll deduction or allotment.
Public Relations/	TMA	TBD at Transition Specifications Meeting	Contact information for established TRICARE contacts (e.g.,

Installation Listings			Uniformed Service DTFs, public affairs offices, BCACs, military publications, TRICARE regional offices, etc.) as available.

2.3 Transfer of Automated Data Processing (ADP) Files. The outgoing Contractor will prepare in non-proprietary electronic format and transfer to the incoming Contractor, by the 60th calendar day following the Outgoing/Incoming Transition Meeting unless, otherwise negotiated by the incoming and outgoing Contractors, all specified ADP files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming Contractor or TMA.

2.3.1. Contractor File Conversions and Testing. The incoming Contractor shall perform initial conversion and testing of all ADP files NLT 30 calendar days following receipt of the files from the outgoing Contractor. ADP file conversions testing shall be initiated prior to the Benchmark Test and fully tested, loaded and operational prior to the start of dental care delivery. Integration testing will be conducted to validate the Contractor's internal interfaces. This testing will verify the Contractor's system integration, functionality, and implementation process. The incoming Contractor shall be responsible for the preparation and initiation of Integration Testing prior to the start of Benchmark Testing. TMA Test Managers will work with the Contractor to plan, execute and evaluate the Integration Testing efforts. The Contractor shall identify a primary and a back-up Testing Coordinator to work with the TMA Test Managers. The Testing Coordinator is responsible for Contractor testing preparations, coordination of tests, identification of issues and their resolution, and verification of test results. A web application will be available for use by Contractor Test Coordinators to report and track issues and problems identified during integration testing.

2.4. Systems Development. Approximately 60 calendar days prior to the initiation of dental care delivery, the non-claims processing systems and the telecommunications interconnections between these systems shall be reviewed by TMA or its designees, to include a demonstration by the Contractor of the system(s) capabilities, to determine whether the systems satisfy the contract requirements. This includes the telecommunications links with TMA and Defense Enrollment Eligibility Reporting System (DEERS). This review is in addition to Benchmark testing. The Contractor shall make any modifications required by TMA prior to the initiation of services.

2.5. Execution of Agreements with Contract Providers.

2.5.1. All contract provider agreements shall be executed, and loaded to the Contractor's system, 60 calendar days prior to the start of dental care delivery date, or at such other time as is mutually agreed between the Contractor and TMA.

2.5.2. The Contractor shall begin reporting on network adequacy on a monthly basis three months prior to the first day of dental care delivery.

2.6. Memorandum Of Understanding (MOU) with TMA Beneficiary Education and Support (BE&S) Directorate. The Contractor shall meet with the TMA BE&S Directorate

within 60 calendar days after dental care contract award to develop a MOU, including deliverables and schedules. The MOU shall be executed within 90 days of the MOU meeting with the BE&S. The Contractor shall provide copies of the executed MOU to the Contracting Officer and the Contracting Officer Representative within 10 calendar days following the execution of the MOU.

2.7. Transition-In of TRDP Enrollment.

2.7.1. Three months prior to the start of dental care delivery, the outgoing Contractor will transfer to DMDC an initial load file of enrollee records in a mutually agreed format. The file will contain identification, enrollment, and address information on each enrollee. No later than 45 calendar days prior to the start of dental care delivery, DMDC will provide the Gold File to the incoming Contractor. After the initial load file is sent, the outgoing Contractor will provide any new enrollments to the incoming contractor who will then enter them via DOES. Within five business days of when the outgoing Contractor ceases performing all enrollment activity, they will provide a 'delta' file to DMDC of all enrollments they had entered since the initial Gold File was sent to the incoming Contractor. DMDC will use this to produce a 'delta" Gold File and provide this to the incoming Contractor 10 days prior to the start of dental care delivery. The timing of these file transfers may be modified as needed during the Outgoing/Incoming Transition Meeting.

2.7.2. The incoming Contractor shall begin the enrollment process for the TRDP NLT 60 calendar days prior to the scheduled start of dental care delivery, with actual enrollment processing to begin 40 days prior to the start of dental care delivery, subject to TMA approval of systems under the contract.

2.7.3. No later than 30 days prior to the start of dental care delivery, the incoming Contractor shall contact all current TRDP enrollees by mail to inform them of the new Contractor's assumption of the TRDP contract, its effective date, enrollment transition provisions, and new premium amounts. Enrollees shall further be informed that unless they initiate action to disenroll or change their type of enrollment (single or family) their enrollment will continue at its current level without interruption of coverage.

2.8. Enrollment Actions During Dual Operations.
The incoming Contractor and outgoing Contractor will be performing enrollment actions during the same time (approximately 40 days) prior to start of dental care delivery.

2.8.1. For new enrollments with an effective date prior to the start of dental care delivery (e.g., partial-month enrollment; transfer-in), the incoming Contractor must make an enrollment to begin on the start of dental care delivery once notified by the outgoing Contractor of the new enrollment. Any enrollment fees due for a period of coverage prior to the start of dental care delivery will be retained by the outgoing Contractor. Once the enrollment is achieved, the outgoing Contractor will notify the incoming Contractor of the enrollee's method of payment preference.

2.8.2. When informed by the outgoing Contractor that a current enrollment requires deletion with an effective date prior to the start of dental care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), the incoming Contractor must cancel the future enrollment segment that was included on the initial enrollment file provided by DMDC and then the outgoing Contractor will complete the appropriate disenrollment action.

2.8.3. For all other enrollment actions with an effective date prior to start of dental care delivery (e.g.,; enrollment begin date changes), the outgoing Contractor will inform the incoming Contractor to correct the future enrollment segment. If the outgoing Contractor needs to modify their segment, they will notify the incoming Contractor to remove their segment first and then the outgoing Contractor will complete the correction. The out going Contractor will notify the incoming contractor as to when the incoming Contractor can re-add the enrollment.

2.8.4. Any enrollment action not completed by the outgoing Contractor prior to DMDC freezing the DEERS for transitioning enrollment and after the initial enrollment file is created by DMDC, the enrollments will have to be accomplished by the incoming Contractor following the above procedures.

2.8.5. The outgoing Contractor will terminate enrollment activity 40 calendar days prior to the start of the incoming Contractor's dental care delivery. Any enrollment requests or applications received within 40 calendar days prior to the start of dental care delivery will be forwarded to the incoming Contractor.

2.8.6. Once dental care delivery begins, all enrollment actions will be accomplished by the incoming Contractor. If the incoming Contractor makes a change that affects an enrollment segment that is prior to the start of dental care delivery, the incoming Contractor shall notify the outgoing Contractor. If the outgoing Contractor requires a retroactive change, they must submit their request to the incoming Contractor who shall perform the change and notify the outgoing Contractor when it is complete. The outgoing Contractor will collect retroactive change information and forward to the incoming contractor for a minimum of 90 days after dental care delivery begins.

2.8.7. Throughout the 45 days prior to dental care delivery, the outgoing Contractor will coordinate enrollment files with the incoming Contractor no less than weekly to ensure that new enrollment and enrollment renewals are accurately and timely reflected in the incoming Contractor's enrollment files and in DEERS.

2.9. Ongoing Transfer of Enrollment Files.

2.9.1. Not later than 60 days prior to dental care delivery under the new contract, DMDC will transfer to the incoming Contractor a file of enrollee records (Gold File). The file shall contain identification, enrollment, and address information on each enrollee. The timing of this file transfer may be modified as needed during the transition specifications meeting.

2.9.2. The incoming Contractor shall obtain enrollment policy information (Gold File) from DMDC through an initial enrollment load file. The incoming Contractor shall process the enrollment load file within 24 hours or less from receipt of the file.

2.9.3. Beginning approximately 30 days prior to the start of dental care delivery, the incoming Contractor shall send billing statements to current TRDP enrollees where the enrollment fee payment would be due on or after the start of dental care delivery.

2.9.4. Outstanding enrollment record discrepancies and issues reported to the DEERS Support Office by the outgoing Contractor will be transferred to the incoming Contractor for reconciliation for the 120 calendar days after the start of dental care delivery under this contract. Records will be reconciled in accordance with TRICARE Systems Manual (TSM), Chapter 3, Section 1.5.

2.10. Enrollment Fees.

2.10.1. The Contractor who collects the enrollment fee will retain the enrollment fee based on the start date of the enrollment. The incoming Contractor shall resolve any discrepancies of cumulative enrollment fees and paid through dates with the outgoing Contractor within 90 days of start of dental care on policies inherited during the transition. The incoming Contractor shall send the corrected fee information to DEERS using the batch fee interface outlined in the TSM, Chapter 3 as of the start of dental care delivery.

2.10.2. The incoming Contractor shall obtain information from the outgoing Contractor on fees that are being paid other than by allotment, and shall transition these monthly payment types in the least disruptive manner for the beneficiary.

2.10.3. The incoming Contractor shall submit a start allotment file to the Finance Centers approximately 30 to 40 days before the start of dental care delivery. The date will be mutually agreed upon between the incoming Contractor, TMA and the Finance Centers (see TSM Chap 1, Section 1.1).

2.11 Outgoing Contractor's Weekly Shipment of History Updates and Dual Operations.

2.11.1. Ongoing Transfer of Claims History Updates. The outgoing Contractor will transfer to the incoming Contractor, in a mutually agreed format, all processed claims history in accordance with the specifications in the final transition schedule. The transfer will occur at least weekly, or in accordance with the specifications in the final transition schedule, until such time that all claim-related processing is completed by the outgoing Contractor.

2.11.2. Claims Processing Dual Operations. During the period in which both the incoming Contractor and the outgoing Contractor are processing claims (365 calendar days after the start of dental care delivery under this contract), the outgoing Contractor will transfer to the incoming Contractor processed claims files following each processing cycle or according to a schedule determined during the Outgoing/Incoming Transition Meeting. The incoming Contractor shall

utilize the processed claim history files received from the outgoing Contractor for claim adjudication beginning with the first claims processing cycle.

2.11.3. Transition-In Requirements Related To Transitional Cases. In notifying beneficiaries of the transition to another Contractor, the incoming Contractor shall and the outgoing Contractor will include instructions on how the beneficiary may obtain assistance with transitional care. If the outgoing Contractor succeeds itself, costs related to each contract will be kept separate for purposes of contract accountability.

2.11.4. Health Insurance Portability and Accountability Act of 1996 (HIPAA). The incoming Contractor, as a covered entity under HIPAA, may honor an authorization or other express legal document obtained from an individual permitting the use and disclosure of protected health information prior to the start of dental care delivery date (HHS Privacy Regulation, §164.532).

2.11.5. Residual Processing. The outgoing Contractor will process all residual claims with dates of service prior to the start of dental care delivery and received up to 365 days after the date of service. The filing deadline for residual claims is one year from the date of service. The outgoing Contractor will also complete processing of written and telephonic inquiries, appeals and grievances related to dental care provided prior to the start of dental care delivery.

2.12. Web-Based Services And Applications. NLT 60 days prior to the start of dental care delivery, the incoming Contractor shall demonstrate to TMA successful implementation of all web-based capabilities as described in the contract.

3.0 READINESS DEMONSTRATION.

The incoming Contractor shall arrange to provide a demonstration of its readiness to perform all requirements of this contract no later than 60 days before the date of dental care delivery. The demonstration shall take place at the incoming Contractor’s primary business location and shall include the TMA Contracting Officer, Contracting Officer's Representative and the Contracting Technical Representative. The demonstration shall include, but is not limited to, review of enrollment and eligibility processes, authorization and referral.

3.1. Instructions for Benchmark Testing.

3.1.1. Prior to the start of dental care delivery, the incoming Contractor shall demonstrate the ability of its staff and its automated enrollment, authorization and referral, and claims processing systems to accurately process TRICARE claims in accordance with current requirements. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by the Contractor under the oversight of TMA and must be completed NLT 60 days prior to the start of services delivery. In the event that an incumbent Contractor succeeds itself, the extent of Benchmark testing may be reduced at the discretion of the TMA Contracting Officer.

3.1.2. A Benchmark Test shall consist of at least 300 but not more than 1,000 network and non-network claims, testing a multitude of claim conditions including, but not limited to, TRDP covered/non-covered services, network/non-network providers, and eligible/non-eligible beneficiaries. This Benchmark Test will require a TMA presence at the Contractor's site.

3.1.3. A Benchmark Test is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle after the initial one will include new test claims, as well as claims not completed during preceding cycles. At the Government's discretion, any or all aspects of claims processing may be tested, e.g., provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, and access control.

3.1.4. The Contractor shall demonstrate its ability to conduct enrollment, authorization and referral, and claims processing functions to include: claims control and development, accessing and updating internal and external enrollment data, accessing and updating DEERS for eligibility status, calculating cost-shares, submitting and modifying provider and pricing records, issuing referrals, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output for paper and electronic transactions (Explanation of Dental Benefits (DEOB), summary vouchers, payment records, checks, and management reports). Clerical functions will be evaluated including correctly coding procedures and accurately resolving edit exceptions. Enrollment functions may also be included in the benchmark. At the Government's discretion, the Benchmark Test may include testing of any or all systems (internal and external) used by the Contractor to process claims. Contractor compliance with applicable HIPAA requirements and security requirements will be included in Benchmark tests as appropriate.

3.1.5. The Benchmark Test will be comprised of both paper and electronic claims. The Contractor can provide test scenarios with any internal conditions they feel appropriate for testing.

3.1.6. A Benchmark Test of a current Contractor's system may be administered at any time by TMA upon instructions by the Contracting Officer. All Contractor costs incurred to comply with the performance of the Benchmark Test are the responsibility of the Contractor.

3.2. Conducting the Benchmark Test.

3.2.1. At the time of the scheduled Benchmark Test a TMA Benchmark Team comprised of up to 12 people will arrive at the Contractor's work site to conduct the testing and evaluate the Benchmark Test results.

3.2.2. The amount of time a Contractor shall have to process the Benchmark Test claims and provide all of the output to the Benchmark Team for evaluation will vary depending on the scope of the Benchmark and volume of claims being tested.

3.2.3. The Contractor will be informed at the pre-benchmark meeting of the exact number of days to be allotted for processing the benchmark claims and test scenarios and providing all of the output to the Benchmark Team for evaluation.

3.2.4. The Benchmark Team will provide answers to the Contractor's written and telephonic development questions related to the test scenarios provided by TMA and will evaluate the Contractor's output against the Benchmark Test conditions.

3.2.5. The Benchmark Team will require a conference room that can be locked with table(s) large enough to accommodate up to 12 people. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

3.2.6. The incoming Contractor shall provide up-to-date copies of the TRICARE Operations Manual (TOM), TRICARE Systems Manual (TSM), TRICARE Policy Manual (TPM) and a current American Dental Association's Current Dental Terminology (CDT), in either hard copy or on-line, whichever is used by the Contractor, explanations of the Contractor's DEOB message codes, edits, and denial reason codes, and any overlays required to evaluate DEOBs, checks, or summary vouchers.

3.2.7. The incoming Contractor shall provide an appropriate printer and a minimum of three computer terminals in the conference room with on-line access to all internal and external systems used to process the Benchmark Test claims to include, but not limited to: provider files , including the contracted rate files for each provider; pricing files, DEERS; and any other files used in processing claims, predeterminations, and enrollments. The Contractor's requirements for issuing system passwords for members of the Benchmark Team will be discussed at the pre-benchmark meeting.

3.2.8. The Contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the Contractor's staff involved in performing the Benchmark Test by function (e.g., data entry, development, review, etc.) is also required. Claims flow/decision diagrams including authorization and referral requirements will be provided prior to the Benchmark Test.

3.3. Benchmark Test Procedures.

3.3.1. Approximately 60 calendar days following award to the Contractor, representatives from TMA will meet with the incoming Contractor's staff to provide an overview of the Benchmark Test and discuss the dates of the test and information regarding the administration of the Benchmark Test. TMA will provide the first set of test claims and supporting documentation to the Contractor no later than three business days prior to the arrival of the TMA Benchmark team. At TMA's discretion, the test must be completed NLT 60 days prior to the start of dental care delivery to allow time to make any needed corrections. The pre-benchmark meeting will be conducted at the incoming Contractor's claims processing site. Provider and beneficiary data, to include enrollment forms and referrals, will be coordinated at the pre-benchmark meeting to ensure that the Contractor adequately prepares all files prior to the Benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

3.3.2. On the first day of the Benchmark Test, a brief entrance conference will be held with Contractor personnel to discuss the schedule of events, expectations and administrative instructions.

3.3.3. During the Benchmark Test the Contractor shall process the claims and provide TMA with all output, including DEOB, summary vouchers, suspense reports, checks, and claims histories. Paper checks and DEOB may be printed on plain paper, with DEOB and check overlays. Electronic output is required for electronic transactions.

3.3.4. The Contractor shall provide output for evaluation by the TMA Benchmark Team as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the Benchmark Team will be discussed with the Contractor at the pre-benchmark meeting.

3.3.5. TMA personnel will compare the Benchmark Test claim output against the benchmark test conditions for each claim processed during the test and provide the findings to the Contractor. All appropriate Contractor and Benchmark Team personnel shall be present to answer any questions raised during the Benchmark Test claims review.

3.3.6. At the conclusion of the on-site portion of the Benchmark Test, an exit conference may be held with the Contractor staff to brief the Contractor on all findings identified during the Benchmark. The initial test results will be provided to the Contractor. The initial Benchmark Test Report will be forwarded to the Contractor by TMA within 20 calendar days of the last day of the onsite test. For any claims processing errors assessed with which the Contractor disagrees, a written description of the disagreement along with any specific references must be included with the claims. The Contractor's response to the Initial Benchmark Test Report shall be submitted to the TMA Contracting Officer within 20 days. Following the Contractor's response, TMA shall provide the Final Benchmark Test Report to the Contractor within 20 calendar days.

3.4. Operational Aspects of the Benchmark Test.

3.4.1. The Benchmark Test may be conducted on the Contractor's production system or an identical copy of the production system (test system). Whichever system is used for the Benchmark, it must meet all TRICARE requirements and contain all the system interconnections and features of the production system in the Contractor's proposal. When the Benchmark Test is conducted on the Contractor's production system, the Contractor shall prevent checks and DEOB from being mailed to the beneficiaries and providers.

3.4.2. Certain external test systems and files (e.g., DEERS) are an integral component of the Benchmark Test and the Contractor is expected to perform all necessary verifications and queries according to TRICARE procedures and policy. The Contractor shall coordinate through TMA, Contract Operations Branch, to ensure that direct interface with any required external test systems (i.e., DEERS) is established and operational prior to the Benchmark Test.

4.1. CONTRACT PHASE-OUT.

Note: The contract phase-out requirements listed below are for this contract in the future and therefore do not necessarily match the requirements of the outgoing Contractor for the previous contract.

4.2. If the Contractor is not the successful offeror for the successor contract, the outgoing Contractor shall work to achieve a smooth and efficient transition of activities to the incoming Contractor and to facilitate minimal disruption of services to enrollees and providers. The services required by the Phase-out CLINS will only be exercised in the event of a transition; therefore, the Government will only exercise this CLIN once if and when a transition occurs. If the Contractor succeeds itself in a subsequent procurement for the same or similar services, no phase-out costs will be paid.

4.3. Phase-Out Plan. The outgoing Contractor shall provide to TMA a proposed Phase-Out Plan within 60 calendar days following award of a successor contract. This plan shall include a timeline of major events and provide names of key individuals responsible for each of the functional areas involved in the phase-out of inventories, staffing and other resources, and activities under this contract, e.g., claims processing, appeals, grievances, support services, finance.

4.4. Outgoing/Incoming Transition Meeting. The outgoing Contractor shall attend a meeting with TMA and the incoming Contractor within 90 calendar days following award of a successor contract. Contractor representatives attending this meeting shall have the experience, expertise, and authority to provide approvals and establish project commitments on behalf of their organization. The purpose of this meeting is to finalize the schedule of events associated with the transfer of responsibilities and information to the incoming Contractor and the phase-out of activities and workload from the outgoing Contractor. TMA will notify all parties of the meeting date and location, and provide a draft transition schedule to all parties prior to the meeting followed by a revised schedule within 10 calendar days after the meeting. The outgoing Contractor shall incorporate the applicable specifications of the final transition schedule into its Phase-Out Plan and submit the revised plan within 15 calendar days or as agreed to by TMA.

4.5. Transfer of Information. The outgoing Contractor shall provide to TMA (or, at the option of TMA, to the incoming Contractor) any information as TMA shall require to facilitate transition from the outgoing Contractor's operations to operations under the incoming contract. Such information may include, but is not limited to, the following: enrollment information, claims processing history, active cases, active third-party liability cases, and information about the management of the outgoing contract that is not considered, under applicable Federal Law, to be proprietary to the Contractor. The outgoing Contractor shall provide samples and descriptions of applicable files at the Outgoing/Incoming Transition Meeting and, subsequently, any documentation (e.g., record layouts with specifications, formats, definitions of fields and data elements, access keys, etc.) necessary for read capability and conversion of any electronic files that may be transferred as determined at that meeting. In addition, the table below is provided as a guideline and is not all inclusive or absolute. It may be revised by mutual agreement of the involved parties at the Outgoing/Incoming Transition Meeting.

Information Files Transfers

File/ Information Type	Source	On or About Receipt Date	General Description
Processed Claims Histories	Outgoing Contractor	TBD at the Outgoing/Incoming Transition Meeting	Individual records of processed claims, both paid & denied, with enrollee and dental service detail.
Active Orthodontic Cases	Outgoing Contractor	TBD at the Outgoing/Incoming Transition Meeting	Ongoing orthodontic cases, which includes the amount paid towards the lifetime maximum and provider information.
Billed Enrollees	Outgoing Contractor	TBD at the Outgoing/Incoming Transition Meeting	Information (which includes enrollees names and addresses) needed by the incoming Contractor to continue collecting premiums directly from enrollees not paying through a payroll deduction or allotment.

4.6. Transfer Of ADP Files (Electronic). The outgoing Contractor shall prepare in non-proprietary electronic format and transfer to the incoming Contractor or TMA, by the 60th calendar day following the Outgoing/Incoming Transition Meeting unless, otherwise negotiated by the incoming and outgoing Contractors, all specified ADP files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming Contractor or TMA.

4.7. Ongoing Transfer of Claims History Updates. The outgoing Contractor shall transfer to the incoming Contractor, or other party as directed by the Contracting Officer, in a mutually agreed format all processed claims history in accordance with the specifications in the final transition schedule. The transfer shall occur at least weekly, or in accordance with the specifications in the final transition schedule, until such time that all claim-related processing is completed by the outgoing Contractor.

4.8. Outgoing Contractor Monthly Status Reporting. Until all inventories have been processed, the outgoing Contractor shall submit a monthly status report of inventories and phase-out activities to TMA beginning the 10th calendar day of the second month following the end of the contract period, until otherwise notified by the Contracting Officer to discontinue. This shall be done in accordance with specifications of the final transition schedule.

4.9. Final Processing Of Outgoing Contractor. The outgoing Contractor shall complete processing of its claims, adjustments, telephone inquiries, written correspondence, appeals, and

grievances related to services under this contract within the contractually established standards until the start of dental care delivery. The outgoing Contractor is not required to comply with the contract standards after the start of dental care delivery by the incoming contractor (i.e. beginning the day after the end of the last option period).

4.9.1. Residual Processing. The outgoing Contractor shall process all residual claims with dates of service prior to the start of dental care delivery and received up to 365 days after the date of service. The filing deadline for residual claims is one year from the date of service. The outgoing Contractor shall also complete processing of written and telephonic inquiries, appeals and grievances related to dental care provided during the period of this contract.

4.9. The Contractor shall be liable, after the termination of services under this contract, for any payments to subcontractors of the Contractor arising from events that took place during the period of this contract.

4.10. Phase-Out Requirements Related to Transitional Cases. In notifying beneficiaries of the transition to another Contractor, both the incoming and outgoing Contractors shall include instructions on how the beneficiary may obtain assistance with transitional care. The instructions must include at a minimum the date and amount the care is paid up to and the incoming Contractor's contact information. If the outgoing Contractor succeeds itself, costs related to each contract will be kept separate for purposes of contract accountability.

4.11. The outgoing Contractor shall maintain toll-free lines and web-based customer service capabilities, accessible to the public during the first 120 calendar days (Monday – Friday, 8 hours per day) of dual operations in order to properly respond to inquiries related to claims processed for services incurred during the period of their respective liability. Beneficiary inquiry lines will continue to be staffed in order to provide adequate customer service. The outgoing Contractor shall maintain their IVR for beneficiary calls from the 121st day for a minimum of 60 days and it will include information on how to contact the incoming Contractor. The outgoing Contractor is not required to comply with the contractually established telephone standards during this 180-day period.

4.12. Phase-Out of Enrollment Activities. Prior to the start of dental care delivery under the successor contract, for all enrollment payments in which the new enrollment period or period covered by the premium payment will begin under the new contract, the outgoing Contractor shall amend billing statements (or include a stuffer/insert) to advise the enrollee to direct any enrollment related correspondence and enrollment fee payments to the successor Contractor.

4.13. Enrollment Actions During Dual Operations. The incoming Contractor and outgoing Contractor will be performing enrollment actions during the same time (approximately 40 days) prior to start of dental care delivery.

4.13.1. For new enrollments with an effective date prior to the start of dental care delivery (e.g., partial-month enrollment), the outgoing Contractor must make an enrollment with the end date of the current contract period (i.e., one day prior to the start of dental care delivery under the incoming contract). Any enrollment fees due for a period of coverage that is prior to the start of

dental care delivery will be retained by the outgoing Contractor. Once the enrollment is achieved, the outgoing Contractor will notify the incoming Contractor of the enrollee's method of payment preference.

4.13.2. When a current enrollment requires deletion with an effective date prior to the start of dental care delivery (e.g., disenrollments for failure to pay fees; cancellations, etc.), the outgoing Contractor shall inform the incoming Contractor to cancel the future enrollment segment that was included on the enrollment file provided by DMDC and then the outgoing Contractor shall complete the appropriate disenrollment action.

4.13.3. For all other enrollment actions with an effective date prior to start of dental care delivery (e.g., enrollment begin date changes), the outgoing Contractor shall inform the incoming Contractor to correct the future enrollment segment. If the outgoing Contractor needs to modify their segment, they shall notify the incoming Contractor to remove their segment first and then the outgoing contractor shall complete the correction. The outgoing Contractor shall notify the incoming Contractor as to when the incoming Contractor can re-add the enrollment.

4.13.4. The outgoing Contractor should complete all pending enrollment actions prior to the DEERS freeze to transition enrollment. Any enrollment action not completed by the outgoing Contractor prior to the freeze (and after the initial enrollment file is created by DMDC) will have to be accomplished by the incoming Contractor following the above procedures.

4.13.5. Once dental care delivery begins, all enrollment actions will be accomplished by the incoming Contractor. If the outgoing Contractor requires a retroactive change, they must submit their request to the incoming Contractor who will perform the change and notify the outgoing Contractor when it is complete. The outgoing Contractor shall collect retroactive change information and forward to the incoming contractor for a minimum of 90 days after dental care delivery begins.

4.13.6. For paper enrollments and checks made out to the outgoing Contractor for coverage beginning on or after the start of dental care delivery, the outgoing Contractor shall return the enrollment application and check to the beneficiary with instructions to contact the incoming Contractor. The period of time will be mutually agreed upon by all involved parties.

4.13.7. The outgoing Contractor shall terminate marketing and enrollment activity 40 calendar days prior to the start of the incoming Contractor's dental care delivery. Any enrollment correspondence or applications received after the 40th calendar day shall be transferred to the incoming Contractor by overnight delivery at the outgoing Contractor's expense. The period of time will be mutually agreed upon by all involved parties.

4.13.8. Throughout the 45 days prior to start of dental care delivery, the outgoing Contractor shall coordinate enrollment files with the incoming Contractor no less than weekly to ensure that new enrollments and enrollment renewals are accurately and timely reflected in the incoming Contractor's enrollment files and in DEERS.

4.14. Enrollment Fees.

4.14.1. The Contractor who collects the enrollment fee will retain the enrollment fee based on the start date of the enrollment. The incoming Contractor will resolve any discrepancies of cumulative enrollment fees and paid through dates with the outgoing Contractor within 90 days of start of dental care on policies inherited during the transition. The incoming Contractor will send the corrected fee information to DEERS using the batch fee interface outlined in the TSM, Chapter 3 as of the start of dental care delivery.

4.14.2. The incoming Contractor will obtain information from the outgoing Contractor on fees that are being paid other than by allotment, and shall transition these monthly payment types in the least disruptive manner for the beneficiary.

4.14.3. The outgoing Contractor shall submit a one time stop allotments file to the Finance Centers approximately 40 days before the start of dental care delivery. The date will be mutually agreed upon between the outgoing Contractor, TMA and the Finance Centers (see TSM Chapter 1, Section 1.1).

4.15. Cost Accounting. If the outgoing Contractor succeeds itself, costs related to each contract shall be kept separate for purposes of contract accountability, according to the above guidelines.

4.16 Records Disposition. The outgoing Contractor shall comply with the provisions of TOM Chapter 2 in final disposition of all files and documentation. The Contractor shall include a records disposition plan as part of their Phase-Out Plan.

Attachment J-3A
Benefits, Limitations and Exclusions
Enhanced Program

1. Summary of Coverage

All new TRDP enrollments shall be to the Enhanced Program. The following types of services will be covered under the TRICARE Retiree Dental Program (TRDP) when the services are determined to have been necessary and furnished in an appropriate manner consistent with generally accepted dental practice standards.

Level I Benefit – *Immediate*	**Benefits include:** • diagnostic services • preventive services • restorative services • endodontic services • periodontic services • oral surgery services • emergency and post-surgical services • drugs • anesthesia • professional consultation and visits • post-surgical services • miscellaneous services
Level II Benefit – *After 12 months continuous enrollment*	**Level I Benefits PLUS** • crowns and cast restorations and bridges • full and partial dentures • orthodontic services • implant services

Dental Accident Coverage

The Enhanced program provides a separate annual maximum benefit of $1,200.00 per enrollee for dental accident coverage. The annual deductible will not apply, however benefit limitations and cost shares will apply as defined in C.7.8.2

Orthodontics

Orthodontic coverage is for both children and adults. A lifetime maximum of $1,750.00 is allowed for each enrollee and the annual deductible will not apply. Payments for diagnostic services performed in conjunction with orthodontics are not applied to the enrollee's annual or orthodontic lifetime maximums or annual deductible.

Annual Benefit Maximum and Annual Deductible

The annual maximum is $1,300.00 per person per contract year. The annual deductible is $50.00 per person, not to exceed $150.00 per family, per contract year. The entire annual maximum and deductible amounts apply beginning on the TRDP enrollment effective date, regardless of when during the year an individual enrolls. Subsequently, new annual maximum and deductible amounts begin again at the start of each contract year.

Emergency Dental Care Overseas

Enhanced Program enrollees enrolled in the United States, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, Northern Marianna Islands or Canada that visit overseas countries are entitled to only receive care for emergency services (see Section C.7.8.5.2).

2. General Policies

Covered services for the TRICARE Retiree Dental Program are determined by the Department of Defense and are based upon generally accepted dental practice standards. In accordance with Section C.7.1, all covered services listed in this attachment conform to the most current version of the Code on Dental Procedures and Nomenclature (Code) published in the American Dental Association's (ADA) Current Dental Terminology (CDT) manual throughout the life of the contract. These services conform to the ADA's CDT 2011-2012 guidelines.

1. Under normal billing processes, procedures designated as TRDP procedure codes (covered services) cannot be redefined or substituted for other coded procedures (noncovered services) for billing purposes with the exception of dental services delivered overseas (see Section C.7.8.4).

2. Claims received on or after the first of the month following 12 months of the date of service are not payable by the contractor. The fees for the contractor's portion of the payment are not chargeable to the patient by a network dentist.

3. Network dentists must agree not to charge the patient more than the deductible and/or cost-share amount as shown on the Explanation of Benefits.

4. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable.

5. Consultation, diagnosis, prescriptions, etc. are considered part of the examination/evaluation or procedure performed.

6. Local anesthesia is considered integral to the procedure(s) for which it is provided and is included in the fee for the procedure(s).

7. Infection control procedures and fees associated with compliance with Occupational Safety & Health Administration (OSHA) and/or other governmental agency requirements are considered to be part of the dental services provided.

8. Postoperative care and evaluation are included in the fee for the service.

9. The fee for medicaments/solutions is part of the fee for the total procedure.

10. Procedure codes may be modified by the contractor based on the description of service and submitted supporting documentation.

11. For procedures limited to a certain number during a 12-month period, the 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days

later, regardless of the total services used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods.

12. Procedures denied due to time limitations or performed prior to the TRDP enrollment effective date are not covered.

13. Procedures done for cosmetic purposes are not covered benefits. Payment is the patient's responsibility.

14. Covered procedures, except orthodontic procedures as described in this attachment, are payable only upon completion of the procedure billed.

15. Services must be necessary and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a network dentist unless the dentist notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Network dentists should document such notification in their records.

16. Medical procedures as well as dental procedures coverable as adjunctive dental care under TRICARE medical policy are not covered under the TRDP.

17. An "R" to the right of the procedure code means "by report" and that these services will be paid only in unusual circumstances, and that documentation of the diagnosis, necessity and reason for the treatment must be provided by the dentist to determine benefits. For procedure codes that indicate "by report", the contractor may utilize their best business practices to determine whether or not there is a necessity for the "by report" requirement. The contractor may not add new "by report" requirements to procedure codes that do not indicate an "R".

18. An "**X**" to the right of the procedure code means that these services will be paid only when a current radiograph is submitted with the dental claim. For procedure codes that indicate an "X", the contractor may utilize their best business practices to determine whether or not there is a necessity for the submission of a current radiograph with the dental claim. The contractor may not add new "radiographs required" requirements to procedure codes that do not indicate an "X".

3. Diagnostic Services

Coverage: **100%**
Patient Pays: **0%**
Subject to Deductible: **No**
Applies to Maximum: **No**

D0120		Periodic oral evaluation - established patient
D0145		Oral evaluation for a patient under three years of age and counseling with a primary caregiver
D0150		Comprehensive oral evaluation—new or established patient
D0160	**R**	Detailed and extensive oral evaluation—problem-focused
D0170	**R**	Re-evaluation—limited, problem-focused (established patient; not post-operative visit)
D0180		Comprehensive periodontal evaluation—new or established patient

D0210		Intraoral—complete series (including bitewings)
D0220		Intraoral—periapical first film
D0230		Intraoral—periapical each additional film
D0240		Intraoral—occlusal film
D0250		Extraoral—first film
D0260		Extraoral—each additional film
D0270		Bitewing—single film
D0272		Bitewings—two films
D0273		Bitewings—three films
D0274		Bitewings—four films
D0277		Vertical bitewings—seven to eight films
D0290		Posterior-anterior or lateral skull and facial bone survey film
D0330		Panoramic film
D0340		Cephalometric film
D0425	**R**	Caries susceptibility tests
D0460		Pulp vitality tests
D0470		Diagnostic casts

The following policies apply to diagnostic services:

1. Limited oral evaluations are only covered when performed on an emergency basis.

2. A comprehensive oral examination/evaluation is payable once per dentist or group practice per year. Additional examinations/evaluations are considered periodic examinations/evaluations and are paid as such.

3. Payment is limited to two examinations/evaluations, comprehensive and/or periodic, in a 12-month period.

4. The 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits will not be carried over to subsequent benefit periods.

5. An examination/evaluation fee is not payable when a charge is not usually made or is included in the fee for another procedure.

6. Examinations/evaluations by specialists are payable as comprehensive or periodic examinations/evaluations and are counted towards the two-in-12-months limitation on examinations/evaluations.

7. A full-mouth series (complete series) of radiographs includes bitewings. Any additional film taken with a complete radiographic series is considered integral to the complete series.

8. A panoramic radiograph taken with any other film is considered a full-mouth series and is paid as such, and is subject to the same benefit limitations.

9. If the total fee for individually listed radiographs equals or exceeds the fee for a complete series, these radiographs are paid as a complete series and are subject to the same benefit limitations.

10. Payment for more than one of any category of full-mouth radiographs within a 48-month period is the patient's responsibility. If a full-mouth series (complete series) is denied because of the 48-month limitation, it cannot be reprocessed and paid as bitewings and/or additional films.

11. Payment for panoramic radiograph is limited to one within a 48-month period.

12. Payment for periapical films (other than as part of a complete series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.

13. Payment for a bitewing survey, whether single, two, three, four or vertical film(s), including those taken as part of a complete series, is limited to one within a 12-month period.

14. Radiographs of non-diagnostic quality are not payable.

15. Duplication of radiographs for administrative purposes is not payable.

16. Test reports must describe the pathological condition, type of study and rationale.

17. Pulp vitality tests are payable only on a per-visit basis in connection with emergency care. Otherwise, they are considered part of other services rendered.

18. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.

19. Detailed and extensive oral evaluations (D0160) are only payable by report upon review and are limited to once per patient per dentist, per year. They will not be paid if related to noncovered medical or dental procedures.

20. Re-evaluations (D0170) are limited to problem-focused assessments of previously existing conditions, specifically, conditions relating to traumatic injury or undiagnosed continuing pain. They will not be paid if related to non-covered medical or dental procedures.

21. Two cephalometric films (D0340) or two facial bone films (D0290) or one of each film are payable for orthodontic diagnostic purposes only. The fee for additional films taken during treatment or for post-operative records by the same dentist/office is included in the fee for orthodontic treatment.

22. Diagnostic casts (study models) are payable once per case as orthodontic diagnostic benefits. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

4. Preventive Services

Coverage: **100%**
Patient Pays: **0%**
Subject to Deductible: **No**
Applies to Maximum: **No**

D1110	Prophylaxis—adult (two per 12-month period)
D1120	Prophylaxis—child (two per 12-month period)
D1203	Topical application of fluoride — child
D1204	Topical application of fluoride — adult
D1206	Topical fluoride varnish, therapeutic application for moderate to high caries risk patients

The following policies apply to preventive services covered at 100%:

1. Persons age 14 years and older are considered to be adults.

2. Two prophylaxes for non-diabetic adults and children are covered in a period of 12 consecutive months. One periodontal maintenance procedure can be substituted for one of the prophylaxes if the patient is in active periodontal therapy. The patient may also substitute both prophylaxes with one periodontal maintenance procedure covered at 100% and a second one covered at 60% (see Periodontic Services below).

3. Three prophylaxes for adults and children with Type 1 or Type 2 diabetes are covered in a period of 12 consecutive months. One periodontal maintenance procedure can be substituted for one of the prophylaxes if the patient is in active periodontal therapy. The patient may substitute two prophylaxes with one periodontal maintenance procedure covered at 100% and a second one covered at 60%. The patient may also substitute all three prophylaxes with one periodontal maintenance procedure covered at 100% and the second and third procedures covered at 60%. The enrollee's medical condition may be obtained from the dental claim form or the dental provider. (See Periodontic Services below.)

4. Two fluoride treatments for both adults and children are covered in a period of 12 consecutive months.

5. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.

6. There are no provisions for special consideration for a prophylaxis based on degree of difficulty. Scaling or polishing to remove plaque, calculus and stains from teeth is considered to be part of the prophylaxis procedure.

7. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance.

8. Preventive control programs, including oral hygiene programs and dietary instructions, are not covered benefits.

9. Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

Coverage: **80%**
Patient Pays**: 20%**

Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D1351	Sealant—per tooth
D1352	Preventative Resin Restoration in a moderate to high caries risk patient – permanent tooth
D1510	Space maintainer—fixed - unilateral
D1515	Space maintainer—fixed - bilateral
D1520	Space maintainer—removable - unilateral
D1525	Space maintainer—removable - bilateral
D1550	Re-cementation of space maintainer
D1555	Removal of fixed space maintainer

The following policies apply to preventive services covered at 80%:

1. Sealants are only covered on permanent molars through age 18.

2. One sealant per tooth is covered in a three year period.

3. Sealants are only payable for molars that are caries free with no previous restorations on the mesial, distal or occlusal surfaces.

4. Sealants for teeth other than permanent molars are not covered.

5. Sealants completed on the same date of service and on the same tooth as a restoration on the occlusal surface are considered integral procedures and included in the fee for the restoration.

6. Sealants are covered for prevention of occlusal pit and fissure type cavities. Sealants done for treatment of sensitivity or for prevention of root or smooth surface caries are not payable.

7. The tooth number of the space to be maintained is required when requesting payment for space maintainers.

8. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are not covered

9. Only one space maintainer is paid for a space, except under unusual circumstances (where changes due to growth patterns or additional extractions make replacement necessary).

10. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.

11. Repair of a damaged space maintainer is not covered.

12. Re-cementation of space maintainers is payable once within 12 months.

13. Space maintainers are not covered for patients 14 years and older.

14. Removal of a fixed space maintainer (D1555) by the same dentist or dental practice that placed the space maintainer is not payable by contractor
or chargeable to the patient by a network dentist.

5. Restorative Services

Coverage: **80%**
Patient Pays: **20%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D2140		Amalgam—one surface, primary or permanent
D2150		Amalgam—two surfaces, primary or permanent
D2160		Amalgam—three surfaces, primary or permanent
D2161		Amalgam—four or more surfaces, primary or permanent
D2330		Resin-based composite—one surface, anterior
D2331		Resin-based composite—two surfaces, anterior
D2332		Resin-based composite—three surfaces, anterior
D2335		Resin-based composite—four or more surfaces or involving incisal angle (anterior)
D2390		Resin-based composite crown, anterior
D2391		Resin-based composite – one surface, posterior
D2392		Resin-based composite – two surfaces, posterior
D2393		Resin-based composite – three surfaces, posterior
D2910		Recement inlay, onlay, or partial coverage restoration
D2915		Recement cast or prefabricated post and core
D2920		Recement crown
D2930		Prefabricated stainless steel crown—primary tooth
D2931		Prefabricated stainless steel crown—permanent tooth
D2932		Prefabricated resin crown
D2933		Prefabricated stainless steel crown with resin window
D2951		Pin retention - per tooth, in addition to restoration
D2970	**R**	Temporary crown (fractured tooth)

The following policies apply to restorative services covered at 80%:

1. Coverage is for basic restorative services of amalgam fillings, anterior composite restorations, and one and two surface posterior composite restorations. Working models taken in conjunction with restorative procedures are considered integral to the restorative procedures.

2. Payment is made for restoring a surface once within 24 months regardless of the number of combinations of restorations placed.

3. Replacement of a restoration by the same dentist or group practice within 24 months is not a benefit. Duplication of an occlusal surface restoration is payable when it is necessary to restore one or more proximal surfaces due to subsequent caries.

4. A separate fee for services related to restorations, such as etching, bases, liners, local anesthesia, temporary restorations, polishing, preparation, supplies, caries removal agents,

gingivectomy, infection control and expenses for compliance with OSHA regulations, and/or other governmental agency requirements, etc. is not payable.

5. Restorations are covered benefits only when necessary to replace tooth structure loss due to fracture or decay. Restorations placed for any other reason, such as cosmetic purposes or due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension, are not covered.

6. Anterior restorations involving the incisal edge but not the proximal are paid as one-surface restorations, subject to review**.**

7. Posterior restorations not involving the occlusal surface are paid as one-surface restorations, subject to review.

8. Posterior restorations involving the proximal and occlusal surfaces on the same tooth are considered connected for payment purposes, subject to review.
9. An allowance for comparable amalgam restorations with a patient co-payment of 20% is allowed when the patient opts for the resin procedure code D2394 (Resin-based composite – four or more surfaces, posterior), on posterior teeth. The patient is responsible for the difference between the dentist's charge for the posterior resin and the TRDP paid amount.

10. X-rays may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.

11. Pin retention is payable once per restoration to the same dentist or group practice and only payable in connection with a four or more surface restoration or a restoration involving the incisal angle. The restoration and pin retention must be done at the same appointment.

12. Replacement of a stainless steel crown or prefabricated resin crown by the same dentist or group practice within 36 months is not covered.

13. Prefabricated stainless steel crowns with resin windows are payable only on anterior primary teeth.

14. Pin retention and buildups on primary teeth are covered in the fee for the restoration.

15. Pin retention and buildups done with stainless steel crowns on permanent teeth are included in the fee for the stainless steel crown.

16. Re-cementation of prefabricated crowns within six months of initial placement is included in the fee for the restoration.

17. After six months from the initial cementation date, re-cementation of crowns is payable once within 12 months.

18. Payment for a temporary crown (D2970) will be made for a damaged tooth as an immediate protective device once per tooth per lifetime unless justified by treating dentist, by report.

19. Payment for a prefabricated resin crown (D2932) will be made when resin-based composite crowns are performed.

6. Major Restorative Services

Coverage: **50% after 12 months**
Patient Pays: **50% after 12 months**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D2542	**X**	Onlay—metallic - two surfaces
D2543	**X**	Onlay—metallic - three surfaces
D2544	**X**	Onlay—metallic - four or more surfaces
D2740	**X**	Crown—porcelain/ceramic substrate
D2750	**X**	Crown—porcelain fused to high noble metal
D2751	**X**	Crown—porcelain fused to predominantly base metal
D2752	**X**	Crown—porcelain fused to noble metal
D2780	**X**	Crown—3/4 cast high noble metal
D2781	**X**	Crown—3/4 cast predominantly base metal
D2782	**X**	Crown—3/4 cast noble metal
D2783	**X**	Crown—3/4 porcelain/ceramic
D2790	**X**	Crown—full cast high noble metal
D2791	**X**	Crown—full cast predominantly base metal
D2792	**X**	Crown—full cast noble metal
D2794	**X**	Crown—titanium
D2950	**X**	Core buildup, including any pins
D2952	**X**	Post and core in addition to crown, indirectly fabricated
D2954	**X**	Prefabricated post and core in addition to crown
D2980	**R**	Crown repair

The following policies apply to major restorative services covered at 50% after 12 months:

1. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

2. Facings on crowns posterior to the first molar position are considered to be cosmetic components. An allowance is made for a full cast crown.

3. After six months from the initial cementation date, re-cementation of cast crowns is payable once within 12 months.

4. Cast restorations are covered benefits only when necessary to replace natural tooth structure loss due to fracture or decay. Restorations placed for any other reason, such as cosmetic purposes or due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension are not covered.

5. The charge for a crown or onlay is considered to include all charges for work related to its placement including, but not limited to, preparation of gingival tissue, tooth preparation,

temporary crown, diagnostic casts (study models), impressions, try-in visits, and cementations of both temporary and permanent crowns.

6. Onlays, permanent single crown restorations and necessary posts and cores for patients under 14 years of age are excluded from coverage unless specific rationale is provided indicating the reason for such treatment.

7. Replacement of crowns, onlays, buildups, and posts and cores is covered only if the existing crown, onlay, buildup, or post and core was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing crown, onlay, buildup or post and core is not and cannot be made serviceable.

8. Temporary crowns placed in preparation for a permanent crown are considered integral to the placement of the permanent crown and are not payable as a separate procedure.

9. Re-cementation of prefabricated and cast crowns, bridges, onlays, inlays, and posts within six months of placement by the same dentist is considered integral to the original procedure.

10. Onlays, crowns, and posts and cores are payable to restore a natural tooth due to decay or fracture. However, if the degree of breakdown does not qualify for a cast restoration, a benefit allowance will be made for an amalgam restoration on a posterior tooth and a resin restoration on an anterior tooth.

11. When performed as an independent procedure, the placement of a post is not a covered benefit. Posts are only eligible when provided as part of a buildup for a crown and are considered integral to the buildup.

12. Cores and other substructures are benefits in exceptional circumstances and with documentation of the necessity to retain a crown on a tooth because of excessive breakdown due to caries or fracture. Otherwise, the procedure is considered part of the final restoration.

13. Cast restorations and substructures include pins. A separate fee is not covered.

14. Veneers are not covered benefits. An allowance will be made for a resin restoration on an anterior tooth based on the degree of breakdown.

15. Porcelain/ceramic inlays and onlays are not covered benefits. An alternate benefit allowance toward a porcelain/ceramic inlay will be paid with a corresponding amalgam restoration on a posterior tooth, and a resin restoration on an anterior tooth. An alternate benefit allowance toward a porcelain/ceramic onlay will be paid with a metallic onlay.

16. The completion date for crowns, onlays and buildups is the cementation date.

17. Resin or metallic inlays and resin onlays are not covered benefits. An alternate benefit allowance will be paid for an amalgam restoration on a posterior tooth and a resin restoration on an anterior tooth.

18. Glass ionomer restorations are not covered benefits.

19. Gold foil restorations are not covered benefits.

20. Cast crowns with resin facings are not covered benefits.

7. Endodontic Services

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D3120	**R**	Pulp cap—indirect (excluding final restoration)
D3220		Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament
D3221		Pulpal debridement, primary and permanent teeth
D3222		Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230		Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)
D3240		Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)
D3310		Root canal therapy—anterior (excluding final restoration)
D3320		Root canal therapy—bicuspid (excluding final restoration)
D3330		Root canal therapy—molar (excluding final restoration)
D3332	**R**	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3346		Retreatment of previous root canal therapy—anterior
D3347		Retreatment of previous root canal therapy—bicuspid
D3348		Retreatment of previous root canal therapy—molar
D3351		Apexification/recalcification—interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3352		Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3353		Apexification/recalcification—final visit (includes completed root canal therapy—apical closure/calcific repair of perforations, root resorption, etc.)
D3410		Apicoectomy/periradicular surgery—anterior
D3421		Apicoectomy/periradicular surgery—bicuspid (first root)
D3425		Apicoectomy/periradicular surgery—molar (first root)
D3426		Apicoectomy/periradicular surgery (each additional root)
D3430		Retrograde filling—per root
D3450		Root amputation—per root
D3920		Hemisection (including any root removal), not including root canal therapy

The following policies apply to endodontic services:

1. An indirect pulp cap is payable only by report with radiographs documenting a near exposure of the pulp and when the final restoration is not completed for at least 60 days. An indirect pulp cap is included in the fee for the restoration when the restoration is placed in less than 60 days.

2. An indirect pulp cap is only payable once per tooth by the same dentist.

3. A direct pulp cap is included in the fee for the restoration or palliative treatment.

4. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist or group practice is to be included in the fee for the root canal therapy.

5. A paste-type root canal filling incorporating formaldehyde or paraformaldehyde is not a benefit.

6. Endodontic procedures in conjunction with overdentures are not covered benefits.

7. The completion date for endodontic therapy is the date the tooth is sealed.

8. Retreatment of apical surgery or root canal therapy by the same dentist or group practice within 24 months is considered part of the original procedure.

9. Apexification is payable only on permanent teeth with incomplete root development or for repair of perforation. Otherwise, the fee is included in the fee for the root canal.

10. Payment for gross pulpal debridement is limited to the relief of pain prior to conventional root canal therapy and when performed by a dentist not completing the endodontic therapy.

11. Incompletely filled root canals, other than for reason of an inoperable or fractured tooth, are not covered.

12. A therapeutic pulpotomy is payable on primary teeth only. One pulpotomy is payable per tooth.

13. Partial pulpotomy for apexogenesis will be covered only on permanent teeth and once per tooth per lifetime. The procedure is considered integral if performed on the same day or within 30 days/same tooth/same dentist/same office as root canal therapy or codes D3351-D3353.

8. Periodontic Services

Coverage: **100%**
Patient Pays: **0%**
Subject to Deductible: **No**
Applies to Maximum: **No**

D4910	Periodontal maintenance (one per 12-month period when substituted – see policy below)

The following policies apply to periodontic services covered at 100%:

1. For non-diabetic adults and children in active periodontal therapy, one periodontal maintenance may be substituted for one of the annual routine prophylaxes and be covered at 100% within a consecutive 12-month period. The patient may also substitute both prophylaxes with one periodontal maintenance procedure covered at 100% and a second one covered at 60% (see Preventive Services above).

2. For adults and children with Type 1 or Type 2 diabetes that are in active periodontal therapy, one periodontal maintenance procedure can be substituted for one of the three prophylaxes and be covered at 100% in a period of 12 consecutive months. The patient may substitute two prophylaxes with one periodontal maintenance procedure covered at 100% and a second one covered at 60%. The patient may also substitute all three prophylaxes with one periodontal maintenance procedure covered at 100% and the second and third procedures covered at 60%. The enrollee's medical condition may be obtained from the dental claim form or the dental provider. (See Preventive Services above.)

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D4210	**R**	Gingivectomy or gingivoplasty—four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	**R**	Gingivectomy or gingivoplasty—one to three contiguous teeth or bounded teeth spaces per quadrant
D4240	**R**	Gingival flap procedure, including root planing—four or more contiguous teeth or bounded teeth spaces per quadrant
D4241	**R**	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant
D4245	**R**	Apically positioned flap
D4249	**X**	Clinical crown lengthening—hard tissue
D4260	**R**	Osseous surgery (including flap entry and closure)—four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	**R**	Osseous surgery (including flap entry and closure)—one to three contiguous teeth or bounded teeth spaces per quadrant
D4263	**R**	Bone replacement graft—first site in quadrant
D4264	**R**	Bone replacement graft—each additional site in quadrant
D4266	**R**	Guided tissue regeneration—resorbable barrier, per site
D4267	**R**	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)
D4270	**R**	Pedicle soft tissue graft procedure
D4271	**R**	Free soft tissue graft procedure (including donor site surgery)
D4273	**R**	Subepithelial connective tissue graft procedures, per tooth
D4341	**R**	Periodontal scaling and root planing—four or more teeth per quadrant
D4342	**R**	Periodontal scaling and root planing—one to three teeth per quadrant
D4355	**R**	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis
D4910		Periodontal maintenance
D4920	**R**	Unscheduled dressing change (by someone other than treating dentist)

The following policies apply to periodontic services covered at 60%:

1. Documentation of the need for periodontal treatment includes periodontal pocket charting, case type, prognosis, amount of existing attached gingiva, etc. Periodontal pocket charting should indicate the area/quadrants/teeth involved and is required for most procedures.

2. Gingivectomy/gingivoplasty in conjunction with and for the purpose of placement of restorations is included in the fee for the restorations.

3. Gingivectomy/gingivoplasty is considered to be part of the gingival flap procedures or osseous surgery at the same site and, therefore, not payable with these procedures.

4. Root planing performed in the same quadrant within 30 days prior to periodontal surgery is considered to be included in the fee for the surgery.

5. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II periodontal disease. All procedures must be completed within 90 days.

6. Osseous, gingival and synthetic grafts must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis.

7. Bone grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, implants or other non-periodontal surgical procedures.

8. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.

9. Periodontal surgical services include all necessary postoperative care, finishing procedures, splinting and evaluation for three months, as well as any surgical re-entry for three years, if performed by the same dentist.

10. Routine prophylaxes are considered integral when performed by the same dentist on the same day as scaling and root planing, periodontal surgery and periodontal maintenance.

11. Periodontal maintenance is a benefit subsequent to active periodontal therapy and subject to the time limitations for prophylaxes.

12. Up to two periodontal maintenance procedures may be paid with a consecutive 12-month period for non-diabetics enrollees and up to three periodontal maintenance procedures may be paid within a consecutive 12-month period for diabetic enrollees (see instructions above under procedure D4910).

13. Full-mouth debridement is a benefit once per patient per lifetime.

14. One crown lengthening per tooth, per lifetime, is covered.

15. Osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same dentist, and in the same area of the mouth, will be processed as crown lengthening.

16. Subepithelial connective tissue grafts are payable at the level of free soft tissue grafts.

17. An apically positioned flap is subject to documentation when performed and when not related to implants.

9. Prosthodontic Services, Removable and Fixed

Coverage: **50% after 12 months**
Patient Pays: **50% after 12 months**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

Prosthodontics, Removable

D5110	Complete denture—maxillary
D5120	Complete denture—mandibular
D5130	Immediate denture—maxillary
D5140	Immediate denture—mandibular
D5211	Maxillary partial denture—resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture—resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	Mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5410	Adjust complete denture—maxillary
D5411	Adjust complete denture—mandibular
D5421	Adjust partial denture—maxillary
D5422	Adjust partial denture—mandibular
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth—complete denture (each tooth)
D5610	Repair resin denture base—partial denture
D5620	Repair cast framework—partial denture
D5630	Repair or replace broken clasp—partial denture
D5640	Replace broken teeth—partial denture, per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)—partial denture
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)—partial denture
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture

D5721		Rebase mandibular partial denture
D5730		Reline complete maxillary denture (chairside)
D5731		Reline complete mandibular denture (chairside)
D5740		Reline maxillary partial denture (chairside)
D5741		Reline mandibular partial denture (chairside)
D5750		Reline complete maxillary denture (laboratory)
D5751		Reline complete mandibular denture (laboratory
D5760		Reline maxillary partial denture (laboratory)
D5761		Reline mandibular partial denture (laboratory)
D5810		Interim complete denture (maxillary)
D5811		Interim complete denture (mandibular)
D5820		Interim partial denture (maxillary)
D5821		Interim partial denture (mandibular)
D5850		Tissue conditioning, maxillary
D5851		Tissue conditioning, mandibular

Prosthodontics, Fixed

D6210	**X**	Pontic—cast high noble metal
D6211	**X**	Pontic—cast predominantly base metal
D6212	**X**	Pontic—cast noble metal
D6214	**X**	Pontic—titanium
D6240	**X**	Pontic—porcelain fused to high noble metal
D6241	**X**	Pontic—porcelain fused to predominantly base metal
D6242	**X**	Pontic—porcelain fused to noble metal
D6245	**X**	Pontic—porcelain/ceramic
D6545	**X**	Retainer—cast metal for resin bonded fixed prosthesis
D6548	**X**	Retainer—porcelain/ceramic for resin bonded fixed prosthesis
D6610	**X**	Onlay—cast high noble metal, two surfaces
D6611	**X**	Onlay—cast high noble metal, three or more surfaces
D6612	**X**	Onlay—cast predominatly base metal, two surfaces
D6613	**X**	Onlay—cast predominatly base metal, three or more surfaces
D6614	**X**	Onlay—cast noble metal, two surfaces
D6615	**X**	Onlay—cast noble metal, three or more surfaces
D6634	**X**	Onlay—titanium
D6740	**X**	Crown—porcelain/ceramic
D6750	**X**	Crown—porcelain fused to high noble metal
D6751	**X**	Crown—porcelain fused to predominantly base metal
D6752	**X**	Crown—porcelain fused to noble metal
D6780	**X**	Crown—3/4 cast high noble metal
D6781	**X**	Crown—3/4 cast predominantly base metal
D6782	**X**	Crown—3/4 cast noble metal
D6783	**X**	Crown—3/4 porcelain/ceramic
D6790	**X**	Crown—full cast high noble metal
D6791	**X**	Crown—full cast predominantly base metal
D6792	**X**	Crown—full cast noble metal
D6794	**X**	Crown—titanium
D6930	**X**	Recement fixed partial denture
D6970	**X**	Post and core in addition to fixed partial denture retainer, indirectly

		fabricated
D6972	**X**	Prefabricated post and core in addition to fixed partial denture retainer
D6973	**X**	Core build-up for retainer, including any pins
D6980	**R**	Fixed partial denture repair

The following policies apply to prosthodontic, removable and fixed:

1. The fee for diagnostic casts (study models) fabricated in conjunction with prosthetic and restorative procedures is included in the fee for these procedures.

2. Removable cast base partial dentures for patients under 16 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment.

3. Tissue conditioning is considered integral when performed on the same day as the delivery of a denture or a reline/rebase.

4. Tissue conditioning is limited to twice per denture within 36 months.

5. Payment for the replacement of missing natural teeth will be made up to the normal complement of natural teeth. Additional pontics are optional and, if placed should be done with the agreement of the patient to assume the additional cost. (Benefits for pontics are based on the number necessary for the spaces, not to exceed the number of missing teeth.)

6. Cores and other substructures are benefits in exceptional circumstances and with documentation of the necessity to retain a crown on a tooth because of excessive breakdown due to caries or fracture. Otherwise, the procedure is considered part of the final restoration.

7. Cast restorations and substructures include pins.

8. After six months from the initial re-cementation date, re-cementation of fixed partial dentures, inlays or onlays is payable once within 12 months.

9. The permanent cementation date is considered to be the completion date for crowns and fixed bridges.

10. Adjustments provided within six months of the insertion of an initial or replacement denture are integral to the denture.

11. The relining or rebasing of a denture is considered integral when performed within six months following the insertion of that denture.

12. A reline/rebase is covered once in any 36 months.

13. The fee for the complete replacement of denture base material (rebase) includes a reline.

14. Reline or rebase of an existing appliance will not be covered when such procedures are performed in addition to a new denture for the same arch.

15. Fixed partial dentures, buildups, and posts and cores for patients under 16 years of age are not covered unless specific rationale is provided indicating the necessity of such treatment.

16. Payment for a denture made with precious metals or an overdenture is based on the allowance for a conventional denture. Payment for flexible base partials is based on the allowance for a resin based partial denture.

17. Specialized procedures performed in conjunction with an overdenture are not covered.

18. Cast unilateral removable partial dentures are not covered benefits.

19. Precision attachments, personalization, precious metal bases and other specialized techniques are not covered benefits.

20. The completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances.

21. Temporary fixed partial dentures are not a covered benefit when done in conjunction with permanent fixed partial dentures and are considered integral to the allowance for the fixed partial dentures.

22. Interim removable partial dentures are a benefit only to replace permanent anterior teeth during the healing period. Interim complete dentures are a benefit only under extenuating circumstances such as jaw or cancer surgery.

23. Repair of temporary appliances is not a covered benefit.

24. A posterior fixed bridge and partial denture in the same arch are not a benefit. Benefit is limited to the allowance for the partial denture.

25. The total allowed fee for repairs including rebases and relines should not exceed half of the allowed amount for a new prosthesis.

26. Fixed partial denture repairs (D6980) are payable by report with documentation of tooth numbers, type of appliance and description of repair.

27. Prosthodontics is not a benefit for patients under age 14. Payment is the patient's responsibility.

28. Substructures in connection with fixed prosthetics are a benefit once in five years per tooth. Payment for additional procedures is the patient's responsibility.

29. Replacement of a removable prosthesis (D5110 through D5210) or fixed prosthesis (D6210 through D6792) is covered only if the existing prosthesis was inserted at least five years prior to the replacement and satisfactory evidence is presented that the existing prosthesis cannot be made serviceable.

30. Porcelain/ceramic inlays and onlays are not covered benefits. An alternate benefit allowance toward a porcelain/ceramic inlay will be paid with a corresponding amalgam restoration on a

posterior tooth, and a resin restoration on an anterior tooth. An alternate benefit allowance toward a porcelain/ceramic onlay will be paid with a metallic onlay. Any amount greater than the allowance is the patient's responsibility.

10. Implant Services

Coverage: **50% after 12 months**
Patient Pays: **50% after 12 months**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D6010		Surgical placement of implant body: endosteal implant
D6050		Surgical placement: transosteal implant
D6056		Prefabricated abutment – includes placement
D6057		Custom abutment – includes placement
D6058		Abutment supported porcelain/ceramic crown
D6059		Abutment supported porcelain fused to metal crown (high noble metal)
D6060		Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061		Abutment supported porcelain fused to metal crown (noble metal)
D6062		Abutment supported cast metal crown (high noble metal)
D6063		Abutment supported cast metal crown (predominantly base metal)
D6064		Abutment supported cast metal crown (noble metal)
D6065		Implant supported porcelain/ceramic crown
D6066		Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067		Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068		Abutment supported retainer for porcelain/ceramic FPD
D6069		Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070		Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)
D6071		Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072		Abutment supported retainer for cast metal FPD (high noble metal)
D6073		Abutment supported retainer for cast metal FPD (predominately base metal)
D6074		Abutment supported retainer for cast metal FPD (noble metal)
D6075		Implant supported retainer for ceramic FPD
D6076		Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077		Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6078		Implant/abutment supported fixed denture for completely edentulous arch
D6079		Implant/abutment supported fixed denture for partially edentulous arch
D6090	**R**	Repair implant supported prosthesis
D6094		Abutment supported crown – (titanium)
D6095	**R**	Repair implant abutment
D6194		Abutment supported retainer crown for FPD – (titanium)

The following policies apply to implants:

1. Implant services are subject to a 50 percent cost-share and the annual program maximum.

2. Implant services are not eligible for members under age 14 unless submitted with X-rays and approved by the Contractor.

3. Implants are not covered when placed for a removable denture.

4. Replacement of implants is covered only if the existing implant was placed at least five years prior to the replacement and the implant has failed.

5. Replacement of implant prosthesis is covered only if the existing prosthesis were placed at least five years prior to the replacement and satisfactory evidence is presented that demonstrates they are not, and cannot be made, serviceable.

6. Repair of an implant supported prosthesis (D6090) and repair of an implant abutment (D6095) are only payable by report upon Contractor Dentist Advisor review. The report should describe the problem and how it was repaired.

11. Oral Surgery Services

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D7111		Extraction, coronal remnants—deciduous tooth
D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	**X**	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	**X**	Removal of impacted tooth—soft tissue
D7230	**X**	Removal of impacted tooth—partially bony
D7240	**X**	Removal of impacted tooth—completely bony
D7250	**X**	Surgical removal of residual tooth roots (cutting procedure)
D7260		Oroantral fistula closure
D7261		Primary closure of a sinus perforation
D7270		Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280		Surgical access of an unerupted tooth
D7283		Placement of device to facilitate eruption of impacted tooth
D7285	**R**	Biopsy of oral tissue—hard (bone, tooth)
D7286	**R**	Biopsy of oral tissue—soft
D7290	**R**	Surgical repositioning of teeth
D7291	**R**	Transseptal fiberotomy/supra crestal fiberotomy
D7310		Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant
D7311		Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant

D7320		Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant
D7321		Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant
D7471		Removal of lateral exostosis (maxillary or mandibular)
D7472		Removal of torus palatinus
D7473		Removal of torus mandibularis
D7485		Surgical reduction of osseous tuberosity
D7510		Incision and drainage of abscess—intraoral soft tissue
D7511	**R**	Incision and drainage of abscess—intraoral soft tissue—complicated (includes drainage of multiple fascial spaces)
D7910	**R**	Suture of recent small wounds—up to 5 cm
D7911	**R**	Complicated suture—up to 5 cm
D7912	**R**	Complicated suture—greater than 5 cm
D7971		Excision of pericoronal gingiva
D7972		Surgical reduction of fiberous tuberosity

The following policies apply to oral surgery services:

1. Unsuccessful extractions are not covered.

2. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.

3. All hospital costs and any additional fees charged by the dentist arising from procedures rendered in the hospital are the patient's responsibility.

4. Surgical removal of impactions is payable according to the anatomical position.

5. Procedure D7241 is not a covered procedure. However, an allowance will be made for a D7240 upon x-ray review for degree of difficulty.

6. The fee for root recovery is included in the treating dentist's or group practice's fee for the extraction.

7. The fee for reimplantation of an avulsed tooth includes the necessary wires or splints, adjustments and follow-up visits.

8. Surgical exposure of an impacted or unerupted tooth to aid eruption is payable once per tooth and includes post-operative care.

9. Excision of pericoronal gingiva is payable once per tooth.

10. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered.

11. Biopsies are defined as the surgical removal of tissues specifically for histopathologic examination/evaluation. Removal of tissues during other procedures (such as extractions and apicoectomies) is not payable as a biopsy.

12. Incision and drainage on the same date of service with any palliative or oral surgery procedure is not payable. The procedure is considered part of those services.

13. Simple incision and drainage reported with root canal therapy is considered integral to the root canal therapy.

14. Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered integral to the procedure.

12. Orthodontic Services

Coverage: **50% after 12 months**
Patient Pays: **50% after 12 months**
Subject to Deductible: **No**
Applies to Maximum: **Yes (separate, lifetime maximum)**

D8010	**R**	Limited orthodontic treatment of the primary dentition
D8020	**R**	Limited orthodontic treatment of the transitional dentition
D8030	**R**	Limited orthodontic treatment of the adolescent dentition
D8040	**R**	Limited orthodontic treatment of the adult dentition
D8050	**R**	Interceptive orthodontic treatment of the primary dentition
D8060	**R**	Interceptive orthodontic treatment of the transitional dentition
D8070	**R**	Comprehensive orthodontic treatment of the transitional dentition
D8080	**R**	Comprehensive orthodontic treatment of the adolescent dentition
D8090	**R**	Comprehensive orthodontic treatment of the adult dentition
D8210	**R**	Removable appliance therapy
D8220	**R**	Fixed appliance therapy
D8670	**R**	Periodic orthodontic treatment visit (as part of contract)
D8680	**R**	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8690	**R**	Orthodontic treatment (alternative billing to a contract fee)

The following policies apply to orthodontic services:

1. Initial payment for orthodontic services will not be made until a banding date has been submitted.

2. All retention and case-finishing procedures are integral to the total case fee.

3. Observations and adjustments are integral to the payment for retention appliances. Repair of damaged orthodontic appliances is not covered.

4. Re-cementation of an orthodontic appliance by the same dentist who placed the appliance and/or who is responsible for the ongoing care of the patient is integral to the orthodontic appliance. However, re-cementation by a different dentist will be considered for payment as palliative emergency treatment.

5. The replacement of a lost or missing appliance is not a covered benefit.

6. Myofunctional therapy is integral to orthodontic treatment and not payable as a separate benefit.

7. Orthodontic treatment (alternative billing to contract fee) will be reviewed for individual consideration with any allowance being applied to the orthodontic lifetime maximum. It is only payable for services rendered by a dentist other than the dentist rendering complete orthodontic treatment.

8. Periodic orthodontic treatment visits (as part of contract) are considered an integral part of a complete orthodontic treatment plan and are not reimbursable as a separate service. The contractor uses this code when making periodic payments as part of the complete treatment plan payment.

9. It is the dentist's and the patient's responsibility to promptly notify the contractor if orthodontic treatment is discontinued or completed sooner than anticipated.

10. Post-operative orthodontic records including radiographs and models and records taken during treatment are included in the fee for the orthodontic treatment.

11. When a patient transfers to a different orthodontic dentist, payment and any additional charges involved with the transfer of an orthodontic case, such as changes in treatment plan, additional records, etc., will be subject to review and recalculation of benefits.

12. Diagnostic casts (study models) are payable once per case as orthodontic diagnostic benefits. The fee for working models taken in conjunction with restorative and prosthodontic procedures is included in the fee for those procedures.

13. Two cephalometric films (D0340) or two facial bone films (D0290) or one of each film are payable for orthodontic diagnostic purposes. The fee for additional films taken during treatment or for post-operative records by the same dentist/office is included in the fee for orthodontic treatment.

13. General Services

The TRDP will provide coverage for the following services. To be eligible, these services must be directly related to the covered services already listed.

Emergency Services

Coverage: **100%**
Patient Pays: **0%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D0140 Limited oral evaluation – problem focused

Coverage: **80%**
Patient Pays: **20%**

Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9110 Palliative (emergency) treatment of dental pain – minor procedures

The following policies apply to emergency services:

1. Emergency palliative treatment is payable on a per visit basis, once on the same date. All procedures necessary for relief of pain are included.

2. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist is to be included in the fee for the root canal therapy.

Anesthesia

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9220 **R** Deep sedation/general anesthesia—first 30 minutes
D9221 **R** Deep sedation/general anesthesia—each additional 15 minutes
D9241 **R** Intravenous conscious sedation/analgesia—first 30 minutes
D9242 **R** Intravenous conscious sedation/analgesia—each additional 15 minutes

The following policies apply to anesthesia services:

1. General anesthesia provides coverage by report only and for the administration of anesthesia provided in connection with a covered procedure(s).

2. General anesthesia (D9220, D9221) will be covered only by report and if determined to be mentally or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.

3. Intravenous sedation (D9241, D9242) will be covered only by report in conjunction with covered procedures for documented handicapped or uncontrollable patients or justifiable medical or dental conditions.

4. Payment is limited to when and if performed by a qualified dentist recognized by the state or jurisdiction in which he/she practices as authorized to perform IV sedation/general anesthesia.

Professional Consultation

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9310 **R** Consultation-diagnostic service provided by dentist or physician other

than the requesting dentist or physician

The following policies apply to professional consultation:

1. Consultations reported for a non-covered procedure or condition, such as temporomandibular joint dysfunction, is not covered.

Professional Visits

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9440		Office visits - after regularly scheduled hours

The following policies apply to professional visits:

1. After-hours visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the patient in an emergency situation.

Drugs

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9610	**R**	Therapeutic parenteral drug, single administration
D9612	**R**	Therapeutic parenteral drugs, two or more administrations, different medications
D9630	**R**	Other drugs and/or medicaments

The following policies apply to coverage of drugs and medications:

1. Drugs and medications not dispensed by the dentist and those available without prescription or used in conjunction with medical or non-covered services are not covered benefits.

2. The fee for medicaments/solutions is part of the fee for the total procedure.

3. Reimbursement for pharmacy-filled prescriptions is not a benefit.

4. Over the counter fluoride gels, rinses, tablets and other preparations for home use are not covered benefits.

5. Therapeutic drug injections are only payable in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

Post-Surgical Services

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9930	**R**	Treatment of complications (post-surgical), unusual circumstances

The following policies apply to post-surgical services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.

Miscellaneous Services

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9940	**R**	Occlusal guard
D9941		Fabrication of athletic mouthguard
D9974		Internal bleaching-per tooth

The following policies apply to miscellaneous services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.

2. Occlusal guards are covered by report for patients over the age of 12 for purposes other than TMJ treatment.

3. Athletic mouth guards limited to one per 12-consecutive month period.

4. Payment for internal bleaching is limited to permanent anterior teeth and when performed in conjunction with root canal therapy.

Fixed Partial Denture Sectioning

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9120	**R**	Fixed partial denture sectioning

The following policies apply to coverage of fixed partial denture sectioning

1. Fixed partial denture sectioning is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

2. If fixed partial denture sectioning is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is not allowed unless the sectioning is performed by a different dentist or group practice.

3. Polishing and recontouring are considered an integral part of the fixed partial denture sectioning.

14. Exclusions

The following services are not benefits:

1. Services for injuries or conditions that are covered under Worker's Compensation or Employer's Liability Laws.

2. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

3. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county or other political subdivision.

4. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.

5. Those performed prior to the member's effective coverage date.

6. Those incurred after the termination date of the member's coverage unless otherwise indicated.

7. Medical procedures and dental procedures coverable as adjunctive dental care under TRICARE medical policy.

8. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

9. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to: equilibration and periodontal splinting.

10. Prescribed or applied therapeutic drugs, premedication, sedation, or analgesia.

11. Drugs, medications, fluoride gels, rinses, tablets and other preparations for home use.

12. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist.

13. Those not meeting accepted standards of dental practice.

14. Those which are for unusual procedures and techniques.

15. Plaque control programs, oral hygiene instruction, and dietary instruction.

16. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for malalignment of teeth.

17. Gold foil restorations.

18. Premedication and inhalation analgesia.

19. House calls and hospital visits.

20. Telephone consultations.

21. Those performed by a dentist who is compensated by a facility for similar covered services performed for members.

22. Those resulting from the patient's failure to comply with professionally prescribed treatment.

23. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.

24. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.

25. Duplicate and temporary devices, appliances, and services.

26. Experimental procedures.

27. All hospital costs and any additional fees charged by the dentist for hospital treatment.

28. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

29. Removal of implants.

30. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

31. Replacement of existing restorations for any purpose other than to restore tooth structure lost due to fracture or decay.

32. When the enrollee is visiting overseas treatment will not be covered for routine dental services provided outside the United States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands or Canada.

33. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.

34. Procedures not specifically listed are not payable, other than those modified by the contractor or those toward which an alternate benefit is provided by the program and as defined within the benefit policies.

35. Services submitted by a dentist which are for the same services performed on the same date for the same member by another dentist.

ENHANCED PROGRAM
Benefits, Plan Coverage, Deductibles and Maximums

Benefit Categories	Plan Coverage In Year 1	Plan Coverage In Year 2+*
Diagnostic Services	100%	100%
Preventive Services	80%-100%	80%-100%
Restorative Services	80%	80%
Major Restorative Services	NAB	50%
Endodontic Services	60%	60%
Periodontic Services	60%	60%
Prosthodontic Services, Removable and Fixed	NAB	50%
Implant Services	NAB	50%
Oral Surgery Services	60%	60%
Orthodontic Services	NAB	50%
Emergency Services	80%-100%	80%-100%
Anesthesia	60%	60%
Professional Consultation	60%	60%
Professional Visits	60%	60%
Drugs	60%	60%
Post-Surgical Services	60%	60%
Miscellaneous Services	60%	60%
Deductible		
Annual deductible per patient (Not to exceed $150.00 per family) *(Note: Diagnostic & preventive procedures covered at 100%, orthodontics and dental accident coverage are exempt from the annual deductible)*	$50	$50
Maximums per patient		
Annual maximum *(Note: Diagnostic & preventive procedures covered at 100% are exempt from the annual maximum)*	$1,300	$1,300
Separate annual maximum for dental accident	$1,200	$1,200
Lifetime orthodontic maximum	NAB	$1,750

Note: NAB = Not A Benefit

* Credit for the 12-month benefit waiting period will be granted to those individuals who elect to enroll in the TRDP within 4 months after their retirement from active duty, the National Guard or the Reserves. Those procedures scheduled to become effective after 12 months of continuous enrollment will be available to these enrollees immediately.

A comparable credit shall be applied to surviving family members whose enrollment in the TRDP takes place within 4 months of the termination of survivors' coverage under the TRICARE Dental Program (TDP).

Attachment J-3B
Benefits, Limitations and Exclusions
Basic Program

The Basic Program is closed to new enrollments. However, all current Basic Program enrollees will be allowed to continue that enrollment throughout the period covered by this contract, so long as they remain continuously enrolled and current on premium payments. If an enrollee permanently moves out of the following locations: United States, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands and Canada, they must disenroll from the Basic Program or upgrade to the Enhanced Program. Only the Enhanced Program will be offered to those living outside of the previously stated locations.

1. Summary of Coverage

Under the law which created the TRICARE Retiree Dental Program, the benefits which can be provided under the Basic Program are limited to basic dental care and treatment involving diagnostic services, preventive services, basic restorative services, endodontic services, periodontic services, surgical and post-surgical services, and emergency services.

Annual Benefit Maximum and Annual Deductible

The annual benefit maximum is $1,000.00 per person per contract year. A $50.00 annual per person deductible, not to exceed $150.00 per family, shall apply, except as specifically waived below. The entire annual benefit maximum and deductible amounts apply beginning on the TRDP enrollment effective date, regardless of when during the year an individual enrolls. Subsequently, new annual benefit maximum and deductible amounts begin again at the start of each contract year. No deductible or yearly maximum shall apply to diagnostic or preventive services as listed below.

2. General Policies

As stated in Section C.7.1, all covered services listed in this Attachment conform to the most current version of the Code on Dental Procedures and Nomenclature (Code) published in the American Dental Association's (ADA) Current Dental Terminology (CDT) manual throughout the life of the contract.

1. Procedures designated as TRDP procedure codes (covered services) cannot be redefined or substituted for other coded procedures (noncovered services) for billing purposes.

2. Claims received on or after the first of the month following 12 months of the date of service are not payable by the Contractor. The fees for the Contractor's portion of the payment are not chargeable to the patient by a participating network dentist.

3. Participating providers must agree not to charge the patient more than the deductible and/or cost-share amount as shown on the Explanation of Benefits.

4. Charges for the completion of claim forms and submission of required information for determination of benefits are not payable.

5. Consultation, diagnosis, prescriptions, etc. are considered part of the examination/evaluation or procedure performed.

6. Local anesthesia is considered integral to the procedure(s) for which it is provided and is included in the fee for the procedure(s).

7. Infection control procedures and fees associated with compliance with Occupational Safety & Health Administration (OSHA) and/or other governmental agency requirements are considered to be part of the dental services provided.

8. Postoperative care and evaluation are included in the fee for the service.

9. The fee for medicaments/solutions is part of the fee for the total procedure.

10. Procedure codes may be modified by the contractor based on the description of service and submitted supporting documentation.

11. For procedures limited to a certain number during a 12-month period, the 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods.

12. Procedures denied due to time limitations or performed prior to the TRDP enrollment effective date are not covered.

13. Procedures done for cosmetic purposes are not covered benefits. Payment is the patient's responsibility.

14. Covered procedures are payable only upon completion of the procedure billed.

15. Services must be necessary and meet accepted standards of dental practice. Services determined to be unnecessary or which do not meet accepted standards of practice are not billable to the patient by a participating provider unless the provider notifies the patient of his/her liability prior to treatment and the patient chooses to receive the treatment. Participating providers should document such notification in their records.

16. Medical procedures as well as dental procedures coverable as adjunctive dental care under TRICARE medical policy are not covered under the TRDP.

17. An "**R**" to the right of the procedure code means "by report" and that these services will be paid only in unusual circumstances, and that documentation of the diagnosis, necessity and reason for the treatment must be provided by the dentist to determine benefits. For procedure codes that indicate "by report", the contractor may utilize their best business practices to determine whether or not there is a necessity for the "by report" requirement. The contractor may not add new "by report" requirements to procedure codes that do not indicate an "R".

18. An "**X**" to the right of the procedure code means that these services will be paid only when a current radiograph is submitted with the dental claim. For procedure codes that indicate an "X", the contractor may utilize their best business practices to determine whether or not there is a necessity for the submission of a current radiograph with the dental claim. The contractor may not add new "radiographs required" requirements to procedure codes that do not indicate an "X".

3. Diagnostic Services

Attachment J-3B
Benefits, Limitations and Exclusions
Basic Program

Coverage: **100%**
Patient Pays: **0%**
Subject to Deductible: **No**
Applies to Maximum: **No**

D0120		Periodic oral evaluation - established patient
D0145		Oral evaluation for a patient under three years of age and counseling with a primary caregiver
D0150		Comprehensive oral evaluation—new or established patient
D0160	**R**	Detailed and extensive oral evaluation—problem-focused
D0170	**R**	Re-evaluation—limited, problem-focused (established patient; not post-operative visit)
D0180		Comprehensive periodontal evaluation—new or established patient
D0210		Intraoral—complete series (including bitewings)
D0220		Intraoral—periapical first film
D0230		Intraoral—periapical each additional film
D0240		Intraoral—occlusal film
D0270		Bitewing—single film
D0272		Bitewings—two films
D0273		Bitewings—three films
D0274		Bitewings—four films
D0277		Vertical bitewings—seven to eight films
D0330		Panoramic film
D0425	**R**	Caries susceptibility tests
D0460		Pulp vitality tests

The following policies apply to diagnostic services:

1. Limited oral evaluations are only covered when performed on an emergency basis.

2. A comprehensive oral examination/evaluation is payable once per provider or group practice per year. Additional examinations/evaluations are considered periodic examinations/evaluations and are paid as such.

3. Payment is limited to two examinations/evaluations, comprehensive and/or periodic, in a 12-month period.

4. The 12-month benefit period begins with the first date any covered service of this nature was received and ends 365 days later, regardless of the total services used within the benefit period. Unused benefits will not be carried over to subsequent benefit periods.

5. An examination/evaluation fee is not payable when a charge is not usually made or is included in the fee for another procedure.

6. Examinations/evaluations by specialists are payable as comprehensive or periodic examinations/evaluations and are counted towards the two-in-12-months limitation on examinations/evaluations.

7. A full-mouth series (complete series) of radiographs includes bitewings. Any additional film taken with a complete radiographic series is considered integral to the complete series.

8. A panoramic radiograph taken with any other film is considered a full-mouth series and is paid as such, and is subject to the same benefit limitations.

9. If the total fee for individually listed radiographs equals or exceeds the fee for a complete series, these radiographs are paid as a complete series and are subject to the same benefit limitations.

10. Payment for more than one of any category of full-mouth radiographs within a 48-month period is the patient's responsibility. If a full-mouth series is denied because of the 48-month limitation, it cannot be reprocessed and paid as bitewings and/or additional films.

11. Payment for panoramic radiograph is limited to one within a 48-month period.

12. Payment for periapical films (other than as part of a full-mouth series) is limited to four within a 12-month period except when done in conjunction with emergency services and submitted by report.

13. Payment for a bitewing survey, whether single, two, three, four or vertical film(s), including those taken as part of a complete series, is limited to one within a 12-month period.

14. Radiographs of non-diagnostic quality are not payable.

15. Duplication of radiographs for administrative purposes is not payable.

16. Test reports must describe the pathological condition, type of study and rationale.

17. Pulp vitality tests are payable only on a per-visit basis in connection with emergency care. Otherwise, they are considered part of other services rendered.

18. Procedures used for patient education, screening purposes, motivation or medical purposes are not covered benefits.

19. Detailed and extensive oral evaluations (D0160) are only payable by report upon review and are limited to once per patient per dentist, per lifetime. They will not be paid if related to noncovered medical or dental procedures.

3.1.20. Re-evaluations (D0170) are limited to problem-focused assessments of previously existing conditions, specifically, conditions relating to traumatic injury or undiagnosed continuing pain. They will not be paid if related to non-covered medical or dental procedures.

4. Preventive Services

Coverage: **100%**
Patient Pays: **0%**
Subject to Deductible: **No**
Applies to Maximum: **No**

D1110 Prophylaxis—adult (one per 12-month period)

D1120	Prophylaxis—child (two per 12-month period)
D1203	Topical application of fluoride — child
D1204	Topical application of fluoride — adult
D1206	Topical fluoride varnish, therapeutic application for moderate to high caries risk patients

The following policies apply to preventive services covered at 100%:

1. Persons age 14 years and older are considered to be adults.

2. One prophylaxis for adults and two prophylaxes for children are covered in a period of 12 consecutive months.

3. One fluoride treatment for adults and two fluoride treatments for children are covered in a period of 12 consecutive months.

4. Topical fluoride applications are covered only when performed as independent procedures. Use of a prophylaxis paste containing fluoride is payable as a prophylaxis only.

5. There are no provisions for special consideration for a prophylaxis based on degree of difficulty. Scaling or polishing to remove plaque, calculus and stains from teeth is considered to be part of the prophylaxis procedure.

6. Routine prophylaxes are considered integral when performed by the same provider on the same day as scaling and root planing, periodontal surgery and periodontal maintenance.

7. Preventive control programs, including oral hygiene programs and dietary instructions, are not covered benefits.

8. Routine oral hygiene instructions are considered integral to a prophylaxis service and are not separately payable.

Coverage: **80%**
Patient Pays**: 20%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D1351	Sealant—per tooth
D1510	Space maintainer—fixed - unilateral
D1515	Space maintainer—fixed - bilateral
D1520	Space maintainer—removable - unilateral
D1525	Space maintainer—removable - bilateral
D1550	Re-cementation of space maintainer
D1555	Removal of fixed space maintainer

The following policies apply to preventive services covered at 80%:

1. Sealants are payable once per tooth.

2. One sealent per tooth is covered in a three year period.

3. Sealants are payable for first permanent molars that are free from caries and restorations on the occlusal surface for patients under age 9 and for second permanent molars for patients under age 14.

4. Sealants for teeth other than permanent molars or for teeth with restorations or decay on the occlusal surface or for patients over age 13 are not covered.

5. Sealants completed on the same date of service and on the same tooth as a restoration on the occlusal surface are considered integral procedures and included in the fee for the restoration.

6. Sealants are covered for prevention of occlusal pit and fissure type cavities. Sealants done for treatment of sensitivity or for prevention of root or smooth surface caries are not payable.

7. The tooth number of the space to be maintained is required when requesting payment for space maintainers.

8. The fee for space maintainer-type appliances done in connection with orthodontic treatment is not covered.

9. Space maintainers for missing permanent teeth or primary anterior teeth (except primary cuspids) are not covered.

10. Only one space maintainer is paid for a space, except under unusual circumstances (where changes due to growth patterns or additional extractions make replacement necessary).

11. The fee for a stainless steel crown or band retainer is considered to be included in the total fee for the space maintainer.

12. Repair of a damaged space maintainer is not covered.

13. Re-cementation of space maintainers is payable once within 12 months.

14. Space maintainers are not covered for patients 14 years and older.

15. Removal of a fixed space maintainer (D1555) by the same dentist or dental practice that placed the space maintainer is not payable by contractor
or chargeable to the patient by a participating network dentist.

5. Restorative Services

Coverage: **80%**
Patient Pays: **20%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D2140	Amalgam—one surface, primary or permanent
D2150	Amalgam—two surfaces, primary or permanent

D2160		Amalgam—three surfaces, primary or permanent
D2161		Amalgam—four or more surfaces, primary or permanent
D2330		Resin-based composite—one surface, anterior
D2331		Resin-based composite—two surfaces, anterior
D2332		Resin-based composite—three surfaces, anterior
D2335		Resin-based composite—four or more surfaces or involving incisal angle (anterior)
D2390		Resin-based composite crown, anterior
D2910		Recement inlay, onlay, or partial coverage restoration
D2915		Recement cast or prefabricated post and core
D2920		Recement crown
D2930		Prefabricated stainless steel crown—primary tooth
D2931		Prefabricated stainless steel crown—permanent tooth
D2932		Prefabricated resin crown
D2933		Prefabricated stainless steel crown with resin window
D2951		Pin retention - per tooth, in addition to restoration
D2970	**R**	Temporary crown (fractured tooth)

The following policies apply to restorative services:

1. Coverage is for basic restorative services of amalgam fillings and anterior composite restorations. Working models taken in conjunction with restorative procedures are considered integral to the restorative procedures.

2. Payment is made for restoring a surface once within 24 months regardless of the number of combinations of restorations placed.

3. Replacement of a restoration by the same provider or group practice within 24 months is not a benefit. Duplication of an occlusal surface restoration is payable when it is necessary to restore one or more proximal surfaces due to subsequent caries.

4. A separate fee for services related to restorations, such as etching, bases, liners, local anesthesia, temporary restorations, polishing, preparation, supplies, caries removal agents, gingivectomy, infection control and expenses for compliance with OSHA regulations, etc. is not payable.

5. Restorations are covered benefits only when necessary to replace tooth structure loss due to fracture or decay. Restorations placed for any other reason, such as cosmetic purposes or due to abrasion, attrition, erosion, congenital or developmental malformations or to restore vertical dimension, are not covered.

6. Anterior restorations involving the incisal edge but not the proximal are paid as one-surface restorations, subject to review**.**

7. Posterior restorations not involving the occlusal surface are paid as one-surface restorations, subject to review.

8. Posterior restorations involving the proximal and occlusal surfaces on the same tooth are considered connected for payment purposes, subject to review.

9. X-rays may be requested for anterior resin restorations involving four or more surfaces or if the restoration involves the incisal angle.

10. Pin retention is payable once per restoration to the same provider or group practice and only payable in connection with a four or more surface restoration or a restoration involving the incisal angle. The restoration and pin retention must be done at the same appointment.

11. Replacement of a stainless steel crown or prefabricated resin crown by the same provider or group practice within 36 months is not covered.

12. Prefabricated stainless steel crowns with resin windows are payable only on anterior primary teeth.

13. Pin retention and buildups on primary teeth are covered in the fee for the restoration.

14. Pin retention and buildups done with stainless steel crowns on permanent teeth are included in the fee for the stainless steel crown.

15. Re-cementation of prefabricated crowns within six months of initial placement is included in the fee for the restoration.

16. After six months from the initial cementation date, re-cementation of crowns is payable once within 12 months.

17. Payment for a temporary crown (D2970) will be made for a damaged tooth as an immediate protective device once per tooth per lifetime unless justified by treating dentist, by report.

6. Endodontic Services

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D3120	**R**	Pulp cap—indirect (excluding final restoration)
D3220		Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to the dentinocemental junction and application of medicament
D3221		Pulpal debridement, primary and permanent teeth
D3222		Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230		Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)
D3240		Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)
D3310		Root canal therapy—anterior (excluding final restoration)
D3320		Root canal therapy—bicuspid (excluding final restoration)
D3330		Root canal therapy—molar (excluding final restoration)
D3332	**R**	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

D3346	Retreatment of previous root canal therapy—anterior
D3347	Retreatment of previous root canal therapy—bicuspid
D3348	Retreatment of previous root canal therapy—molar
D3351	Apexification/recalcification—interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
D3353	Apexification/recalcification—final visit (includes completed root canal therapy—apical closure/calcific repair of perforations, root resorption, etc.)
D3410	Apicoectomy/periradicular surgery—anterior
D3421	Apicoectomy/periradicular surgery—bicuspid (first root)
D3425	Apicoectomy/periradicular surgery—molar (first root)
D3426	Apicoectomy/periradicular surgery (each additional root)
D3430	Retrograde filling—per root
D3450	Root amputation—per root
D3920	Hemisection (including any root removal), not including root canal therapy

The following policies apply to endodontic services:

1. An indirect pulp cap is payable only by report with radiographs documenting a near exposure of the pulp and when the final restoration is not completed for at least 60 days. An indirect pulp cap is included in the fee for the restoration when the restoration is placed in less than 60 days.

2. An indirect pulp cap is only payable once per tooth by the same provider.

3. A direct pulp cap is included in the fee for the restoration or palliative treatment.

4. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same provider or group practice is to be included in the fee for the root canal therapy.

5. A paste-type root canal filling incorporating formaldehyde or paraformaldehyde is not a benefit.

6. Endodontic procedures in conjunction with overdentures are not covered benefits.

7. The completion date for endodontic therapy is the date the tooth is sealed.

8. Retreatment of apical surgery or root canal therapy by the same provider or group practice within 24 months is considered part of the original procedure.

9. Apexification is payable only on permanent teeth with incomplete root development or for repair of perforation. Otherwise, the fee is included in the fee for the root canal.

10. Payment for gross pulpal debridement is limited to the relief of pain prior to conventional root canal therapy and when performed by a provider not completing the endodontic therapy.

11. Incompletely filled root canals, other than for reason of an inoperable or fractured tooth, are not covered.

12. A therapeutic pulpotomy is payable on primary teeth only. One pulpotomy is payable per tooth.

13. Partial pulpotomy for apexogenesis will be covered only on permanent teeth and once per tooth per lifetime. The procedure is considered integral if performed on the same day or within 30 days/same tooth/same provider/same office as root canal therapy or codes D3351-D3353.

7. Periodontic Services

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D4210	**R**	Gingivectomy or gingivoplasty—four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	**R**	Gingivectomy or gingivoplasty—one to three contiguous teeth or bounded teeth spaces per quadrant
D4240	**R**	Gingival flap procedure, including root planing—four or more contiguous teeth or bounded teeth spaces per quadrant
D4241	**R**	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant
D4245	**R**	Apically positioned flap
D4260	**R**	Osseous surgery (including flap entry and closure)—four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	**R**	Osseous surgery (including flap entry and closure)—one to three contiguous teeth or bounded teeth spaces per quadrant
D4263	**R**	Bone replacement graft—first site in quadrant
D4264	**R**	Bone replacement graft—each additional site in quadrant
D4266	**R**	Guided tissue regeneration—resorbable barrier, per site
D4267	**R**	Guided tissue regeneration—nonresorbable barrier, per site (includes membrane removal)
D4270	**R**	Pedicle soft tissue graft procedure
D4271	**R**	Free soft tissue graft procedure (including donor site surgery)
D4273	**R**	Subepithelial connective tissue graft procedures, per tooth
D4341	**R**	Periodontal scaling and root planing—four or more teeth per quadrant
D4342	**R**	Periodontal scaling and root planing—one to three teeth per quadrant
D4355	**R**	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis
D4910		Periodontal maintenance
D4920	**R**	Unscheduled dressing change (by someone other than treating dentist)

The following policies apply to periodontic services:

1. Documentation of the need for periodontal treatment includes periodontal pocket charting, case type, prognosis, amount of existing attached gingiva, etc. Periodontal pocket charting should indicate the area/quadrants/teeth involved and is required for most procedures.

2. Gingivectomy/gingivoplasty in conjunction with and for the purpose of placement of restorations is included in the fee for the restorations.

3. Gingivectomy/gingivoplasty is considered to be part of the gingival flap procedures or osseous surgery at the same site and, therefore, not payable with these procedures.

4. Root planing performed in the same quadrant within 30 days prior to periodontal surgery is considered to be included in the fee for the surgery.

5. Up to four different quadrants of root planing are payable in a 24-month period with documentation of case type II periodontal disease. All procedures must be completed within 90 days.

6. Osseous, gingival and synthetic grafts must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis.

7. Bone grafts and guided tissue regeneration must be submitted with documentation. These procedures are payable only for treatment of functional teeth with a reasonable prognosis. These procedures are not a covered benefit when performed in connection with ridge augmentation, apicoectomies, extractions, implants or other non-periodontal surgical procedures.

8. Periodontal soft tissue grafts require a narrative report documenting the diagnosis and necessity for the procedure.

9. Periodontal surgical services include all necessary postoperative care, finishing procedures, splinting and evaluation for three months, as well as any surgical re-entry for three years, if performed by the same provider.

10. Routine prophylaxes are considered integral when performed by the same provider on the same day as scaling and root planning, periodontal surgery and periodontal maintenance.

11. Periodontal maintenance is a benefit subsequent to active periodontal therapy and subject to the time limitations for prophylaxes.

12. An apically positioned flap is subject to documentation when performed and when not related to implants.

13. Full-mouth debridement is a benefit once per patient per lifetime.

8. Oral Surgery Services

Coverage: **60%**
Patient Pays: **40%**
Subject to Deductible: **Yes**

Applies to Maximum: **Yes**

D7111		Extraction, coronal remnants—deciduous tooth
D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	**X**	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	**X**	Removal of impacted tooth—soft tissue
D7230	**X**	Removal of impacted tooth—partially bony
D7240	**X**	Removal of impacted tooth—completely bony
D7250	**X**	Surgical removal of residual tooth roots (cutting procedure)
D7260		Oroantral fistula closure
D7261		Primary closure of a sinus perforation
D7270		Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280		Surgical access of an unerupted tooth
D7285	**R**	Biopsy of oral tissue—hard (bone, tooth)
D7286	**R**	Biopsy of oral tissue—soft
D7290	**R**	Surgical repositioning of teeth
D7291	**R**	Transseptal fiberotomy/supra crestal fiberotomy
D7310		Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant
D7311		Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant
D7910	**R**	Suture of recent small wounds—up to 5 cm
D7911	**R**	Complicated suture—up to 5 cm
D7912	**R**	Complicated suture—greater than 5 cm
D7971		Excision of pericoronal gingiva

The following policies apply to oral surgery services:

1. Unsuccessful extractions are not covered.

2. Routine post-operative care, including office visits, local anesthesia and suture removal, is included in the fee for the extraction.

3. All hospital costs and any additional fees charged by the provider arising from procedures rendered in the hospital are the patient's responsibility.

4. Surgical removal of impactions is payable according to the anatomical position.

5. Procedure D7241 is not a covered procedure. However, an allowance will be made for a D7240 upon x-ray review for degree of difficulty.

6. The fee for root recovery is included in the treating dentist's or group practice's fee for the extraction.

7. The fee for reimplantation of an avulsed tooth includes the necessary wires or splints, adjustments and follow-up visits.

8. Surgical exposure of an impacted or unerupted tooth to aid eruption is payable once per tooth and includes post-operative care.

9. Excision of pericoronal gingiva is payable once per tooth.

10. Laboratory charges for histopathologic examinations/evaluations (D0501) are not covered.

11. Biopsies are defined as the surgical removal of tissues specifically for histopathologic examination/evaluation. Removal of tissues during other procedures (such as extractions and apicoectomies) is not payable as a biopsy.

12. Incision and drainage on the same date of service with any palliative or oral surgery procedure is not payable. The procedure is considered part of those services.

9. General Services

The TRDP will provide coverage for the following services. To be eligible, these services must be directly related to the covered services already listed.

Emergency Services

Coverage: **100%**
Patient Pays: **0%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D0140 Limited oral evaluation—problem focused

Coverage: **80%**
Patient Pays: **20%**
Subject to Deductible: **Yes**
Applies to Maximum: **Yes**

D9110 Palliative (emergency) treatment of dental pain—minor procedures

The following policies apply to emergency services:

1. Emergency palliative treatment is payable on a per visit basis, once on the same date. All procedures necessary for relief of pain are included.

2. Palliative pulpotomy/pulpectomy in conjunction with root canal therapy by the same dentist is to be included in the fee for the root canal therapy.

Drugs

Coverage: 60%

Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9610 **R** Therapeutic parenteral drug, single administration
D9612 **R** Therapeutic parenteral drugs, two or more administrations, different medications
D9630 **R** Other drugs and/or medicaments

The following policies apply to coverage of drugs and medications:

1. Drugs and medications not dispensed by the dentist and those available without prescription or used in conjunction with medical or non-covered services are not covered benefits.

2. The fee for medicaments/solutions is part of the fee for the total procedure.

3. Reimbursement for pharmacy-filled prescriptions is not a benefit.

4. Fluoride gels, rinses, tablets and other preparations for home use are not covered benefits.

5. Therapeutic drug injections are only payable in unusual circumstances, which must be documented by report. They are not benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

Post-Surgical Services

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9930 **R** Treatment of complications (post-surgical), unusual circumstances

The following policies apply to post-surgical services:

1. Post-operative care and/or suture removal done by the same dentist who rendered the original procedure is not a benefit.

Fixed Partial Denture Sectioning

Coverage: 60%
Patient Pays: 40%
Subject to Deductible: Yes
Applies to Maximum: Yes

D9120 R Fixed partial denture sectioning

The following policies apply to coverage of fixed partial denture sectioning:

1. Fixed partial denture sectioning is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

2. If fixed partial denture sectioning is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is not allowed unless the sectioning is performed by a different dentist or group practice.

3. Polishing and recontouring are considered an integral part of the fixed partial denture sectioning.

10. Exclusions

The following services are not benefits under the basic TRDP:

1. Services for injuries or conditions that are covered under Worker's Compensation or Employer's Liability Laws.

2. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.

3. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county or other political subdivision.

4. Those for which the member would have no obligation to pay in the absence of this or any similar coverage.

5. Those performed prior to the member's effective coverage date.

6. Those incurred after the termination date of the member's coverage unless otherwise indicated.

7. Medical procedures and dental procedures coverable as adjunctive dental care under TRICARE medical policy.

8. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).

9. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to: equilibration and periodontal splinting.

10. Prescribed or applied therapeutic drugs, premedication, sedation, analgesia and general anesthesia.

11. Drugs, medications, fluoride gels, rinses, tablets and other preparations for home use.

12. Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist.

13. Those not meeting accepted standards of dental practice.

14. Those which are for unusual procedures and techniques.

15. Plaque control programs, oral hygiene instruction, and dietary instruction.

16. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation,

17. Gold foil restorations.

18. Premedication and inhalation analgesia.

19. House calls and hospital visits.

20. Experimental procedures.

21. Telephone consultations.

22. Those performed by a provider who is compensated by a facility for similar covered services performed for members.

23. Those resulting from the patient's failure to comply with professionally prescribed treatment.

24. Any charges for failure to keep a scheduled appointment or charges for completion of a claim form.

4.25. Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.

26. Duplicate and temporary devices, appliances, and services.

27. All hospital costs and any additional fees charged by the dentist for hospital treatment.

28. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).

29. Implants (materials implanted into or on bone or soft tissue), maintenance of implants or the removal of implants.

30. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.

31. Replacement of existing restorations for any purpose other than to restore tooth structure lost due to fracture or decay.

32. Orthodontic services.

33. Prostodontic services.

34. Cast crowns, inlays, onlays or partial crowns.

35. Treatment provided outside the United States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands or Canada.

36. Treatment by anyone other than a dentist or person who, by law, may provide covered dental services.

37. Procedures not specifically listed in this attachment by code number.

38. Services submitted by a provider which are for the same services performed on the same date for the same member by another provider.

BASIC PROGRAM
Benefits, Plan Coverage, Deductibles and Maximums

Benefit Categories	Plan Coverage In All Years
Diagnostic Services	100%
Preventive Services	80%-100%
Restorative Services	80%
Endodontic Services	60%
Periodontic Services	60%
Oral Surgery Services	60%
Emergency Services	80%-100%
Drugs	60%
Post-Surgical Services	60%

Deductible

Annual deductible per patient (Not to exceed $150.00 per family)	$50

(Note: Diagnostic & preventive procedures covered at 100% are exempt from the annual deductible)

Maximums per patient

Annual maximum	$1,000

(Note: Diagnostic & preventive procedures covered at 100% are exempt from the annual maximum)

Attachment J-4A
TRDP Claims File Data Elements

TRDP Claims File Data Elements

Data File Requirements:

1. File Content: Monthly data feeds, reflecting previous month's claim activity.

2. Format: ASCII File, Fixed Length, and in order listed below.

3. Contractor will submit the entire Claims database each month.

4. Method of Delivery to Government: TRDP files will be sent to the MHS Data Repository (MDR) via secure FTP, to a fixed IP address provided by the Government.

Description of Data File Elements:

Col. No.					
1	Sponsor SSN	9	1-9	A/N	Social Security Number (SSN) of the sponsor.
2	Patient PIN ID	3	10-12	A/N	A Personal Identification Number (PIN) assigned sequentially to each dependent within a contract for the purpose of unique patient identification during claims processing. [*Note: The combination of Sponsor SSN and patient PIN identifies a unique individual.]*
3	DEERS ID	14	13-26	A/N	The identifier assigned by Defense Enrollment Eligibility Reporting System (DEERS) that is used to represent a patient within a Department of Defense Electronic Data Interchange (DoD EDI_PN).
4	Relationship Code	1	27	A/N	Categorization of the relationship of a patient to the subscriber (sponsor). Coded as follows: 1 = Self (Applicant Subscriber, also Sponsor) 2 = Spouse (Dependent) 3 = Child (Dependent) 4 = Handicapped (Dependent) 5 = Sponsored (Dependent)

Attachment J-4A
TRDP Claims File Data Elements

Col. No.					
5	Type of Contract	1	28	A/N	Code designating the type of contract (also called Enrollment Type). Coded as follows: 1 or 2 = Sponsor 3 or 7 = Individual coverage (i.e., one dependent) 4 or 9 = Family coverage (i.e., more than one dependent)
6	Patient Gender	1	29	A/N	Service member's sex code. Coded as follows: F = Female M = Male X = Unknown
7	Patient Birth Date	8	30-37	A/N	Patient's birth date. Format: YYYYMMDD
8	Branch of Service	1	38	A/N	Code representing the sponsor's branch of service. Coded as follows: A = Army C = Coast Guard F = Air Force M = Marine Corps N = Navy O = Commissioned Corps of the National Oceanographic and Atmospheric Administration (NOAA) P = Commissioned Corps of the Public Health Service
9	Phone Number	14	40-53	A/N	The home telephone number of the patient. Format: Area code, exchange, and number (10 digits) plus four positions for extension. (No parentheses, hyphens or spaces.)
10	Performing Provider Number	9	54-62	A/N	A unique number assigned by the contractor to the individual who performs dental services.
11	Provider Tax ID	9	63-71	A/N	The Internal Revenue Service assigned Taxpayer Identification Number (TIN) of the provider.
12	National Provider ID (NPI)	14	72-85	A/N	National Provider Identification (NPI) number of the provider rendering the dental services.
13	Performing Provider Zip	5	86-90	A/N	ZIP code of the performing provider's business location.

Attachment J-4A
TRDP Claims File Data Elements

Col. No.					
14	Performing Provider Specialty	3	91-93	A/N	Code describing the performing provider's specialty. See Appendix A-1.
15	Provider Network Status	1	94	A/N	Indicates whether or not the provider is a network or non-network provider. Coded as follows: 1 = Network provider 2 = Non-network provider 3 = Not eligible
16	Provider Suffix	3	95-97	A/N	The Professional Degree which a doctor receives upon graduation from a college or university (e.g., DDS, DMD).
17	Billing Provider Number	9	98-106	A/N	A unique number assigned by the contractor to an individual or organization that bills for dental services performed. *[Note: May or may not be the same as the Performing Provider.]*
18	Billing Provider Zip	5	107-111	A/N	The ZIP Code of the billing provider's business location.
19	Billing Provider Specialty	3	112-114	A/N	Code describing the billing provider's specialty. See Appendix A-1.
20	Claim Number	13	115-127	A/N	A unique number for each claim. Format for first eleven positions: YYJJJBBBBSS YY = last two digits of year JJJ = julian day BBBB = batch number SS = sequence number of item within batch *[Note: Last two positions are reserved for future use.]*
21	Claim Line-Item Number	4	128-131	A/N	The line number of each detail line of services on the claim. Range: 0001 – 9999
22	Processed Status	1	132	A/N	The processing status of each line of a claim. Coded as follows: A = Active J = Adjusted V = Voided

Col. No.					
23	Line-Item Final Status	1	133	A/N	The claim processing final status for the line-item. Coded as follows: A = Approved R = Rejected
24	Claim Rejection Reason Code	5	134-138	A/N	The reason for the rejection of the (entire) claim. See Appendix A-2.
25	Line-Item Rejection Reason Code	5	139-143	A/N	The reason for the rejection of the line-item within the claim. See Appendix A-2.
26	Special Processing Code	2	144-145	A/N	D1 = TRICARE Retiree Dental Program – Basic (2013-2018) D2 = TRICARE Retiree Dental Program – Enhanced (U.S., District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands and Canada) (2013-2018) D3 = TRICARE Retiree Dental Program – Enhanced (all other overseas locations) (2013-1018)
27	Alternate Treatment Code	2	146-147	A/N	Code representing the type of alternate treatment which was allowed for processing and payment. Coded as follows: AA = Dental Advisor Alternate Materials AO = Dental Advisor Review Optional Treatment AS = Dental Advisor Allows Single Crown BA = Benefit Automatic Alternate Materials BC = Benefit Automatic Amalgams and Composites BD = Benefit Automatic Over Denture BI = Benefit Automatic Basic Restoration BL = Benefit Automatic Metal Inlay/Onlay BO = Benefit Automatic Optional Treatment BP = Benefit Automatic Prefab Post and Core
28	Benefit Category	6	148-153	A/N	Category into which the dental benefit falls. See Appendix A-3
29	Date of Service	8	154-161	A/N	The date that the dental services were first provided for this claim detail line. Format: YYYYMMDD

Col. No.					
30	End Date of Service	8	162-169	A/N	The last date when dental services were provided for this claim detail line. Format: YYYYMMDD
31	Claim Receipt Date	8	170-177	A/N	The date that the claim was received for payment. Format: YYYYMMDD
32	Claim Paid Date	8	178-185	A/N	The date that the claim was paid. Format: YYYYMMDD
33	Claim Finalized Date	8	186-193	A/N	The date that the claim was adjudicated and payment decision made. Format: YYYYMMDD
34	Date of Last Exam	8	194-201	A/N	The date of the patient's last dental examination. Format: YYYYMMDD
35	CDT Procedure Code	5	202-206	A/N	Current Dental Terminology (CDT) procedure code for the patient.
36	CDT Version	2	207-208	A/N	The CDT version that was used to determine the procedure code. Coded as follows: First position: last digit of year (e.g., 5 for 2005) Second position: reserved for future use
37	Number of Services	4	209-212	A/N	The number of services identified on this claim detail line.
38	Adjustment Reason	2	213-214	A/N	Code identifying the reason for adjustment (or non-payment of services) of this claim detail line item. See Appendix A-4

Col. No.					
39	Adjustment Code	1	215	A/N	Code indicating the reason an adjustment was made to this claim detail line. Coded as follows: A = Additional payment B = History change C = Refund reprocess D = Cancel refund E = Transfer funds F = Utilization transfer/original (intraplan) G = Utilization transfer/secondary (intraplan) H = Administrative I = Refund J = Product line transfer (interface claim)
40	Tooth Code	2	216-217	A/N	Code indicating the tooth entered on the pricing grid on the Claim Adjudication screen for this claim detail line. See Appendix A-5.
41	Anterior/Posterior Indicator	1	218	A/N	Indicates anterior or posterior location. Coded as follows: A = Anterior P = Posterior
42	Buccal Surface Indicator	1	219	A/N	Indicates buccal surface. Coded as follows: N = No Y = Yes
43	Distal Surface Indicator	1	220	A/N	Indicates distal surface. Coded as follows: N = No Y = Yes
44	Facial Surface Indicator	1	221	A/N	Indicates facial surface. Coded as follows: N = No Y = Yes
45	Incisal Surface Indicator	1	222	A/N	Indicates incisal surface. Coded as follows: N = No Y = Yes

Col. No.					
46	Lingual Surface Indicator	1	223	A/N	Indicates lingual surface. Coded as follows: N = No Y = Yes
47	Mesial Surface Indicator	1	224	A/N	Indicates mesial surface. Coded as follows: N = No Y = Yes
48	Occlusal Surface Indicator	1	225	A/N	Indicates occlusal surface. Coded as follows: N = No Y = Yes
49	Mouth area code	2	226-227	A/N	Identifies the area of the mouth involved. Coded as follows: L = Tooth No's 9-24 R = Tooth No's 1-8 & 25-32 00 = Full Mouth 01 = Tooth No's 1-16 02 = Tooth No's 17-32 09 = Tooth No's >32 10 = Upper Right Quadrant 20 = Upper Left Quadrant 30 = Lower Left Quadrant 40 = Lower Right Quadrant
50	Copayment	9	228-236	A/N	The amount, in dollars, of the patient co-payment for this service. Format: "dddddd.cc"
51	Deductible	9	237-245	A/N	Portion of amount allowed which is applied toward the patient or family deductible for the option year. Format: "dddddd.cc" *[NOTE: This value is 0.0, since there is no deductible for the TRDP contract.]*
52	Provider Charge	9	246-254	A/N	The amount, in dollars, charged by the provider for services. Format: "dddddd.cc"

Col. No.					
53	Allowed Amount	9	255-263	A/N	The amount, in dollars, allowed under the plan for the specified services. Format: "dddddd.cc"
54	Approved Amount	9	264-272	A/N	The approved amount, in dollars, that the plan would pay towards the dental services. Format: "dddddd.cc"
55	Other Carrier Payment	9	273-281	A/N	The amount, in dollars, paid by Other Health Insurance (OHI) toward the Provider Charges. Format: "dddddd.cc"
56	Third Party Liability	9	282-290	A/N	The amount, in dollars, paid by Third Party Liability (TPL) carriers toward the Provider Charges. Format: "dddddd.cc"
57	Alteration Amount	9	291-299	A/N	The amount, in dollars, of any alteration amount approved. Format: "dddddd.cc"
58	Alteration Type	3	300-302	A/N	The type of alteration made to the claim. See Appendix A-6.
59	Optional Treatment Identifier	1	303	A/N	Identifies optional treatment. Coded as follows: Y = Yes. A dental advisor reviewed the service reported on the claim detail line and determined that optional treatment could have been performed. N = No. Either such review did not occur, or review did not result in a determination of any optional treatment.
60	Prior Placement Date	8	304-311	A/N	The date of prior placement. Format: YYYYMMDD.
61	Replacement Reason	1	312	A/N	Code indicating the reason a specific crown, prosthesis, inlay or onlay is to be replaced. Coded as follows: 1 = Lost 2 = Broken 3 = Accident 4 = No longer serviceable
62	Length of Ortho Treatment	2	313-314	A/N	Total number of months of active treatment scheduled for an approved orthodontic treatment plan.

Col. No.					
63	Ortho Indicator	1	315	A/N	Indicates orthodontic treatment. Coded as follows: Y = Yes, the service line items associated with the claim are related to the orthodontic care of the patient. N = No, service line items are not related to orthodontic care.
64	Ortho Amount	9	316-324	A/N	The amount charged for orthodontics treatment. Format: "dddddd.cc"
65	Treatment Type	1	325	A/N	Code indicating the status of a restorative prosthetic treatment. Coded as follows: I = Initial placement P = Prior placement
66	Blank field	1	326	A/N	Coded as follows: Z = no data
67	Adjustment Voided Service Line Item #	4	327-330	A/N	Number of the claim detail line that has been voided. (also see Field 22: Claim Line-Item Number)
68	Reserved for Future Use		332-400	A/N	Placeholder for future requirements.

APPENDIX A-1: PROVIDER SPECIALY CODES

CODE	
020	**Anesthesia**
025	**General Dentistry**
032	**Oral Surgery**
033	**Endodontics**
034	**Orthodontics**
036	**Pediatric Dentistry**
037	**Periodontics**
038	**Prosthodontics**
079	**Certified Registered Nurse Anesthetist**
084	**Multi-Specialty**
110	**Dental Hygienist**

APPENDIX A-2: REJECTION REASON CODES

	Five positions: the first position is alpha and the second through fifth positions are numeric.
A0001 – A9999	Policy
B0001 – B9999	Benefits
C0001 – C9999	Radiograph
D0001 – D9999	Provider
E0001 – E9999	Edits
H0001 – H9999	History
L0001 – L9999	Liability
P0001 – P9999	Procedure
Q0001 – Q9999	Unknown - Advisor Rejections
R0001 – R9999	Pricing
S0001 – S9999	Subscriber
T0001 – T9999	Benefits
U0001 – U9999	Benefits
V0001 – V9999	Benefits
W0001 – W9999	Benefits
X0001 – X9999	Benefits

APPENDIX A-3: BENEFIT CATEGORY CODES

A SURG	ASSISTANT SURGERY
ANES	ANESTHESIA
CIO	CROWNS, INLAYS AND ONLAYS
D DIAG	DENTAL DIAGNOSTIC
D GENL	DENTAL GENERAL SERVICES
D ORAL	DENTAL ORAL SURGERY
D PREV	DENTAL PREVENTATIVE
D PROS	DENTAL PROSTHETIC
M ORAL	MEDICAL/SURGICAL ORAL SURGERY
M REST	MINOR RESTORATIVE
ORTHO	ORTHODONTIC
PERIO	PERIODONTIC
SURG	SURGERY

APPENDIX A-4: ADJUSTMENT REASON CODES

C	CODING/KEYING ERROR
E	DOCTOR/PROVIDER ID ERROR
I	REPORTING ERROR/MISSING INFORMATION
J	COMPUTER PROGRAMMING ERROR/SYSTEMS ERROR
K	DUPLICATE COVERAGE
M	DUPLICATE PAYMENT
N	FEE PAID INDICATOR/WRONG PAYEE
O	RETROACTIVE CANCELLED GROUP
R	ADVISOR REVIEW OF INQUIRY
S	MISSING MEDICAL INFORMATION
Z	OTHER
01	LIABILITY (SUBROGATION)
02	NON-DUPLICATION/COB
03	WORKER'S COMPENSATION
04	MOTOR VEHICLE
05	MAXIMUM CORRECTION
07	CO-INSURANCE CORRECTION
09	SPECIAL PROJECTS
10	EXCEPTION PAYMENT/CHARGED TO GROUP'S UTILIZATION
11	CUSTOMER CODED ERROR, INCLUDING BENEFITS AND DLPS
12	SUBSCRIBER DATA BASE ERROR, FILE DISCREPANCY
13	ADDITIONAL INFORMATION RECEIVED FROM PROVIDER

CODE	
14	PERSONAL IDENTIFICATION NUMBER (PINS) PROCESSING ERROR
16	DID NOT RECEIVE CHECK

APPENDIX A-5: TOOTH CODES

51	UPPER RIGHT 3RD MOLAR
52	UPPER RIGHT 2ND MOLAR
53	UPPER RIGHT 1ST MOLAR
54	UPPER RIGHT 2ND BICUSPID
55	UPPER RIGHT 1ST BICUSPID
56	UPPER RIGHT CUSPID
57	UPPER RIGHT LATERAL INCISOR
58	UPPER RIGHT CENTRAL INCISOR
59	UPPER LEFT CENTRAL INCISOR
60	UPPER LEFT LATERAL INCISOR
61	UPPER LEFT CUSPID
62	UPPER LEFT 1ST BICUSPID
63	UPPER LEFT 2ND BICUSPID
64	UPPER LEFT 1ST MOLAR
65	UPPER LEFT 2ND MOLAR
66	UPPER LEFT 3RD MOLAR
67	LOWER LEFT 3RD MOLAR
68	LOWER LEFT 2ND MOLAR
69	LOWER LEFT 1ST MOLAR
70	LOWER LEFT 2ND BICUSPID
71	LOWER LEFT 1ST BICUSPID
72	LOWER LEFT CUSPID
73	LOWER LEFT LATERAL INCISOR
74	LOWER LEFT CENTRAL INCISOR
75	LOWER RIGHT CENTRAL INCISOR
76	LOWER RIGHT LATERAL INCISOR
77	LOWER RIGHT CUSPID
78	LOWER RIGHT 1ST BICUSPID
79	LOWER RIGHT 2ND BICUSPID
80	LOWER RIGHT 1ST MOLAR
81	LOWER RIGHT 2ND MOLAR
82	LOWER RIGHT 3RD MOLAR

APPENDIX A-6: ALTERATION TYPE CODES

COP	COPAYMENT
LDM	LIFETIME DOLLAR EXCEEDING MAXIMUM
LSX	LIFETIME SERVICE DOLLAR EXCEEDING MAXIMUM
PCO	PROGRAM COINSURANCE
PDM	PROGRAM DOLLAR EXCEEDING MAXIMUM
SPA	SPECIAL ALTERATION

APPENDIX A-7: SPECIAL PROCESSING CODES

D1	TRICARE Retiree Dental Program – Basic (2013-2018)
D2	TRICARE Retiree Dental Program – Enhanced (United States, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands and Canada) (2013-2018)
D3	TRICARE Retiree Dental Program – Enhanced (all other overseas locations) (2013-1018)

Attachment J-4B
TRDP Provider File Data Element Layout

Data File Requirements:

1. Data file must be designed so that Provider Tax ID / Provider Identifier Suffix will link to Claim File and Data Elements Required by TMA for TRICARE Dental.

2. Contractor must submit the entire Provider database each month, sorted ascending by Provider Number, inclusive of all providers that accept TRICARE Dental assignment.

3. File Content: Previous month provider data feeds.

4. Format: ASCII File, Fixed Length, and in order listed below.

5. Method of Delivery to Government: TRDP files will be sent to the MHS Data Repository (MDR) via secure FTP, to a fixed IP address provided by the Government.

Description of Data File Elements:

No.					
1	Provider Tax Identifier	9	1-9	A/N	The Internal Revenue Service assigned Taxpayer Identification Number (TIN) of the provider.
2	Provider Identifier	9	10-18	A/N	A unique number assigned to an individual or organization which performs or facilitates health care services.
3	Provider/Group Name	53	19-71	A/N	The business name under which a health care provider (individual or group) operates and reports taxable income.
4	Provider Specialty	3	72-74	A/N	Code describing the provider's specialty. See Appendix A-1.
5	Provider Social Security Number	9	75-83	A/N	Social Security (SSN) of the dental provider. Can be left blank for foreign country providers. Do not insert dashes in the Social Security Number.
6	Provider Network Status	1	84	A/N	Indicates whether or not the provider is a network or non-network provider. Enter "1" for a Network Provider Enter "2" for a Non-network Provider
7	Provider Telephone Number	10	85-94	A/N	Business telephone number of the provider.

Description of Data File Elements Cont'd:

8	Provider Street Address Line 1	36	95-130	A/N	Provider's business street address line 1.
9	Provider Street Address Line 2	36	131-166	A/N	Provider's business street address line 2.
10	State	2	167-168	A/N	Provider's business state code. May be left blank for foreign country providers. See Appendix A-2.
11	Provider Zip Code	9	169-177	A/N	Provider's business zip code.
12	Country Code	3	178-180	A/N	Provider's business country code. See Appendix A-3.
13	National Provider Identifier	14	181-194	A/N	National Provider ID (NPI) number of the Provider
14	Reserved For Future Use	11	195-205	A/N	Placeholder for future requirements.

APPENDIX A-1: PROVIDER SPECIALTY CODES

020	Anesthesia
025	General Dentistry
032	Oral Surgery
033	Endodontics
034	Orthodontics
036	Pediatric Dentistry
037	Periodontics
038	Prosthodontics
079	Certified Registered Nurse Anesthetist
084	Multi-Specialty
110	Dental Hygienist

APPENDIX A-2: STATE CODES

United States

ALABAMA	AL		MAINE	ME		PENNSYLVANIA	PA
ALASKA	AK		MARYLAND	MD		RHODE ISLAND	RI
ARIZONA	AZ		MASSACHUSETTS	MA		SOUTH CAROLINA	SC
ARKANSAS	AR		MICHIGAN	MI		SOUTH DAKOTA	SD
CALIFORNIA	CA		MINNESOTA	MN		TENNESSEE	TN
COLORADO	CO		MISSISSIPPI	MS		TEXAS	TX
CONNECTICUT	CT		MISSOURI	MO		UTAH	UT
DELAWARE	DE		MONTANA	MT		VERMONT	VT
DISTRICT OF COLUMBIA	DC		NEBRASKA	NE		VIRGINIA	VA
FLORIDA	FL		NEVADA	NV		WASHINGTON	WA
GEORGIA	GA		NEW HAMPSHIRE	NH		WEST VIRGINIA	WV
HAWAII	HI		NEW JERSEY	NJ		WISCONSIN	WI
IDAHO	ID		NEW MEXICO	NM		WYOMING	WY
ILLINOIS	IL		NEW YORK	NY		UNKNOWN	ZZ
INDIANA	IN		NORTH CAROLINA	NC			
IOWA	IA		NORTH DAKOTA	ND			
KANSAS	KS		OHIO	OH			
KENTUCKY	KY		OKLAHOMA	OK			
LOUISIANA	LA		OREGON	OR			

United States Territories (considered as States for TRDP)

GUM	GUAM
PRI	PUERTO RICO
VIR	VIRGIN ISLANDS, U.S.

APPENDIX A-3: COUNTRY CODES

Afghanistan	AFG
Aland Islands	ALA
Albania	ALB
Algeria	DZA
American Samoa	ASM
Andorra	AND
Angola	AGO
Anguilla	AIA
Antarctica	ATA
Antigua and Barbuda	ATG
Argentina	ARG
Armenia	ARM
Aruba	ABW
Australia	AUS
Austria	AUT
Azerbaijan	AZE
Bahamas	BHS
Bahrain	BHR
Bangladesh	BGD
Barbados	BRB
Belarus	BLR
Belgium	BEL
Belize	BLZ
Benin	BEN
Bermuda	BMU
Bhutan	BTN
Bolivia	BOL
Bosnia and Herzegowina	BIH
Botswana	BWA
Bouvet Island	BVT
Brazil	BRA
British Indian Ocean Territory	IOT
British Virgin Islands	VGB
Brunei Darussalam	BRN
Bulgaria	BGR
Burkina Faso (formerly Upper Volta)	BFA
Burundi	BDI
Cambodia (formerly Khmer Republic/Kampuchea, Democratic)	KHM

COUNTRY AND/OR ISLAND	
Cameroon	CMR
Canada	CAN
Cape Verde	CPV
Cayman Islands	CYM
Central African Republic	CAF
Chad	TCD
Chile	CHL
China	CHN
Christmas Island	CXR
Cocos (Keeling)Islands	CCK
Colombia	COL
Comoros	COM
Congo (formerly Zaire)	COG
Congo, the Democratic Republic of the	COD
Cook Islands	COK
Costa Rica	CRI
Cote D'Ivoire	CIV
Cuba	CUB
Croatia	HRV
Cyprus	CYP
Czech Republic	CZE
Denmark	DNK
Djibouti (formerly French Afars and Issass)	DJI
Dominica	DMA
Dominican Republic	DOM
Ecuador	ECU
Egypt	EGY
El Salvador	SLV
Equatorial Guinea	GNQ
Eritrea	ERI
Estonia	EST
Ethiopia	ETH
Falkland Islands (Malvinas)	FLK
Faroe Island	FRO
Fiji	FJI
Finland	FIN
France	FRA
French Guiana	GUF
French Polynesia	PYF
French Southern Territories	ATF
Gabon	GAB
Gambia	GMB
Georgia	GEO

COUNTRY AND/OR ISLAND	
Germany	DEU
Ghana	GHA
Gibraltar	GIB
Greece	GRC
Greenland	GRL
Grenada	GRD
Guadeloupe	GLP
Guatemala	GTM
Guernsey	GGY
Guinea	GIN
Guinea-Bissau (formerly Portuguese Guinea)	GNB
Guyana	GUY
Haiti	HTI
Heard Island and McDonald Islands	HMD
Holy See (formerly Vatican City State)	VAT
Honduras	HND
Hong Kong	HKG
Hungary	HUN
Iceland	ISL
India	IND
Indonesia	IDN
Iran, Islamic Republic of	IRN
Iraq	IRQ
Ireland	IRL
Isle of Man	IMN
Israel	ISR
Italy	ITA
Jamaica	JAM
Japan	JPN
Jersey	JEY
Jordan	JOR
Kazakhstan	KAZ
Kenya	KEN
Kiribati (formerly Gilbert Islands)	KIR
Korea, Democratic People’s Republic of	PRK
Korea, Republic of	KOR
Kuwait	KWT
Kyrgyzstan	KGZ
Lao People’s Democratic Republic	LAO
Latvia	LVA
Lebanon	LBN
Lesotho	LSO
Liberia	LBR

COUNTRY AND/OR ISLAND	
Libyan Arab Jamahiriya	LBY
Liechtenstein	LIE
Lithuania	LTU
Luxembourg	LUX
Macao	MAC
Macedonia, the Former Yugoslav Republic of	MKD
Madagascar	MDG
Malawi	MWI
Malaysia	MYS
Maldives	MDV
Mali	MLI
Malta	MLT
Marshall Islands	MHL
Martinique	MTZ
Mauritania	MRT
Mauritius	MUS
Mayotte	MYT
Mexico	MEX
Micronesia, Federated States of	FSM
Moldova, Republic of	MDA
Monaco	MCO
Mongolia	MNG
Montenegro	MNE
Montserrat	MSR
Morocco	MAR
Mozambique	MOZ
Myanmar (formerly Burma)	MMR
Namibia	NAM
Nauru	NRU
Nepal	NPL
Netherlands	NLD
Netherlands Antilles	ANT
New Caledonai	NCL
New Zealand	NZL
Nicaragua	NIC
Niger	NER
Nigeria	NGA
Niue	NIU
Norfolk Island	NFK
Northern Mariana Islands	MNP
Norway	NOR
Oman (formerly Muscat and Oman)	OMN
Pakistan	PAK

COUNTRY AND/OR ISLAND	
Palau	PLW
Palestinian Territory, Occupied	PSE
Panama	PAN
Papua New Guinea	PNG
Paraguay	PRY
Peru	PER
Philippines	PHL
Pitcairn	PCN
Poland	POL
Portugal	PRT
Qatar	QAT
Reunion	REU
Romania	ROU
Russian Federation	RUS
Rwanda	RWA
Saint Helena	SHN
Saint Kitts and Nevis	KNA
Saint Lucia	LCA
Saint Pierre and Miquelon	SPM
Saint Vincent and the Grenadines	VCT
Samoa	WSM
San Marino	SMR
Sao Tome and Principe	STP
Saudi Arabia	SAU
Senegal	SEN
Serbia	SRB
Serbia and Montenegro (formerly Yugoslavia)	SCG
Seychelles	SYC
Sierra Leone	SLE
Singapore	SGP
Slovakia	SVK
Slovenia	SVN
Solomon Islands (formerly British Solomon Islands)	SLB
Somalia	SOM
South Africa	ZAF
South Georgia and the South Sandwich Islands	SGS
Spain	ESP
Sri Lanka (formerly Ceylon)	LKA
Sudan	SDN
Suriname	SUR
Svalbard and Jan Mayen	SJM
Swaziland	SWZ
Sweden	SWE

COUNTRY AND/OR ISLAND	
Switzerland	CHE
Syrian Arab Republic	SYR
Taiwan, Province of China	TWN
Tajikistan	TJK
Tanzania, United Republic of	TZA
Thailand	THA
Timor-Leste, Democratic Republic of	TLS
Togo	TGO
Tokelau	TKL
Tonga	TON
Trinidad and Tobago	TTO
Tunisia	TUN
Turkey	TUR
Turkmenistan	TKM
Turks and Caicos Islands	TCA
Tuvalu	TUV
Uganda	UGA
Ukraine	UKR
United Arab Emirates (formerly Trucial States)	ARE
United Kingdom	GBR
Uraguay	URY
Uzbekistan	UZB
Vanuatu (formerly New Hebrides)	VUT
Venezuela	VEN
Viet Nam	VNM
Virgin Islands, British	VGB
Wallis and Futuna	WLF
Western Sahara (formerly Spanish Sahara)	ESH
Yemen	YEM
Zambia	ZMB
Zimbabwe (formerly Southern Rhodesia)	ZWE

In accordance with HIPAA requirements, TRICARE utilizes the International Organization for Standardization (ISO) 3166 for country and island code determination. The ISO 3166 can also be used if more detailed information is required to assign territories and islands into these countries.

Quality Assurance Surveillance Plan (QASP)

For

TRICARE Retiree Dental Program (TRDP) Contract

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1. INTRODUCTION

1.1 Purpose

The purpose of this Quality Assurance Surveillance Plan (QASP) is to ensure that the Contractor satisfactorily performs the contract requirements, that the Government receives the quality of services defined in the contract and applicable TRICARE Management Activity (TMA) manuals, and to provide a planned process for assessing the Contractor's performance in a systematic manner across TMA. Performance assessment will be accomplished in accordance with TRICARE Acquisition Policies (TAPs) 37-01 - Management of Contractor Performance and 37-02 - Contractor's Performance Assessment Reporting System (CPARS), and the terms of the contract.

This plan is a "living" document that can be revised or modified by the Government as circumstances warrant. It is based on the premise that the Contractor, not the Government, is responsible for managing and ensuring that contract requirements are met and that quality controls meet the terms of the contract. It is not intended to provide details of how the Contractor accomplishes the work.

The surveillance/evaluation methods identified in the QASP, in concert with the Contractor's quality management and quality improvement procedures, will provide a comprehensive approach to contract performance assessment. Following contract award, this document will be reviewed by the COR to ensure that it will work in concert with the Contractor's Quality Management/Quality Improvement Plan. In areas where gaps or increased surveillance is warranted, adjustments may be made to the QASP and/or QM/QI Plan.

1.2Intent

The intent of this surveillance plan is to gain assurance the Contractor is performing contract requirements satisfactorily. As necessary, the Government will adjust its level of oversight to maintain assurance of satisfactory Contractor performance. The Contractor is responsible for implementing management and quality control processes that are adequate to meet the requirements of the contract. The role of the Government is to perform contract surveillance, ensuring contract requirements are met by the Contractor and contract objectives are achieved.

2. ROLES AND RESPONSIBILITIES:

The following individuals have the most direct roles for monitoring contract performance:

2.1 Contracting Officer (CO)

The individual(s) with a prescribed authority to enter into, administer, and/or terminate contracts and make related determinations and findings. CO responsibilities:

- Ensure that appropriate contractual remedies and solutions are applied when Contractors fail to meet contract requirements.

- Ultimately responsible for final determination of the adequacy of the Contractor's performance in accordance with the Federal Acquisition Regulation (FAR), Defense Federal Acquisition Regulation Supplement (DFARS), DoD directives, instructions and policy letters, and the TRICARE Acquisition Manual.

2.2 Contracting Officer's Representative (COR)

The individual(s) designated and authorized in writing by the CO to perform specific technical or administrative functions, and is the senior technical expert responsible for adequate surveillance of Contractor performance. A COR does not have the authority to change the contract terms, as this can only be accomplished by the CO. The COR:

- Defines, guides, and coordinates contract surveillance activities to ensure satisfactory Contractor performance of contract requirements.
- Ensures adequate resolution of Contractor technical performance issues.
- Performs SME duties in designated areas.
- Reviews SME documentation.
- Reviews the Contractor's Quality Management/Quality Improvement Program (QM/QIP) in coordination with SMEs for acceptable quality level in all areas of the contract.

2.3 Subject Matter Expert (SME)

The individual(s) designated by the Chief, TRICARE Dental Care Branch with in-depth knowledge of an area of Contractor performance. A SME may be designated for specific technical areas of the contract. SMEs are the "eyes and ears" relative to the actual performance of the contract. A SME does not have the authority to change the contract terms, as this can only be accomplished by the CO. A SME:

- Is an expert in the technical requirements of the contract in designated area(s).
- Knows and applies the procedures for documenting Contractor performance surveillance and assessment.
- Performs Contractor performance surveillance and assessment activities as required.
- Reviews Contractor deliverables and other reports for adequacy, accuracy, adverse performance trends, and assurance of mission accomplishment.

2.4 Other Government Resources

There are other TMA employees who will also observe the Contractor's performance or serve in a management role of these employees. These individuals will help facilitate the execution of the QASP by providing critical feedback of the Contractor's performance to the appropriate designee.

3. CONTRACT REQUIREMENTS

The contract requirements applicable to this QASP are listed in Section C of the contract. However, the Government is not limited to contract monitoring/surveillance for only those contract requirements included in the QASP. The Contractor is responsible for satisfactory

performance of all contract requirements and the Government will modify monitoring methods and requirements subject to monitoring as necessary.

4. CONTRACT DELIVERABLES (REPORTS)

The contract deliverables applicable to this QASP are included in Section J, Attachment J-6 of the contract.

5. CONTRACT QUALITY REQUIREMENTS

It is important to understand the responsibilities of the parties and distinguish between the quality control plan and this QASP. The Contractor is responsible for developing and managing an internal quality control program to meet the performance standards and requirements established in the contract and TMA manuals. This action is specified under the contract requirement Section C.7.15.2 which requires the Contractor to operate an internal QM/QIP. The role of the Government is to design, implement and conduct adequate contract surveillance and quality assurance to ensure contract requirements and standards are satisfactorily performed.

6. QUALITY ASSURANCE SURVEILLANCE

The methods of evaluating Contractor compliance may vary depending on the tasks specified by the contract. The COR is responsible for selection of the method(s) to be used and the specific detailing of the method(s). In determining the evaluation method, the COR should consider what the contract specifically calls for, how performance can be observed, and if the method of surveillance is adequate to assure the required level of performance has been achieved. In making this determination, the COR will also consider the Contractor's QM/QI Plan (see Attachment J-6 CDRL SP040).

This section describes the available methods to be used in verifying the Contractor's compliance with the contract requirements. Periodic (scheduled or non-scheduled) performance assessments will be accomplished utilizing a combination of assessment methods and metrics as identified in Appendix 1 that contains performance objectives, performance indicators, and frequencies and monitoring methods extracted from sections of the contract. Listed below are some methods to be used:

6.1 Contractor Self Reporting

The Government will use the Contractor's reports as part of its surveillance process for monitoring the performance of the contract requirements. The Government has specified the content, format and/or frequency of reports to be generated by the Contractor as stated in Section J, Attachment J-6 of the contract.

6.2 Customer Input

The SME may receive customer (e.g., beneficiaries, internal Government staff) input about the quality of services performed under the contract. These inputs maximize the Government's

resource potential and are considered in regular assessments as they may identify Contractor process improvement opportunities or required corrective actions. The SME will validate any input before corrective action is required by the Contractor.

6.3 Periodic Performance Reviews

Performance reviews are an effective tool for keeping performance on course, measuring performance levels, and making adjustments as necessary. More frequent opportunities than the required contract briefings with the Contractor are essential in maintaining focus on critical program areas and may occur as deemed necessary.

The SME will identify the specific review items to the Contractor in writing. The Contractor will provide the SME with written documentation of their internal processes of the specified review items. The SME will review this documentation and perform an onsite review if deemed necessary. The SME may be accompanied on the site visit by other Government employees when warranted.

7. DOCUMENTATION PROCEDURES

SMEs will review Contractor deliverables and other submittals (reports or plans) or any other information available and document evaluations in the Performance Assessment Tool (PAT) in accordance with (IAW) TMA established policies.

The Performance Assessment Tracking (PAT) system has been developed to provide standardized assessment and documentation of Contractor performance throughout the Military Health System. As the system of record for all TRICARE contracts, candid and fact based assessment of Contractor performance will be documented in PAT throughout the year.

The process for developing a Performance Assessment Plan in PAT is as follows:

a) List and consolidate requirements to be evaluated

   i) Begin with Section C and H requirements from the contract
   ii) Add manual requirements as deemed appropriate by the COR and/or Program Manager (i.e., Program Integrity)

b) Link requirements to Group, Subject Category and Subject Sub-Category

c) Perform a Risk Assessment (Appendix A)

d) Select Evaluation Frequency based on the result of the Risk Assessment. The purpose for determining Risk for each requirement is to provide a basis for selecting a Frequency of Evaluation for each requirement. The steps for determining Risk and Frequency of Evaluation are as follows:

i) Determine the probability (likelihood) that the Contractor will not meet a specific requirement.

(1) Low = less than 25% of the time
(2) Moderate = 25 to 75% of the time
(3) High = greater than 75% of the time

ii) Determine the severity of consequences if a problem would occur in that specific requirement. Use Table 2 as a guide for determining consequences.
iii) Then use Table 1 and the values identified in Steps 1 and 2 to find the value for Risk (Low, Moderate, or High).
iv) Finally, use the value for Risk as a guideline for determining Frequency of Evaluation.
(1) If Risk is High, then Frequency of Evaluation should be Monthly
(2) If Risk is Moderate, then Frequency of Evaluation should be Semi-Annual or Quarterly
(3) If Risk is Low, then Frequency of Evaluation should be Annual

v) However, if a requirement is to be viewed on the Monthly Performance Summary Report, it must be evaluated monthly, even though the Risk may be Moderate or Low. Senior management may also require that a given requirement be evaluated at a given frequency regardless of the determined Risk level.

2) Select Method of Evaluation.

3) Assign a SME for each requirement and an Assistant Evaluator (optional)

4) If a requirement is a key requirement to be shown on the Monthly Summary Report:

i) Select Key Requirement
ii) Type in Report Heading

5) If Metric Type is Assigned Percent Value:

i) Assign metric values for each requirement.
(1) Yellow
(2) Green (target metric value)
(3) Purple
(4) Blue
ii) Link the deliverable which will provide the metric value to the requirement.

Contract Requirements will be evaluated and those evaluations will be entered into the PAT system based on the frequency of review established in the Performance Assessment Plan. When performance does not meet standards, the SMEs shall follow the TAPs as identified in Section 1.1 and established business procedures for the TRDP contract. The SME shall notify the CO and COR accordingly. This documentation accumulated over the life of the contract

provides the ability to identify Contractors' strengths and weaknesses and is the basis for the annual Contractor Performance Assessment Reporting System (CPARS) Report.

8. ACCEPTANCE OF SERVICES

Services will be accepted as cited in Section E, Inspection and Acceptance of the Contract.

Appendix A

RISK ANALYSIS METHODOLOGY

The PAT system has been developed to provide standardized assessment and documentation of Contractor performance throughout the Military Health System. This risk analysis methodology is designed to aid the agency in documenting Contractor performance consistently. Risk level is assigned based on the probability (likelihood) that the Contractor will not meet the specific requirement along with the severity of consequences if this happens. Assessment of probability and consequences is based on experience with these processes, knowledge of the Contractor's strengths and weaknesses, familiarity with TRICARE program priorities, etc.

The following chart provides a guide to determining an overall Risk Level.

PROBABILITY	**Consequences**			
	Low	**Moderate**	**High**	
High: > 75%				**RISK**
Moderate: 25-75%				
Low: < 25%				

(Table 1)

HIGH RISK ELEMENTS: Any level of Probability with High Consequences

MODERATE RISK ELEMENTS: Moderate Probability with Moderate Consequences; High Probability with Low or Moderate Consequences

LOW RISK ELEMENTS: Low Probability with Low or Moderate Consequences; Moderate Probability with Low Consequences

Examples	
Requirement:	**Enrollment Timeliness**
Probability of Problem: (Contractor does not meet the standard)	**Moderate (25% – 75%)**
Consequence:	**Moderate**
Risk Level:	**Moderate (2)**
Requirement:	**Telephone Busy Signal (Blockage Rate)**
Probability of Problem: (Contractor does not meet the standard	**Moderate (25% - 75%)**
Consequence:	**High**
Risk Level:	**High (3)**

CONSEQUENCES DEFINED

Consequences are determined by evaluating the following four factors:

1. Impacts on Patient Outcomes
2. Impacts on Patient Satisfaction or Convenience
3. Impacts on Public Reaction
4. Impacts on Government Costs

The following chart provides a guide in determining Consequence:

	Consequence Severity Levels		
Impacts on Patient Outcomes			
Impacts on Patient Satisfaction or Convenience			
Impacts on Public Reaction			
Impacts on Government Costs*			

*SME may be asked to provide methodology for determining cost impact
(Table 2)

Attachment J-6
Contract Data Requirement List (CDRL)

CDRL Table of Contents

The Contractor shall provide all reports and plans that are specified here. The Contractor is accountable for assuring that reports contain accurate and complete data. The Contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. All reports must be supported with sufficient documentation and audit trails. The reports shall be titled as listed. The Contractor shall submit a negative report if there is no data to report. Required reports include:

Weekly Reports
W010 Weekly Status Report of Transition-In & Operational Activities
W020 Weekly Status Report of Phase-Out & Operational Activities

Monthly Reports
M010 Monthly Management Report M020
Monthly Network Adequacy Report
M030 Monthly HIPAA/Privacy Complaint Report
M040 Monthly Contractor Data Submission

Quarterly Reports
Q010 Quarterly Report on Quality Management and Quality Improvement Program
Q020 Quarterly Distribution of Services Report
Q030 Quarterly Users Utilization Report

Annual Reports
AR010 Annual Enrollment Report
AR020 Annual Network Status Report
AR040 Annual Regional Premium Breakout Report

Annual Plans
AP010 Annual Education Plan
AP020 Annual TRDP Privacy Risk Assessment & Plan
AP030 Annual Continuity of Operations Plan (COOP)
AP040 Annual Checklist and Certification for Minimum Level of Enhanced Safeguarding for Unclassified DoD Information

Special Reports
SR010 Consolidated TRDP Utilization History Data Report
SR020 Breach Report
SR030 Written Determination Report

Special Plans
SP010 Comprehensive Transition-In Plan
SP020 Revised Transition-In Plan
SP030 Initial TRDP Privacy Risk Assessment & Plan
SP040 Quality Management/Quality Improvement (QM/QI) Program Plan
SP050 Phase-Out Plan
SP060 Disaster Action Plan

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.**

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP_____TM_____OTHER _____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
			18. ESTIMATED TOTAL PRICE

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE

7. DD 250 REQ	9. DIST STATEMENT REQUIRED	10. FREQUENCY	12. DATE OF FIRST SUBMISSION
8. APP CODE		11. AS OF DATE	13. DATE OF SUBSEQUENT SUBMISSION

16. REMARKS

14. DISTRIBUTION			
a. ADDRESSEE	b. COPIES		
	Draft	Final	
		Reg	Repro
15. TOTAL →			

G. PREPARED BY	H. DATE	I. APPROVED BY	J. DATE

CONTRACT DATA REQUIREMENTS LIST
(1 Data Item)

Form Approved
OMB No. 0704-0188

The public reporting burden for this collection of information is estimated to average 110 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0188). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **Please do not return your form to the above organization. Send completed form to the Government Issuing Contracting Officer for the Contract/PR No. listed in Block E.**

A. CONTRACT LINE ITEM NO.	B. EXHIBIT	C. CATEGORY: TDP_____TM_____OTHER _____

D. SYSTEM/ITEM	E. CONTRACT/PR NO.	F. CONTRACTOR

1. DATA ITEM NO.	2. TITLE OF DATA ITEM	3. SUBTITLE	17. PRICE GROUP
			18. ESTIMATED TOTAL PRICE

4. AUTHORITY *(Data Acquisition Document No.)*	5. CONTRACT REFERENCE	6. REQUIRING OFFICE

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Checklist and Certification for Minimum Level of Enhanced Safeguarding for Unclassified DoD Information

Processed in accordance with provisions at H.4. Requirements for Minimum Level of Enhanced Safeguarding for Unclassified DoD Information, and Contract Data Requirements List (CDRL) AP040 Checklist and Certification of Compliance for Minimum Level of Enhanced Safeguarding for Unclassified DoD Information, of Contract (Insert Contract Reference #).

.

AC-2	Account Management	Select Answer	Select Method		
AC-3	Access Enforcement	Select Answer	Select Method		
AC-3(4)	Access Enforcement	Select Answer	Select Method		
AC-4	Information Flow Enforcement	Select Answer	Select Method		
AC-6	Least Privilege	Select Answer	Select Method		
AC-7	Unsuccessful Login Attempts	Select Answer	Select Method		
AC-11	Session Lock	Select Answer	Select Method		
AC-11(1)	Session Lock	Select Answer	Select Method		
AC-17	Remote Access	Select Answer	Select Method		
AC-17(1)	Remote Access	Select Answer	Select Method		
AC-18	Wireless Access	Select Answer	Select Method		
AC-18(1)	Wireless Access	Select Answer	Select Method		
AC-19	Access Control for Mobile Devices	Select Answer	Select Method		

AT-2	Security Awareness	Select Answer	Select Method		

AU-2	Auditable Events	Select Answer	Select Method		
AU-3	Content of Audit Records	Select Answer	Select Method		
AU-6	Audit Review, Analysis & Reporting	Select Answer	Select Method		
AU-6(1)	Audit Review, Analysis & Reporting	Select Answer	Select Method		
AU-7	Audit Reduction & Report Generation	Select Answer	Select Method		
AU-8	Time Stamps	Select Answer	Select Method		
AU-9	Protection of Audit Information	Select Answer	Select Method		
AU-10	Non-Repudiation	Select Answer	Select Method		
AU-10(5)	Non-Repudiation	Select Answer			

CM-2	Baseline Configuration	Select Answer	Select Method		
CM-6	Configuration Settings	Select Answer	Select Method		
CM-7	Least Functionality	Select Answer	Select Method		
CM-9	Information Sys Component Inventory	Select Answer	Select Method		

CP-9	Information System Backup	Select Answer	Select Method		

IA-2	User Identification & Authentication	Select Answer	Select Method		
IA-4	Identifier Management	Select Answer	Select Method		
IA-5	Authenticator Management	Select Answer	Select Method		
IA-5(1)	Authenticator Management	Select Answer			

IR-2	Incident Response Training	Select Answer	Select Method		
IR-4	Incident Handling	Select Answer	Select Method		
IR-5	Incident Monitoring	Select Answer	Select Method		
IR-6	Incident Reporting	Select Answer	Select Method		

MA-4	Remote Maintenance	Select Answer	Select Method		
MA-4(6)	Remote Maintenance	Select Answer			
MA-5	Maintenance Personnel	Select Answer	Select Method		
MA-6	Timely Maintenance	Select Answer	Select Method		

MP-4	Media Storage	Select Answer	Select Method		
MP-6	Media Sanitization & Disposal	Select Answer	Select Method		

PE-5	Access Control for Display Medium	Select Answer	Select Method		
PE-7	Visitor Control	Select Answer	Select Method		

PM-10	Security Authorization Process	Select Answer			

SC-2	Application Partitioning	Select Answer	Select Method		
SC-4	Information Remnance	Select Answer	Select Method		
SC-7	Boundary Protection	Select Answer	Select Method		
SC-7(2)	Boundary Protection	Select Answer	Select Method		
SC-9	Transmission Confidentiality	Select Answer	Select Method		
SC-9(1)	Transmission Confidentiality	Select Answer	Select Method		
SC-13	Use of Cryptography	Select Answer	Select Method		
SC-13(1)	Use of Cryptography	Select Answer			
SC-13(4)	Use of Cryptography	Select Answer			
SC-15	Collaborative Computing	Select Answer	Select Method		
SC-28	Protection of Information at Rest	Select Answer			

SI-2	Flaw Remediation	Select Answer	Select Method		
SI-3	Malicious Code Protection	Select Answer	Select Method		
SI-4		Select Answer	Select Method		

CERTIFICATION OF COMPLIANCE: I certify that I am an official representative for (insert Contract Company's Name), that I have authority to sign this document and obligate (insert Contract Company's Name) to the statements made in this document, and that I have personal knowledge of the matters to which this certification applies. I also certify that (insert Contract Company's Name) is in compliance with the enhanced safeguarding requirements identified within the contract clause stated above, this document and any applicable written determinations.

"(Insert Contract Company's Name) acknowledges that certification and submission of this document does not constitute approval or acceptance by the Government of the processes or procedures of (insert name of contractor) in meeting the expressed, enhanced safeguarding requirements required by contract, and that the Government may effect any or all rights and remedies allowed by law, regulation and/or contract requirements, clauses or special provisions in ensuring (insert name of contractor) meets the identified enhanced safeguarding requirements."

Signature:_____ **Date:** _____

Name: _____

Title: _____

Company: _____

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Chapter 1 Section 1.1

General Automated Data Processing/Information Technology (ADP/IT) Requirements

1.1 GENERAL

1.2 The TRICARE Systems Manual (TSM) describes how TRICARE business functions are implemented technically via system-to-system interactions and government provided applications. The TSM also describes the technical concept of operations, including the responsibilities associated with various Information Systems (IS) including Defense Enrollment Eligibility Reporting System (DEERS), the contractor systems, and selected Direct Care (DC) IS.

1.3 Contractors shall comply with TRICARE Management Activity (TMA) guidance regarding access to Department of Defense (DoD), TMA directed ports, protocols and software and web applications. TMA guidance will be issued based on requirements identified by the Office of the Secretary of Defense (OSD), Office of Homeland Security (OHS) or Interagency or Service or Installation and/or Functional Proponency agreements. If multiple requirements exist among the aforementionened entities, contractors shall comply with the most stringent of the requirements.

1.3.1 Contractors shall comply with DoD guidance regarding allowable ports, protocols and risk mitigation strategies. Contractors accessing DoD systems shall be provided direction from DoD on connectivity requirements that comply with Ports, Protocols and Services (PPS) in accordance with DoD Instructions (DoDIs). Contractors shall review all DoD, TMA, and Joint Task Force-Global Network Operations (JTF-GNO) Notifications provided by TMA for potential or actual impact on their current system infrastructure and business processes within the designated time frame on the notification. All impacts are to be reported to the Contracting Officer (CO) upon identification, but no later than (NLT) the due date indicated on the notice.

1.3.2 Contractors shall ensure that laptops, flash drives, and other portable electronic devices do not contain Protected Health Information (PHI) unless the device is fully encrypted and accredited per DoD standards.

1.3.3 As portable electronic devices are often used to transmit reference materials and data of a general nature at meetings and conferences, contractors shall ensure that their computer systems can accept and load all such information, regardless of the media used to transmit it. All materials provided to contractors at meetings, workgroups, and/or training sessions sponsored by or reimbursed by the government shall be maintained in accordance with the Records Management requirements in the TRICARE Operations Manual (TOM), Chapter 2.

1.3 This chapter addresses major administrative, functional and technical requirements related to the flow of health care related Automated Data Processing/Information Technology (ADP/IT) information between the contractor and the DoD/TMA. TRICARE Encounter Data (TED) records as well as provider information shall be submitted to TMA in electronic media. This information is

essential to both the accounting and statistical needs of TMA in management of the TRICARE program and in required reports to DoD, Congress, other governmental entities, and to the public. Technical requirements for the transmission of data between the contractor and TMA are presented in this section. The requirements for submission of TED records and resubmission of records are outlined in the Chapter 2, Section 1.1, and the government requirements related to submission and updating of provider information are outlined in Chapter 2, Section 1.2.

1.4 For the purposes of this contract, DoD/TMA data includes all information (e.g., test or production data) provided to the contractor for the purposes of determining eligibility, enrollment, disenrollment, capitation, fees, claims, Catastrophic Cap And Deductible (CC&D), patient health information, protected as defined by DoD 6025.18-R, or any other information for which the source is the government. Any information received by a contractor or other functionary or system(s), whether government owned or contractor owned, in the course of performing government business is also DoD/TMA data. DoD/TMA data means any information, regardless of form or the media on which it may be recorded.

1.5 The ADP requirements shall incorporate standards mandated by the DoD Regulation 6025.18-R, dated January 2003, HA Policy 06-010, dated June 27, 2006, Health Insurance Portability and Accountability Act (HIPAA) Security Compliance and the HIPAA Privacy and Security Rule.

1.6 Management and quality controls specific to the accuracy and timeliness of transactions associated with ADP and financial functions are addressed in the TOM, Chapter 1. In addition to those requirements, TMA also conducts reviews of ADP and financial functions for data integrity purposes and may identify issues specific to data quality (e.g., catastrophic cap issue). Upon notification of data quality issues by TMA, contractors are required to participate in the development of a resolution for the issue(s) identified as appropriate. If TMA determines corrective actions are required as a result of government reviews and determinations, the CO will notify the contractor of the actions to be taken by the contractor to resolve the data issues. Corrective actions that must be taken by the contractor to correct data integrity issues, resulting from contractor actions, are the responsibility of the contractor.

1.7 The references below relate to the subject matter covered in this section:

- Privacy Act of 1974
- Health Insurance Portability and Accountability Act (HIPAA) of 1996
- DoD 6025.18-R, “DoD Health Information Privacy Regulation,“ January 2003
- DoD 5200.2-R, “DoD Personnel Security Program,” January 1987
- DoD 5400.11-R “ Department of Defense Privacy Program,” May 14, 2007
- DoDI 8500.1, “Information Assurance (IA),” October 24, 2002
- DoD 5015.2-D, “Records Management Program,” March 6, 2000
- DoD 5015.02-STD, “Electronic Records Management Software Applications Design Criteria Standard,” April 25, 2007

- DoD 5200.08-R, "Physical Security Program," May 27, 2009

- Homeland Security Presidential Directive 12 (HSPD-12), "Policy for a Common Identification Standard for Federal Employees and Contractors," August 27, 2004

- Federal Information Processing Standards Publication 201 (FIPS 201-1), "Personal Identify Verification (PIV) of federal Employees and Contractors," March 2006

- Directive Type Memorandum (DTM) 08-006, "DoD Implementation of Homeland Security Presidential Directive-12 (HSPD-12)," November 26, 2008.

- Office of the Under Secretary of Defense Intelligence (OUSD(I)) Memorandum, "DoD Standardized Investigation Request Procedures", November 4, 2010.

The requirements above must be met by contractors, subcontractors and other individuals who have access to IS containing information protected by the Privacy Act of 1974 and PHI-under HIPAA.

2.1 SYSTEM INTEGRATION, IMPLEMENTATION AND TESTING MEETINGS

The TMA hosts regularly scheduled meetings, via teleconference, with contractor and government representatives. Government attendees may include, but are not limited to Defense Manpower Data Center (DMDC), Tri-Service Information Management Program Office (TIMPO) and Defense Information System Agency (DISA). The purpose of these meetings is to:

- Review the status of system connectivity and communications.

- Identify new DEERS applications or modifications to existing applications, e.g., DEERS On-line Enrollment System (DOES).

- Issue software enhancements.

- Implement system changes required for the implementation of new programs and/or benefits.

- Review data correction issues and corrective actions to be taken (e.g., catastrophic cap effort--review, research and adjustments).

- Monitor results of contractor testing efforts.

- Other activities as appropriate.

TMA provides a standing agenda for the teleconference with the meeting announcement. Additional subjects for the meetings are identified as appropriate. Contractors are required to ensure representatives participating in the calls are subject matter experts for the identified agenda items and are able to provide the current status of activities for their organization. It is also the responsibility of the contractor to ensure testing activities are completed within the scheduled time frames and any problems experienced during testing are reported via "TestTrack Pro" for review and corrective action by TMA or their designee. Upon the provision of a corrective action

strategy or implementation of a modification to a software application by TMA (to correct the problem reported by the contractor), the contractor is responsible for retesting the scenario to determine if the resolution is successful. Retesting shall be accomplished within the agreed upon time frame. Contractors are required to update "TestTrack Pro" upon completion of retesting activities.

TMA will also document system issues and deficiencies into "TestTrack Pro" related to testing and production analysis of the contractors systems and processes. Upon the provision of a corrective action strategy or implementation of a modification to a software application by the contractor (to correct the problem reported by TMA), the contractor is responsible for retesting the scenario to determine if the resolution is successful. Retesting shall be accomplished within the agreed upon time frame. The contractor shall correct internal system problems that negatively impact their interface with the Business to Business (B2B) Gateway, Military Health System (MHS), DMDC, etc. and or the transmission of data, at their own expense.

Each organization identified shall provide two Point of Contacts (POCs) to TMA to include telephone and e-mail contact and will be used for call back purposes, notification of planned and unplanned outages and software releases. POCs will be notified via e-mail in the event of an unplanned outage using the POC notification list, so it is incumbent upon the organizations to notify TMA of changes to the POC list.

3.1 ADP REQUIREMENTS

It is the responsibility of the contractor to employ adequate hardware, software, personnel, procedures, controls, contingency plans, and documentation to satisfy TMA data processing and reporting requirements. Items requiring special attention are listed below.

3.2 Continuity of Operations Plan (COOP)

3.2.1 The contractor shall develop a single plan, deliverable to the TMA CO on an annual basis that ensures the continuous operation of their Information Technologies (IT) systems and data support of TRICARE. The plan shall provide information specific to all actions that will be taken by the prime and subcontractors in order to continue operations should an actual disaster be declared for their region. The COOP shall ensure the availability of the system and associated data in the event of hardware, software and/or communications failures. The COOP shall also include prime and subcontractor's plans for relocation/recovery of operations, timeline for recovery, and relocation site information in order to ensure compliance with the TOM, Chapters 1 and 6. Information specific to connection to the B2B Gateway to and from the relocation/recovery site for operations shall also be included in the COOP. For relocation/recovery sites, contractors must ensure all security requirements are met and appropriate processes are followed for B2B Gateway connectivity. The contractor's COOP will enable compliance with all processing standards as defined in the TOM, Chapter 1, and compliance with enrollment processing and Primary Care Manager (PCM) assignment as defined in TOM, Chapter 6. The COOP should include restoration of critical functions such as claims and enrollment within five days of the disaster. The government reserves the right to re-prioritize the functions and system interactions proposed in the COOP during the review and approval process for the COOP.

3.3 Security Requirements

3.3.1 The contractor shall ensure security and access requirements are met in accordance with existing contract requirements for all COOP and disaster recovery activities. Waivers of security and access requirements will not be granted for COOP or disaster recovery activities.

3.3 Annual Disaster Recovery Tests

3.3.1 The prime contractor will coordinate annual disaster recovery testing of the COOP with its subcontractor(s) and the government. Coordination with the government will begin NLT 90 days prior to the requested start date of the disaster recovery test. Each prime contractor will ensure all aspects of the COOP are tested and coordinated with any contractors responsible for the transmission of TRICARE data. Each prime contractor must ensure major TRICARE functions are tested.

3.3.2 The prime contractor shall also ensure testing support activities (e.g., DEERS, TED, etc.) are coordinated with the responsible government POC NLT 90 days prior to the requested start date of the annual disaster recovery test.

3.3.3 Annual disaster recovery tests will evaluate and validate that the COOP sufficiently ensures continuation of operations and the processing of TRICARE data in accordance with the TOM, Chapters 1 and 6. At a minimum, annual disaster recovery testing will include the processing of:

- TRICARE Prime enrollments in the DEERS contractor test region to demonstrate the ability to update records of enrollees and disenrollees using the government furnished system application, DOES.
- Referrals and Non-Availability Statements (NAS)
- Preauthorizations/authorizations
- Claims
- Claims and catastrophic cap inquiries will be made against production DEERS and the Catastrophic Cap And Deductible Database (CCDD) from the relocation/recovery site. Contractors will test their ability to successfully submit claims inquiries and receive DEERS claim responses and catastrophic cap inquiries and responses. Contractors shall not perform catastrophic cap updates in the CCDD and DEERS production for test claims.
- To successfully demonstrate the ability to perform catastrophic cap updates and the creation of newborn placeholder records on DEERS, the contractor shall process a number of claims using the DEERS contractor test region.
- TED records will be created for every test claims processed during the claims processing portion of the disaster recovery test. The contractor will demonstrate the ability to process provider, institutional and non-institutional claims. These test claims will be submitted to the TMA TED benchmark area.

3.3.4 Contractors shall maintain static B2B Gateway connections or other government approved connections at relocation/recovery sites that can be activated in the event a disaster is declared for their region.

3.3.5 In all cases, the results of the review and/or test results shall be reported to the TMA Contract Management Division within 10 days of the conclusion of the test. The contractor's report shall include if any additional testing is required or if corrective actions are required as a result of the disaster recovery test. The notice of additional testing requirements or corrective actions to be taken should be submitted along with the proposed date for retesting and the completion date for any corrective actions required. Upon completion of the retest, a report of the results of the actions taken should be provided to the CO within 10 business days of completion.

3.4 Information Security Programs

Information Security (Assurance) compliance will be determined using the Defense Information Assurance Certification and Accreditation Process (DIACAP) or the National Institute of Standards and Technology (NIST)-based process. The CO will notify the contractor of the governing IA program to be used for the contract.

3.4.1 Security of Unclassified DoD Information on Non-DoD IS

The new NIST based IA program implemented by TMA is designed to protect sensitive but unclassified (SBU) DoD Information on non-TMA IS as follows:

3.4.1.1 Definitions

3.4.1.1.1 DoD IS

An IS is DoD controlled or operated on behalf of DoD when a contractual agreement or memorandum of agreement exists between the DoD and the non-DoD entity/contractor for the operation of the IS, and the IS is established only for DoD purposes and dedicated only to the processing of DoD-owned information.

3.4.1.1.2 Non-DoD IS

Any IS system that is not owned, used, or operated by the DoD AND that is not used or operated by a contractor or other non-DoD entity exclusively on behalf of the DoD is considered to be a non-DoD IS.

3.4.1.1.3 SBU

Any information that has not been cleared for public release in accordance with DoD Directive (DoDD) 5230.09, "Clearance of DoD Information for Public Release," August 22, 2008, AND that is provided by the DoD to a non-DoD entity, or that is collected, developed, received, transmitted, used, or stored by a non-DoD entity in support of an official DoD activity is considered DoD Information. The PHI (defined in reference (d)) and Personally Identifiable Information (PII) (defined in reference (f)) of DoD beneficiaries is SBU DoD information that is not cleared for public release.

3.4.1.2 References

The references below support the IA requirements outlined in the following paragraphs.

- 48 FR 38089 - 38095 / Vol. 76, No. 125 / Wednesday, June 29, 2011
- DoDD 5230.09, "Clearance of DoD Information for Public Release," August 22, 2008
- DoDI 8582.01, "Security of Unclassified Department of Defense (DoD) Information on Non-DoD Information Systems," June 6, 2012
- NIST SP 800-53, Rev. 3, "Recommended Security Controls for Federal Information Systems and Organizations," August 25, 2011
- NIST Special Publication (SP) 800-53A, Revision (Rev.) 1, "Guide for Assessing the Security Controls in Federal Information Systems," July 25, 2011

3.4.1.3 IA Program Administration

3.4.1.3.1 Security Program Changes

3.4.1.3.1.1 Compliance with Federal Programs

The new NIST-based IA program leverages a contractor's compliance with existing federal IA-related measures (i.e., HIPAA, Federal Information Systems Management Act (FISMA), etc.) to attest to its readiness to process SBU DoD information on non-DoD IS. The new IA program requires participating contractors to document compliance with the review of IA controls that are listed within 48 CFR 252, Table 1 and described in detail within the NIST SP 800-53, "Recommended Security Controls for Federal Information Systems and Organizations, August 2009 including updates as of May 1, 2010" and SP 800-53/A "Guide for Assessing the Security Controls in Federal Information Systems, July 2008."

3.4.1.3.1.2 Risk Management

Contractors certifying compliance with the NIST based process accept sole responsibility for the risk(s) associated with developing and maintaining its IA readiness posture.

3.4.1.3.1.3 Transition From DIACAP

Contractors transitioning from DIACAP to NIST-based IA compliance will continue to maintain DIACAP certification until NIST-based compliance is achieved as evidenced by the successful completion of the government CO's review of contractor-submitted IA compliance materials.

3.4.1.3.1.4 Information Assurance Vulnerability Management (IAVM) Program

As part of the new DoD NIST-based IA program, the contractor fully owns the development, sustainment and overall risk of its IA program in support of the contract. Contractors may continue to participate on a voluntary basis and at no cost to the government in the

Information Assurance Working Group (IAWG), receive Information Assurance Vulnerability Alerts (IAVAs) and have access to Security Technical Information Guides (STIGs); however, compliance with those guidance materials becomes optional unless compliance is directed by the CO. New TMA contractors that would like to participate in the IAVM should contact the Purchased Care Systems Integration Branch (PCSIB) IA Manager for coordination of access with TMA IA.

3.4.1.3.2 IA Program Management

The CO has overall responsibility for the IA program.

3.4.1.3.3 IA Support

The PCSIB IA manager will serve as the technical point of contact for all contract-related IA matters concerning non-DoD IS. At the request of the CO, PCSIB shall provide technical assistance in the review of the contractor-submitted NIST-based IA compliance materials.

3.4.1.3.4 IA Compliance Requirement

The contractor shall obtain and maintain its NIST-related compliance standing, meeting contract transition-in, -out and sustainment requirements as directed by the CO.

3.4.1.3.5 Multiple Contracts and Certifications

Contractors awarded multiple contracts must undergo separate IA certification reviews demonstrating compliance with the requirements for each contract. Therefore, a single contractor may achieve multiple IA certifications. In those cases where a contractor holds either an active DoDI 582.01-related certification statement or an active DIACAP certification on an existing contract, the contractor will submit the certification statement to the CO. If necessary, the CO will engage with the appropriate IA resource to review the contractor's certification materials.

3.4.1.3.6 Government Inspections

As documented in the contract's Inspection Clause, the Government has the right to call for an inspection of the contractor's facilities, systems and work processes to obtain the evidence required to allow the government to make determinations about the effectiveness of the security controls and the security of the IS.

3.4.1.4 Certification/Recertification Procedures

The NIST 800-53/A certification process, as allowed by DoDI 8582.01 and applicable contract clauses, requires compliance by Purchased Care Contractors (PCC) for the protection of DoD information provided to, contained within and/or processed by contractor IS. The following process applies to the NIST-based IA certification process.

3.4.1.4.1 The contractor shall submit a completed/signed "Checklist and Certification for Minimum Level of Enhanced Safeguarding for Unclassified DoD Information" (also known as (aka) the "Checklist") (see Addendum F or applicable CDRL) and any applicable Written Determination Reports (see Addendum E or applicable CDRL) to the CO for review and validation within 60 calendar days of the contract award.

3.4.1.4.2 The CO will review the contractor-submitted Checklist and written determination reports, providing notification to the contractor of the completion of the government's review and/ or identifying areas that need additional information. The contractor will respond within 10 calendar days to CO Notices that require additional information.

3.4.1.4.3 At the Government's discretion, the contractor will provide a NIST compliance briefing to the CO and other government representatives as appropriate (e.g., TRICARE Regional Offices (TROs), Program Offices, etc.), presenting an overview of its IA compliance efforts. The CO and other government representatives will identify any questions and/or clarifications required by the CO. The date, time, and location will be designated by the Government.

3.4.1.4.4 Certification Milestones

As part of each contract that participates in the new IA program, there are three distinct submission milestones that a contractor must comply with in order to obtain and maintain it's IA certification.

3.4.1.4.4.1 Initial

As part of a contract transition-in effort for either a new contract or transition from DIACAP, the contractor shall submit a completed signed Checklist and any applicable written determinations 60 calendar days from either contract award or modification.

3.4.1.4.4.2 Interim

The contractor must document changes in its compliance posture in regard to the required IA controls, resubmitting the certification checklist and any applicable written determination reports to the CO NLT 10 calendar days following completion of the update. If the contractor fails to submit the completed IA documentation within the required time frame, the CO will take the appropriate action until the required documentation is received by the government.

Note: Changes in a contractor's technical approach, such as choosing vendor X's product versus vendor Y's, does not require the attention / review of the government. These decisions and other technical matters of a similar nature are the responsibility of the contractor to manage as part of its overall IA program.

3.4.1.4.4.3 Annual

Thirty calendar days before the anniversary of contract award, the contractor shall submit a completed signed Checklist and applicable written determinations, updating the material as necessary.

3.4.1.4.5 Operation and Connectivity Decisions

3.4.1.4.5.1 Based upon the CO's completed review of the contractor-submitted IA certification materials, the government will authorize the contractor's IS to operate in a particular security mode and connect to government systems and applications.

3.4.1.4.5.2 The government will require a corrective action plan if the contractor fails to achieve and/or maintain its compliance standing with the NIST-based IA program. The contractor's continued access to Government-controlled systems and data will be determined by the CO upon review of the contractor's corrective action plan. The CO will also determine if follow-up inspections of a contractor's IA-related work processes and documentation are required.

3.4.1.5 Documentation

3.4.1.5.1 Checklist

The CO will provide the contractor with the most current version of the Checklist and written determination within 10 calendar days of either contract award or modification to transition to the NIST based IA program.

3.4.1.5.1.1 Contractor Document Updates

When document changes occur, the CO will provide the contractor with replacement versions of the documents.

3.4.1.5.1.2 Contractor-Initiated Changes

If the contractor changes its compliance status with or vulnerability mitigation plan for any IA control shown on the Checklist, the government requires the contractor to submit an updated certification statement to the CO within 10 calendar days of the change action.

3.4.1.5.2 Written Determination Report

If a contractor indicates either "No" or "N/A" for any IA control listed on the Checklist, the government requires the contractor to submit a written determination report to explain its decision rationale and/or mitigating course of action(s). Contractor written determination reports shall be completed as follows:

3.4.1.5.2.1 Tracking Number

To support clear communications, the contractor shall include a simple tracking number in the "Activity Description" field of a particular IA control reference to facilitate response and follow-up. The same tracking number should be included at the top of the associated written determination reports, communications, etc.

3.4.1.5.2.2 Vulnerability Reporting

3.4.1.5.2.2.1 Single Vulnerability

If an IA control has a single vulnerability, the contractor shall identify the planned mitigation activity and completion date in the written determination report.

3.4.1.5.2.2.2 Multiple Vulnerabilities

If an IA control has multiple vulnerabilities with the same mitigation date, the contractor should identify all vulnerabilities within the same written determination report. If an IA control has multiple vulnerabilities with different mitigation dates, the contractor shall group them by date and separately identify each group in separate written determination reports.

3.4.1.5.2.2.3 Mitigation Dates

When the contractor resubmits the Checklist and associated written determination reports, the contractor must always list the actual work completion date rather than the planned completion date for the mitigation activities of an identified vulnerability.

3.4.2 DoD Information Assurance Certification And Accreditation Process (DIACAP) Requirements

Contractor IS/networks involved in the operation of systems of records in support of the MHS requires obtaining, maintaining, and using sensitive and personal information strictly in accordance with controlling laws, regulations, and DoD policy.

3.4.2.1 Policy References

The following references support the DIACAP requirements and may be referenced for additional information specific to protocols established within the DIACAP.

- DoDD 8500.1E, “Information Assurance (IA),” October 24, 2002
- DoDI 8500.2, “Information Assurance (IA) Implementation,” February 6, 2003
- DoD 5200.2-R, “DoD Personnel Security Program,” January 1987
- DoDI 8510.01, “DoD Information Assurance Certification and Accreditation Process (DIACAP),” November 28, 2007
- DoDI 8551.1, “Ports, Protocols, and Services Management (PPSM),” August 13, 2004
- DoD I 8520.2, “Public Key Infrastructure (PKI) and Public Key (PK) Enabling,” April 1, 2004
- Defense Information Systems Agency (DISA), “Security Technical Implementation Guides”
- DoD 5200.08-R, “Physical Security Program”, April 9, 2007
- DoD Assistant Secretary of Defense Health Affairs (ASD (HA)) Memorandum, “Interim Policy Memorandum on Electronic Records and Electronic Signatures for Clinical Documentation,” August 4, 2005

- DoD Assistant Secretary of Defense (ASD) Networks and Information Integration (NII) Memorandum "Department of Defense (DoD) Guidance on Protecting Personally Identifiable Information (PII)," August 18, 2006

- "DISA Computing Services Security Handbook", Version 3, Change 1, December 1, 2000

- "Health Insurance Portability and Accountability Act (HIPAA), Security Standards, Final Rule," February 20, 2003

- MHS Physical Security Assessment Matrix, August 15, 2004

- MHS DIACAP Checklist, August 2006

- MHS Security Incident Checklist, September 2005

- MHS Information Assurance Policy Guidance, March 27, 2007

- MHS IA Implementation Guide No. 2, "Sanitization and Disposal of Electronic Storage Media and IT Equipment Procedures," July 19, 2005

- MHS IA Implementation Guide No. 3, "Incident Reporting and Response Program," March 27, 2007

- MHS IA Implementation Guide No. 5, "Physical Security," July 19, 2005

- MHS IA Implementation Guide No. 6, "Wireless Local Area Networks (WLANs)," July 19, 2005

- MHS IA Implementation Guide No. 7, "Data Integrity" March 27, 2007

- MHS IA Implementation Guide No. 8, "Certification and Accreditation (C&A)," March 27, 2007

- MHS IA Implementation Guide No. 9, "Configuration Management - Security," July 19, 2005

- MHS IA Implementation Guide No. 10, "System Lifecycle Management," July 19, 2005

- MHS IA Implementation Guide No. 11, "DoD Public Key Infrastructure (PKI) and Public Key Enabling (PKE)," July 19, 2005

- MHS IA Implementation Guide No. 12, "Information Assurance Vulnerability Management (IAVM) Program," March 27, 2007

- MHS IA Implementation Guide No. 15, "Identity Protection (IdP)," September 14, 2006

- Federal Information Process Standard 140-3, "Draft Security Requirements for Cryptographic Modules," July 13, 2007

- NIST SP 800-34 Contingency Planning Guidance for Information Technology Systems, June 2002

3.4.2.2 Certification and Accreditation (C&A) Process

Contractors shall achieve C&A of all IS that access, process, display, store or transmit DoD SI. C&A must be achieved as specified in the contract. Contractors awarded multiple contracts must undergo separate C&A reviews for each contract. In those cases where a contractor holds an active Authority to Operate (ATO) for an existing contract, the IA Office may determine only a limited review of the contractor's IS is required. A limited review is defined as an evaluation of portions of the contractor's IS identified by IA. This review may be conducted in lieu of a DIACAP review that would be conducted by IA for an IS that has never connected to DoD or the MHS. A limited review determination may be made at the sole discretion of the IA Office and the Designated Approval Authority (DAA).

Failure to achieve C&A will result in additional visits by assessment teams until C&A is achieved, after which, visits will occur on an annual basis. Return visits by the assessment team may prompt the government to exercise its rights in reducing the contract price. Contract price reductions will reflect costs incurred by the government for each re-assessment of the contractor's IS, as allowed under contract clause 52.246-4, Inspection of Services-Fixed Price, if deemed appropriate by the CO.

3.4.2.2.1 The contractor shall safeguard SI through the use of a mixture of administrative, procedural, physical, communications, emanations, computer and personnel security measures that together achieve the requisite level of security established for a Mission Assurance Category III (MAC III) Confidentiality Level (CL) Sensitive system. The contractor shall provide a level of trust which encompasses trustworthiness of systems/networks, people and buildings that ensure the effective safeguarding of SI against unauthorized modifications, disclosure, destruction and denial of service.

3.4.2.2.2 The contractor shall provide a phased approach to completing the DoD C&A process in accordance with DoDI 8510.01, "DoD Information Assurance Certification and Process (DIACAP)," dated November 28, 2007, within 10 months following the contract award date. C&A requirements apply to all DoD and contractors' ISs that access, process, display, store or transmit DoD information. Contractor shall maintain the MAC III CL Sensitive, Information Assurance (IA) controls defined in reference DoDI 8500.2.

- The contractor's IS'/networks shall comply with the C&A process established under the DIACAP, or as otherwise specified by the government that meet appropriate DoD IA requirements for safeguarding DoD SI accessed, processed, displayed, maintained, stored or transmitted and used in the operation of systems of records under this contract. The C&A requirements shall be met before the contractor's system is authorized access DoD data or interconnect with any DoD IS or network.

Note: Although the DITSCAP has been superseded by the DIACAP, it should be noted there are no differences in the evaluation criteria. The difference between the processes is specific to reporting requirements by the IA evaluation team.

- Certification is the determination of the appropriate level of protection required for contractor IS'/networks. Certification also includes a comprehensive evaluation of the technical and non-technical security features and countermeasures required for each contractor system/network.

3.4.2.2.3 Accreditation is the formal approval by the government for the contractor's IS' to operate in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS to operate within the given operational environment with stated interconnections; and with appropriate levels of IA security controls. The C&A requirements apply to all DoD IS/networks and contractor's IS/networks that access, manage, store, or manipulate electronic SI data.

3.4.2.2.4 The contractor shall comply with C&A requirements, as specified by the government that meet appropriate DoD IA requirements. The C&A requirements shall be met before the contractor's system is authorized to access DoD data or interconnect with any DoD IS, to include test environments. The contractor shall initiate the C&A process by providing the CO, not later than 30 days prior to the start of C&A testing, the required documentation necessary to receive an ATO. The contractor shall make their IS' available for testing, and initiate the C&A testing four months (120 business days) in advance of accessing DoD data or interconnecting with DoD IS'. The contractor shall ensure the proper contractor support staff is available to participate in all phases of the C&A process. They include, but are not limited to: (a) attending and supporting C&A meetings with the government; (b) supporting/conducting the vulnerability mitigation process; and (c) supporting the C&A team during system security testing and evaluation. The contractor should be prepared to provide contractor support staff to participate in person or via remote connection in all C&A testing, assessment and vulnerability mitigation meetings until completion of the DIACAP and an Interim Approval to Operate (IATO) or ATO is issued.

3.4.2.2.5 Contractors must ensure that their system baseline configuration remains static during initial testing by the C&A team. Contractor's IS' must also remain static for mitigation assessment scans and testing periods. Any reconfiguration or changes to the contractor's IS during the C&A evaluation and testing process may require revision to the system baseline, documentation of system changes and may negatively impact the C&A timeline. Confirmation of the system baseline configuration shall be agreed upon during the definition of the C&A boundary, be signed by the government and the contractor and documented as part of the contractor's System Identification Profile (SIP) and artifacts. SIP and artifacts must be submitted to the IA review team in accordance with the schedule agreed upon by the C&A team and the contractor. If the contractor fails to submit the completed documentation, the IA team may postpone C&A testing and assessment until the required documentation is submitted, demonstrating contractor readiness. Upon completion of all testing and assessments by the C&A team, contractors must notify the IA Directorate, via the CO, of any proposed changes to their IS configuration for review and approval by IA prior to implementation. In order to validate implementation of approved changes does not negatively impact the vulnerability level of a contractor's IS', the C&A team may conduct additional testing and evaluation. During the actual baseline and mitigation assessment scans, the IS must remain frozen. The freeze is only in place during the actual testing periods. Changes between baseline testing and mitigation testing must be coordinated and approved by the MHS IA Program Office prior to implementation. Any reconfiguration or changes in the system during the C&A testing process may require a rebaselining of the system and documentation of system changes. This could result in a negative impact to the C&A timeline.

3.4.2.2.6 The C&A process will include the review of compliance with personnel security ADP/IT requirements. The C&A team will review trustworthiness determinations (Background Checks) for personnel accessing DoD sensitive information.

3.4.2.2.7 Vulnerabilities identified by the government during the C&A process must be mitigated in accordance with the timeline identified by the government. The contractor shall also comply with the MHS DIACAP Checklist. Reference materials may be obtained at http://www.tricare.osd.mil/tmis_new/ia.htm. After contract award date, and an ATO is granted to the contractor, reaccreditation is required every three years or when significant changes occur that impact the security posture of the contractors' IS. An annual review shall be conducted by the TMA IA Office that comprehensively evaluates existing contractor system security posture in accordance with DoDI 8510.01, "DoD Information Assurance Certification and Process (DIACAP)," date November 28, 2007.

3.4.2.3 IAVM

3.4.2.3.1 The TMA IAVM program provides electronic security notification against known threats and vulnerabilities. The contractor shall comply with the IAVM program requirements to ensure an effective security posture is maintained.

3.4.2.3.2 The contractor shall acknowledge receipt of Information Assurance Vulnerability Alerts (IAVA) and Information Assurance Vulnerability Bulletins (IAVB). The contractor shall inform the TMA IAVM Coordinator of applicability or non-applicability of IAVA. The contractor shall implement patch or mitigations strategy and report compliance as specified in IAVA to TMA IAVM Coordinator, if IAVA applies. The contractor shall develop and submit a Plan of Action and Milestones (POA&M) for approval, if IAVA applies, but cannot be mitigated within the compliance time frame. The contractor shall ensure that all required risk mitigation actions are implemented in accordance with associated time line, once POA&M is approved. The contractor shall respond to all TMA IAVM Coordinator queries as to compliance status. The contractor shall ensure TMA IAVM program compliance by their subcontractors.

3.4.3 Disposing of Electronic Media

Contractors shall follow the DoD standards, procedures and use approved products to dispose of unclassified hard drives and other electronic media, as appropriate, in accordance with DoD Memorandum, "Disposition of Unclassified Computer Hard Drives," June 4, 2001. DoD guidance on sanitization of other internal and external media components are found in DoDI 8500.2, "Information Assurance (IA) Implementation, "February 6, 2003 (see PECS-1 in Enclosure 4, Attachment 5) and DoD 5220.22-M, "Industrial Security Program Operating Manual (NISPOM)," Chapter 8).

4.1 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The contractor shall be in compliance with the HIPAA Privacy and Security Rules (45 CFR Parts 160 and 164) and corresponding DoD regulations, and TOM Chapter 19, Section 3.

4.2 Data Use Agreements (DUAs)

The contractor shall enter into a Data Use Agreement (DUA) with TMA in order to be compliant with DoD and HIPAA regulations annually or until their contract is no longer valid. Subcontractors or agents working on behalf of the primary contractor that require the use of, or access to individually identifiable data or protected health information under the provisions of their contract must separately comply, (in coordination with the primary contractor), with referenced DoD and HIPAA regulations and the TMA manuals.

Primary contractors and subcontractors requiring access or use of MHS data must also complete an Account Authorization Request From (AARF) and have an ADP / IT-II. Refer to section 7.3 for Access Requirements.

4.2 Disclosure Tracking and Accounting and Other system Capabilities for Privacy Act and HIPAA Privacy Compliance

Contractors shall maintain a history of disclosures of PII/PHI of eligible beneficiaries, to the extent necessary to comply with the requirements for the accounting of disclosures as specified in DoD 5400.11-R, C4.5 and DoD 6025.18-R. In addition, contractors shall maintain systems with the capabilities to track and report on disclosure requests, disclosure restrictions, accounting for disclosures requests, authorizations, PII/PHI amendments, Notice of Privacy Practices distribution management, confidential communications requests, and complaint management. Situation reports may be required to address complaints, inquiries, or unique events related to the foregoing responsibilities..

5.1 PRIVACY IMPACT ASSESSMENT (PIA)

5.2 Contractors are responsible for the employment of practices that satisfy the requirements and regulations of the E-Government Act of 2002 (Public Law 107-347); DoD 5400.16-R, "DoD Privacy Impact Assessment (PIA) Guidance," February 12, 2009; Office of Management and Budget Memorandum M-03-22, "OMB Guidance for Implementing the Privacy Provisions of the E-Government Memorandum Act of 2002," September 26, 2003 and current DoD PIA Guidance Memorandum at http://www.tricare.mil/TMAPrivacy/Info-Papers-PIAs.cfm. When completing a PIA, the contractor is responsible for using the DoD-approved PIA Template, DoD Standard Form DD 2930, available at http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2930.pdf.

5.3 The PIA is an analysis of how information is handled:

- To ensure handling conforms to applicable legal, regulatory, and policy requirements regarding privacy,
- To determine the risks and effects of collecting, maintaining, and disseminating information in identifiable form in an electronic IS, and
- To examine and evaluate protections and alternative processes for handling information to mitigate potential privacy and security risks.

The PIA is a due diligence exercise in which organizations identify and address potential privacy risks that may occur during the various stages of a system's lifecycle.

5.4 Contractors and their subcontractors shall follow the guidance outlined within the TMA PIA policy and the TMA Privacy Impact Procedures located on the TMA Privacy web site: http://www.tricare.osd.mil/TMAPrivacy/PIA-Submittal-Process.cfm.

5.5 For new contracts and/or systems, contractors shall submit a PIA Determination Checklist to the TMA Privacy Office within 10 days of the development, or procurement of IT systems or projects that collect, maintain, or disseminate information in identifiable form from or about members of the public totaling at least 10 individuals. If a PIA is required, the contractor will work with the TMA Privacy Office to create a POA&M for the timely completion of the PIA. The completion date will be established during the development of the POA&M with the TMA Privacy Office. Systems that do not require a PIA should be routinely evaluated for changes that impact the requirements of the information collection. In the event of such a change, a new PIA Determination Checklist should be submitted to the TMA Privacy Office.

5.6 For existing systems, contractors shall:

- Identify systems,
- Submit a PIA Determination Checklist, and
- Develop and submit a POA&M for completing the PIAs.

The POA&M shall be submitted to the TMA Privacy Office within two months following contract award date. If the contractor is not able to meet the two month requirement, the contractor shall request an extension from the TMA Privacy Office.

5.7 If a previously used system is to be retired, the contractor will notify the TMA Privacy Office of the retirement date within thirty days of determining that status, and submit a PIA Determination Checklist for any new systems.

5.8 Contractors shall use the results of the PIA to identify and mitigate any risks associated with the collection of personal information from the public. Contractors shall submit the PIA using the DoD PIA format and the TMA PIA Completion Procedures to the TMA Privacy Office within 10 days of completion.

5.9 Upon completion of review by the TMA Privacy Office, contractors will be notified of any required corrections. Upon approval, the PIA summary submitted by the contractor will be made available to the public upon request via the TMA Privacy web site. The TMA Privacy Office will not publish any PIA summaries that would raise security issues, other concerns or reveal information of a proprietary or sensitive nature to the contractors. Corrective actions to be provided within time frame designated in notification. The contractors are to review and update PIAs, in coordination with the TMA Privacy Office, if there are system modifications or changes in the way information is handled that increase privacy risk.

6.0 PHYSICAL SECURITY REQUIREMENTS

The contractor shall employ physical security safeguards for IS/networks involved in the operation of its systems of records to prevent the unauthorized access, disclosure, modification, destruction, use, etc., of DoD SI and to otherwise protect the confidentiality and ensure the authorized use of SI. In addition, the contractor's safeguards shall be in accordance with the physical security requirements of the NIST SP 800-53 and 800-53A. The contractor shall correct any

deficiencies of its physical security posture required by the government.

7.1 PERSONNEL SECURITY ADP/IT REQUIREMENTS

Personnel to be assigned to positions that require an ADP/IT-I or ADP/IT-II designation shall undergo a successful security screening before being granted access to DoD IT systems and/or all DoD/TMA data (e.g., test and/or production) that contain sensitive information.

7.2 Formal Designations Required

In accordance with DoD Regulations, contractor personnel in positions requiring access to the following must be designated as ADP/IT-I or ADP/IT-II:

- Access to a secure DoD facility;
- Access to a DoD IS or a DoD Common Access Card (CAC)-enabled network;
- Access to DEERS or the B2B Gateway.

7.1.1 Employee Prescreening

7.1.1.1 Contractors shall conduct thorough reviews of information submitted on an individual's application for employment in a position that requires either an ADP/IT background check or involves access via a contractor system to data protected by either the Privacy Act of 1974, as amended, or the HHS HIPAA Privacy and Security Final Rule. This prescreening shall include reviews that:

- Verify United States citizenship;
- Verify education (degrees and certifications) required for the position in question;
- Screen for negative criminal history at all levels (federal, state, and local);
- Screen for egregious financial history; for example, where adverse actions by creditors over time indicate a pattern of financial irresponsibility or where the applicant has taken on excessive debt or is involved in multiple disputes with creditors.

7.1.1.2 The prescreening shall be conducted as part of the preemployment screening and can be performed by the contractor's personnel security specialists, human resource manager, hiring manager, or similar individual.

7.2 Interim Access to DoD IT Network/Systems

The TMA Personnel Security Branch (PSB) will grant an applicant interim access to DoD IT network/system upon confirmation of the following actions:

- Scheduling of background investigation by the Office of Personnel Management (OPM),
- Favorable results from the advance National Agency Check (NAC), and
- A favorable Federal Bureau of Investigation (FBI) fingerprint check.

TMA PSB will notify the Facility Security Officer (FSO) on the status of each applicant's request for interim access.

7.3 ADP/IT Category Guidance

The guidance below shall be used when determining an individual's specific ADP/IT level:

7.3.1 **ADP/IT-I**. Those positions in which the individual is responsible for the planning, direction and implementation of a computer security program; major responsibility for the direction, planning and design of a computer system, including the hardware and software; or, can access a system during the operation or maintenance in such a way, and with a relatively high risk for causing grave damage, or realize a significant personal gain. The required investigation for ADP/IT-I is a Single-Scope Background Investigation (SSBI), and the request format is the Standard Form (SF) 86, Questionnaire for National Security Positions.

7.3.1.1 The Periodic Reinvestigation (PR) requirement for ADP/IT-I requires the individual to submit a new SF 86 every five years from the date the last investigation was closed. The FSO shall track this information and initiate new investigations, as required by DoD regulations. The FSO shall be responsible for tracking this PR requirement and initiating the investigation, as required by DoD regulations.

7.3.2 **ADP/IT-II**.

7.3.2.1 Those positions in which an individual is responsible for the direction, planning, design, operation, or maintenance of a computer system, and whose work is technically reviewed by a higher authority than the ADP/IT-I category to ensure the integrity of the system. The required investigation is equivalent to a National Agency Check with Local Agency Check and Credit Check (NACLC). A request for a NACLC is submitted to TMA PSB on an SF 86.

7.3.2.2 The PR requirement for ADP/IT-II requires the individual to submit a new SF 86 every 10 years from the date the last investigation was closed. It is not necessary to update fingerprints (electronic or FBI FD258 Fingerprint card) for any type of periodic reinvestigation unless specifically requested to do so. The FSO shall track this information and initiate new investigations, as required by DoD regulations.

7.4 Additional ADP/IT Level I Designation Guidance

7.4.1 Contracting companies requiring ADP/IT-I Trustworthiness Determinations for their personnel shall have their FSOs coordinate and submit a written request for approval to the COR prior to forwarding applications to TMA PSB.

7.4.2 The request letter to the COR shall be signed by, at a minimum, the FSO or other appropriate executive, include contact information for the security officer or other appropriate executive, and a thorough job description which justifies the need for the ADP/IT-I Trustworthiness Determination.

7.5 Transfers Between Contractor Organizations

When contractor employees transfer employment from one TMA contract to another TMA contract while their investigation is in process, the investigation being conducted for the previous company may be applied to the new employing company. It shall be the new employing company's responsibility to notify the TMA PSB when a current employee has transferred from

another TMA contract. The notification must contain the following:

- Name
- Name of new employing contractor company
- Effective date of the transfer/current employment
- Name of the former employing contractor company
- ADP/IT level applied for
- Effective date of termination from former company

Notifications shall be submitted via secure fax at (703) 681-3934 or United States Postal Service (USPS) regular mail to TMA PSB.

7.6 Process For Submitting Electronic Application For Positions of Trust

All contractor personnel who require an ADP/IT level investigation shall complete the Electronic Questionnaires for Investigations Processing (e-QIP) prior to working on a TMA contract. The electronic security questionnaire shall be completed and submitted by the contractor personnel through OPM's web based automated system (e-QIP).

7.6.1 Responsibilities (Contractor) - Applicant

The applicant shall:

- Confirm the applicant is a US citizen
- Complete e-QIP
- Complete the required security documents to include, e-QIP signature pages, and update fingerprints (electronic or FBI FD258 fingerprint card) then submit to FSO.

7.6.2 Responsibilities (Contractor) - FSO

7.6.2.1 The FSO shall:

- Be a contractor with a minimum NACLC investigation or equivalent
- Serve as the applicant's main POC
- Initiate an e-QIP request for the applicant
- Select the appropriate Agency Use Block (AUB) template in e-QIP and coordinate with COR
- Inform applicant(s) to begin e-QIP process
- Monitor the e-QIP request
- Cancel investigation requests and/or delete applicant(s)
- Receive from applicant and forward all required security documentation (signature pages and two fingerprint cards) to TMA PSB
- Submit applicant's fingerprints in accordance with OPM's acceptable methods: hardcopy (FD-258 fingerprint card) or electronically [OPM's Fingerprint Transaction System (FTS) via an FBI approved Live-Scan system or fingerprint card scan system]
- If the method of submission is FTS, provide TMA PSB with the transaction number, date of transmission to OPM, and the associated e-QIP request number for the applicant.
- If the method of submission is hardcopy, mail the FD-258 to:

TRICARE Management Activity
Office of Administration
Support Services Division
ATTN: Personnel Security Branch
7700 Arlington Blvd
Suite 5101
Falls Church, Va 22041-5101

7.6.2.2 Process For A New FSO Without An Investigation

The minimum investigation required by OPM to obtain an e-QIP account is a favorably adjudicated NACLC or an equivalent investigation. If the contracting company FSO does not currently meet this investigation requirement, TMA PSB will initiate an investigation in e-QIP for completion by the FSO. The FSO will complete the required SF 86 investigation request in e-QIP and submit the following documents to TMA PSB.

- Two FD-258 fingerprint cards of copy of electronic fingerprint scan
- Signed Authorization to Release Information
- Signed Authorization to Release Medical Information
- Signed Certification Page

The mailing address for the documents is:

TRICARE Management Activity
Office of Administration
Support Services Division
ATTN: Personnel Security Branch
7700 Arlington Blvd
Suite 5101
Falls Church, Va 22041-5101

7.7 New Contractor Personnel With Prior Investigation

7.7.1 A new contractor employee who has had a favorably adjudicated investigation with less than two years break in Federal service do not need to complete the electronic questionnaire for ADP/IT requirements. The contracting company FSO shall verify then notify the TMA PSB of new contractor employees who are in this status by sending a letter containing the individual's full name, Social Security Number (SSN), name of the agency that conducted the prior investigation, and the closed date of the investigation.

7.7.2 Notifications shall be sent to TMA PSB via secure fax (703) 681-3934; or USPS to:

TRICARE Management Activity
Office of Administration
Support Services Division
ATTN: Personnel Security Branch
7700 Arlington Blvd
Suite 5101

Falls Church, Va 22041-5101

7.7.3 TMA PSB will verify the information provided in the letter and notify the FSO if the investigation is reciprocal to the required investigation, based on the contractor employee's position or required access at TMA.

7.8 Requests For Additional Information

TMA PSB may request additional information from the contractor employee submitted for an ADP/IT-I or ADP/IT-II, while the investigation is in progress. The company FSO shall be notified to provide the requested information in the designated timeframe or the investigation may be rejected or returned unacceptable.

7.9 Notification Of Submittal, Termination, And Denial

7.9.1 The contracting company FSO shall notify the COR when an applicant's e-QIP action is submitted so the AUB can be reviewed and approved in the designated timeframe.

7.9.2 If a contracting company moves a contractor employee to another of its TRICARE contracts, TMA PSB should be notified immediately. This notification is important particularly when a contractor employee is being moved from a non-classified contract to a classified contract.

7.9.3 When a contractor employee is terminated from the TRICARE contract, contracting companies shall notify the TMA PSB immediately. The contracting company FSO shall provide the TMA PSB the following information on the employee via secure fax at (703) 681-3934 or USPS.

- Name
- SSN
- Name of the contracting company
- Termination date

7.9.4 Upon receipt of a denial letter from the TMA PSB, the FSO shall immediately terminate that individual's direct access to all MHS IS by confiscating, securing, and returning the issued CAC to TMA PSB. The return receipt letter issued with the denial letter by the TMA PSB will be returned with the CAC to show termination has been completed.

7.9.5 The contracting company FSO shall return CACs issued to terminated or denied contractor employees to the following address:

TRICARE Management Activity
Office of Administration
Support Services Division
ATTN: Personnel Security Branch
7700 Arlington Blvd
Suite 5101
Falls Church, Va 22041-5101

8.1 PROCESS FOR SUBMITTING SF 86P, "QUESTIONNAIRE FOR NATIONAL SECURITY POSITIONS," FOR CONTRACTOR PERSONNEL WORKING IN PUBLIC TRUST POSITIONS

8.2 Contractor personnel who do not have the appropriate level of investigation to obtain access to TMA/DoD IT systems or networks must now complete the SF 86 located in e-QIP. Completed SF 86s will be submitted for processing through e-QIP to the TMA PSB. The requirement to use the SF 86 when requesting ADP/IT level investigations for contractors is implemented in accordance with OUSD(I) memo dated November 4, 2010, subject: Aligning OPM Investigative Levels with Reform Concepts.

8.2.1 TMA PSB will review, approve, and release the investigation form to OPM through the e-QIP system. When there is a discrepancy in the information submitted or if the form is incomplete, further action will be required by the FSO before submission to OPM. Once the investigation is scheduled at OPM, the status will be posted in the Joint Personnel Adjudication System (JPAS) usually within three to five business days. For contracting companies that do not have JPAS access, TMA PSB will notify the FSO via e-mail, within the scheduled date of investigation by OPM.

8.2.2 If the FSO does not receive e-mail notification of a scheduled investigation during the designated timeframe, the FSO shall contact the TMA PSB and request the status of the investigation. Inquiries shall include the employees name, SSN and nature of the inquiry and send to the TMA PSB via secure fax at (703) 681-3934 or US Postal Service.

8.2.3 In the event the contractor employee is no longer with the contracting company or no longer requires the ADP/IT level access, the contractor company FSO shall notify the TMA PSB immediately.

8.2 .Verification Process for Contractor Employees Requiring CACs

Contracting companies must identify all contractor employees who will require a CAC to TMA PSB prior to authorization for access to any TMA/DoD ISs. CAC issuance is limited to contractor employees with job requirements for access to TMA/DoD ISs, or applications not available in the public domain (e.g., via web site to public users). The following actions shall be taken upon identification of employees who will require a CAC:

8.2.1 For current TRICARE contracts, on official company letterhead, the FSO shall submit a list containing the names and SSN for each employee to the COR for review and approval before forwarding to TMA PSB.

8.2.2 For new contractor employees, on official company letterhead, the FSO shall submit a list containing the names and SSN for each employee to the COR for review and approval before forwarding to TMA PSB.

8.2.3 After the FSO receives approval from the COR, an encrypted list (in accordance with TMA specified protocols) will be forwarded to TMA PSB at TMA.PSD@tma.osd.mil at the for verification of ADP/IT status.

8.2.4 TMA PSB shall return the verified list to the FSO. TMA PSB shall provide notification that the CAC issuance process may continue for the verified employee(s).

8.3 Electronic Questionnaires for Investigations Processing (e-QIP)

8.3.1 All contractor applications for ADP trustworthiness positions shall be submitted through the e-QIP system. E-QIP is a secure OPM web-based automated system that facilitates the processing of the following Standard Forms (SFs): SF 85 "Questionnaire for Non-Sensitive Positions," SF 85P, "Questionnaire for Public Trust Positions," and SF 86, "Questionnaire for National Security Positions." Per paragraph 8.1, the SF 86 shall be used when processing contractor investigations in e-QIP.

8.3.2 In order to access the e-QIP system, all FSOs and CORs shall:

- Complete the required e-QIP training course given by TMA PSB, and
- Complete and submit the TMA e-QIP Access User Form to the TMA PSB.

8.3.3 Once each of these actions has been completed, the Agency Administrator for the TMA PSB will create an e-QIP account and grant access to the e-QIP portal.

9.1 DOD/MHS INFRASTRUCTURE SECURITY, PORTS, PROTOCOLS AND RISK MITIGATION STRATEGIES

9.2 Contractors will comply with DoD guidance regarding allowable ports, protocols and risk mitigation strategies. The Joint Task Force for Global Network Operations (JTF-GNO) is the responsible proponent for the security of the DoD/MHS Infrastructure. Upon identification of security risks, the JTF-GNO issues JTF-GNO Warning Orders notifying users of scheduled changes for access to the DoD/MHS Infrastructure. TMA will provide contractors with JTF-GNO Warning Orders for review and identification of impacts to their connections with the DoD/MHS. Contractors are required to review Warning Orders upon receipt and provide timely responses to TMA indicating whether the change will or will not affect their connection.

9.3 Upon identification of an impact by the contractor, the contractor shall develop a mitigation strategy to identify the required actions, schedule for implementation and anticipated costs for implementation. The mitigation strategy must be submitted to TMA for review and approval by the JTF-GNO.

9.4 When connectivity requirements that are designated by the Government for the fulfillment of contract requirements are affected by DoD guidance and/or JTF-GNO Warning Orders, mitigation strategies will be developed by the governing agencies.

10.1 PUBLIC KEY INFRASTRUCTURE (PKI)

The DoD has initiated a PKI policy to support enhanced risk mitigation strategies in support of the protection of DoD's system infrastructure and data. DoD's implementation of PKI requirements are specific to the identification and authentication of users and systems within DoD (DoDD 8190.3 and DoDI 8520.2). The following paragraphs provide current DoD PKI requirements.

10.2 User Authentication

All contractor personnel accessing DoD applications; and networks are required to obtain PKI enabled and Personal Identity Verification (PIV) compliant Government accepted credentials.

Contractor personnel with access limited to internal contractor systems and applications are not required to obtain PKI enabled and PIV compliant credentials. Such credentials must follow the PIV trust model (FIPS 201) and be acceptable to the government. Currently, to meet this requirement, contractors shall obtain Government-issued CACs. PIV compliant credentials are required for access to DoD systems, networks and data. Alternate sign on access will not be granted. They also allow encryption and digital signatures for information transmitted electronically that includes DoD/TMA data covered by the Privacy Act, HIPAA and SI and network requirements.

10.2.1 Process to Obtain a CAC

10.2.1.1 A contracting company FSO shall ensure all users requiring CACs submit the appropriate security documentation for ADP/IT level I or II to the TMA PSB.

- Two FD-258 fingerprint cards or copy of electronic fingerprint scan
- Signed Authorization to Release Information
- Signed Authorization to Release Medical Information
- Signed Certification Page

TMA PSB must receive the following completed forms from OPM before granting interim access to TMA/DoD IS network and allowing a CAC to be issued:

- A contractor's investigation must be scheduled by OPM, and
- The results of a favorable Advance NAC report.

10.2.1.2 In order to obtain a CAC, contractor personnel must first be sponsored by an authorized government representative (sponsor). This representative must be either an active military service member or a federal civilian employee.

10.2.1.3 The contracting company FSO shall coordinate CAC requests with the authorized government representative before forwarding them to the TMA PSB. These requests shall include necessary personal and employment documentation for all personnel requiring CACs. If 20 or more employees require CACS, the FSO may submit this information to TMA PSB on an approved TMA PSB Excel spreadsheet by fax at (703) 681-3934 or e-mail. The e-mail submission must be protected with a TMA-approved encryption method, and the information provided as a file attachment in XML (eXtensible Markup Language) format for initial startup.

10.2.1.4 The Trusted Agent (TA) will provide a user ID and password to each individual contractor employee (hereinafter "individual") in order to access the Contractor Verification System (CVS). CVS is a web-based application which allows DoD contractors, volunteers, and federal agency (other than DoD) employees to register electronically for the CAC through the internet. The TA will provide a unique user ID and password to each individual in a secure manner, e.g., directly provided to user in a written or verbal format.

10.2.1.5 The individual will use the unique user ID and password to log into CVS to complete and submit the online CAC application in accordance with instructions provided by the TA or the online application will be automatically disabled in CVS.

10.2.1.6 The TA will review the online application submitted by the individual in CVS. Upon review, the TA shall determine whether to approve the application, return it to the individual for changes, or reject it.

10.2.1.7 When individuals are notified by e-mail that their application has been approved, they will go to the nearest Real-Time Automated Personnel Identification System (RAPIDS) issuance facility within 90 days to obtain their CAC, or the approved online application will be automatically disabled in CVS. Individuals must bring two forms of identification with them—one being a federal, state or local issued identification card with a photograph (i.e., driver's license/passport). Visit web site for a list of valid forms of identification: https://www.dmdc.osd.mil/cvs/docs/List_Of_Valid_IDs.pdf. RAPIDS issuance facility locations may be obtained at www.dmdc.osd.mil/rsl. The Verifying Official (VO) will verify the identification and capture the biometric data that will be encoded on the CAC.

10.2.2 Initial Contract Start Up

10.2.2.1 When 200 or more contractor employees require CAC issuance, the government may produce the CACs at a Central Issuing Facility (CIF). In order to facilitate the CAC issuance process, the government may also deploy a mobile RAPIDS station to the contractor's site to verify individual employee identity and obtain the biometric data required for the CAC. The site for the mobile RAPIDS station will be determined by the government. Information obtained by the mobile RAPIDS station will be forwarded to the CIF for production of the CAC.

10.2.2.2 The contractor will designate two individuals for the CAC distribution process. The first individual shall be the designated recipient for the CACs that are produced by the CIF; the second will be the recipient for the CAC PINs. Each individual will be responsible for separately distributing the CAC or the PIN, as determined by the responsibility assigned by the contractor.

10.2.3 Reverification

CAC cards for contractors are effective for three years or until the contract end date of the contract, whichever is shorter. The TA is required to confirm (in CVS) every six months from the date access was granted to each user that there is a continued need for an individual to have an active CAC account. During reverification, the TA may have justification to revoke an individual's active CAC.

10.2.4 Lost or Damaged CACs

Lost CACs must be reported by individuals to their contracting company FSO and government representative within 24 hours after the loss is identified. Damaged CACs must be returned to the government when obtaining a new CAC. In order to replace a CAC when lost or damaged, individuals must adhere to paragraph 10.1.1.7 and contact the nearest RAPIDS issuance facility location.

10.2.5 Termination of Employment

10.2.5.1 Upon resignation or termination of an individual's employment with the contract, the CAC must be surrendered to the contracting company FSO within 24 hours. CACs must also be surrendered if the individual employee changes positions and no longer has a valid need for access

to DoD systems or networks. Returned CACs shall be logged and retained by the FSO. The FSO shall immediately notify the government representative and TMA PSB. The individual's access shall be terminated by TMA PSB and arrangements will be made to return the CAC to the government within three days. CACs shall not be destroyed by the contractor and must be returned to the government. The contracting company shall provide the TMA PSB and OPM the following information on the employee:

- Name
- SSN
- Name of the contracting company
- Termination date
- Type of investigation scheduled (if applicable)

10.2.5.2 The information above shall be sent to the TMA PSB via secure fax at (703) 681-3934 or the following USPS address:

TRICARE Management Activity
Office of Administration
Support Services Division
ATTN: Personnel Security Branch
7700 Arlington Blvd
Suite 5101
Falls Church, VA 22041-5101

10.2.5.3 TMA PSB shall notify FSOs when their contractor employee is denied access to TMA/DoD systems or networks. Upon receipt of a denial letter from the TMA PSB, the FSO will immediately terminate the contractor's direct access to all MHS IS, and if the employee was issued a CAC, confiscate and secure the CAC from the employee. The FSO shall confirm to the TMA PSB in writing not later than one week of the date of the letter that actions were taken to include the CAC being returned to TMA PSB.

10.2.6 Personal Identification Number (PIN) Resets

Should an individual's CAC become locked after attempting three times to access it, the PIN will have to be reset at a RAPIDS facility or by designated individuals authorized CAC PIN Reset (CPR) applications. These individuals may be contractor personnel, if approved by the government representative. PIN resets cannot be done remotely. The government will provide CPR software licenses and initial training for the CPR process; the contractor is responsible for providing the necessary hardware for the workstation (PC, Card Readers, Fingerprint capture device). It is recommended that the CPR workstation not be used for other applications, as the government has not tested the CPR software for compatibility. The CPR software must run on the desktop and cannot be run from the Local Area Network (LAN). The contractor shall install the CPR hardware and software, and provide the personnel necessary to run the workstation.

10.2.7 E-Mail Address Change

The User Maintenance Portal (UMP) is an available web service that allows current CAC holders to change e-mail signing and e-mail encryption certificates in the event of a change in e-mail addresses. This service is accessible from a local workstation via web services.

10.2.8 System Requirement for CAC Authentication

Contractors shall procure, install, and maintain desktop level CAC readers and middleware. The middleware software must run on the desktop and cannot be run from the LAN. Technical Specifications for CACs and CAC readers may be obtained at www.dmdc.osd.mil/smartcard.

10.2.9 Contractors shall ensure that CACs are only used by the individual to whom the CAC was issued. Individuals must protect their PIN and not allow it to be discovered or allow the use of their CAC by anyone other than him/herself. Contractors are required to ensure access to DoD systems applications and data is only provided to individuals who have been issued a CAC and whose CAC has been validated by the desktop middleware, including use of a card reader. Sharing of CACs, PINs, and other access codes is expressly prohibited.

10.2.10 The contractor shall provide the contractor locations and approximate number of personnel at each site that will require the issuance of a CAC upon contract award.

10.2.11 The contractor shall identify to Purchased Care Systems Integration Branch (PCSIB) and DMDC the personnel that require access to the DMDC Contractor Test environment and/or the Benchmark Test environment in advance of the initiation of testing activities.

10.2 System Authentication

The contractor is required to obtain DoD acceptable PKI server certificates for identity and authentication of the servers upon direction of the CO. These interfaces include, but are not limited to, the following:

- Contractor systems for inquiries and responses with DEERS
- Contractor systems and the TED Processing Center

11.1 TELECOMMUNICATIONS

11.2 MHS Demilitarized Zone (DMZ) Managed Partner Care B2B Gateway

11.2.1 For all non-DMDC web applications, the contractor will connect to a DISA-established Web DMZ. For all DMDC web applications, the contractor will connect to DMDC.

11.2.2 In accordance with contract requirements, contractors shall connect to the B2B gateway via a contractor procured Internet Service Provider (ISP) connection. Contractors will assume all responsibilities for establishing and maintaining their connectivity to the B2B Gateway. This will include acquiring and maintaining the circuit to the B2B Gateway and acquiring a Virtual Private Network (VPN) device compatible with the MHS VPN device.

11.2.3 Contractors will complete a current version of the DISA B2B gateway questionnaire providing information specific to their connectivity requirements, proposed path for the connection and last mile diagram. The completed questionnaire shall be submitted to DISA for review and scheduling of an initial technical specifications meeting.

11.2 Contractor Provided IT Infrastructure

11.2.1 Platforms shall support HyperText Transfer (Transport) Protocol (HTTP), HyperText Transfer (Transport) Protocol Secure (HTTPS), Web derived Java Applets, secure File Transfer Protocol (FTP), and all software that the contractor proposes to use to interconnect with DoD facilities.

11.2.2 Contractors shall configure their networks to support access to government systems (e.g., configure ports and protocols for access).

11.2.3 Contractors shall provide full time connections to a TIER 1 or TIER 2 ISP. Dial-up ISP connections are not acceptable.

11.3 System Authorization Access Request (SAAR) Defense Department (DD) Form 2875

11.3.1 All contractors that use the DoD gateways to access government IT systems networks, and/or DoD applications (e.g., DEERS applications, PEPR, DCS, MDR, etc.) shall submit the most current version of DD Form 2875 found on the DISA web site: http://www.dtic.mil/whs/directives/infomgt/forms/forminfo/forminfopage3211.html in accordance with CO guidance. A DD Form 2875 is required for each contractor employee who will access any system and/or application on a DoD system or network. The DD Form 2875 must clearly specify the system and/or application name and provide justification for access to that system and/or application.

11.3.2 The contractor FSO must complete and submit the completed DD Form 2875 to the TMA PSB for verification of ADP/IT designation (see paragraph 5.0). TMA PSB will verify if the contractor employee has the appropriate background investigation completed/or a request for background investigation has been submitted at OPM for access to a DoD system or network prior to approval.

11.3.3 Upon verification, TMA PSB will forward the DD Form 2875 to the MHS Cyberinfrastructure Services (MCiS) for processing. MCiS will in turn forward the DD Form 2875 to DISA. DISA will provide an ID and password to the required individual via e-mail upon the establishment of a user account. User accounts will be established for the requested individual use and may not be shared by multiple users or for system generated access to any DoD application. Misuse of user accounts by individuals or contractor entities will result in termination of system access for the individual user account

11.3.4 The contractor FSO shall conduct a monthly review of all contractor employees who have been granted access to DoD IS'/networks or systems to verify that continued access is required. The FSO shall provide the TMA PSB with a report of the findings of their review by the 10th day of the month following the review. Reports identifying changes to contractor employee access requirements shall include the name, SSN, Company, IS/network for which access is no longer required and the date access should be terminated.

11.4 MHS Systems Telecommunications

11.4.1 The primary communication links shall be via Secure Internet Protocol (IPSEC) VPN tunnels between the contractor's primary site and the MHS B2B Gateway.

11.4.2 The contractor shall place the VPN appliance device outside the contractor's firewalls and shall allow full management access to this device (e.g., in router access control lists) to allow Central VPN Management services provided by the DISA or other source of service as designated by the MHS to remotely manage, configure, and support this VPN device as part of the MHS VPN domain.

11.4.3 For backup purposes, an auxiliary VPN device for contractor locations shall also be procured and configured for operation to minimize any downtime associated with problems of the primary VPN.

11.4.4 Devices sent by the contractor to the MHS VPN management authority (e.g., DISA) will be sent postage paid and include prepaid return shipping arrangements for the devices(s).

11.4.5 The MHS VPN management authority (e.g., DISA) will remotely configure the VPN once installed by the contractor.

11.4.6 Maintenance and repair of contractor procured VPN equipment shall be the responsibility of the contractor. Troubleshooting of VPN equipment shall be the responsibility of the government.

11.5 Establishment of Telecommunications

11.5.1 Telecommunications shall be established with the MHS through coordination with TMA, TIMPO and DISA. The contractor shall identify their requirement(s) for the establishment of telecommunications with the MHS, DMDC or other Government entity.

11.5.2 Telecommunications in support of Benchmark Testing (see the TOM, Chapter 1, Section 7 or guidance as stated in the contract) shall be successfully established no later than 30 calendar days in advance of the scheduled Benchmark Test.

11.5.3 The contractor will complete the current version of the B2B Gateway Questionnaire (to be provided by TMA) identifying the required telecommunication infrastructure between the contractor and the MHS systems. This includes all WAN, LAN, VPN, Web DMZ, and B2B Gateway access requirements. The completed Questionnaire shall be returned to the TMA designated POC for review and approval. Upon government request, the contractor shall provide technical experts to provide any clarification of information provided in the Questionnaire. TMA will forward the Questionnaire to TIMPO for further review and processing.

11.5.4 TIMPO will coordinate any requirements for additional information with the TMA POC and schedule any meetings required to review the Questionnaire. Upon approval of the Questionnaire, TIMPO will coordinate a testing meeting with TMA. TMA will notify the contractor POC of the meeting schedule. The purpose of the testing meeting is to complete a final review of the telecommunication requirements and establish testing dates.

11.5.5 The contractor shall provide the TMA Purchased Care Systems Integration Branch (PCSIB) or the equivalent office with a copy of the approved and signed B2B Questionnaire for all telecommunication efforts.

11.5.6 The contractor shall also provide a copy of the SIP and system baseline configuration for DIACAP (see paragraph 3.4.2.2.5) purposes to the TMA PCSIB or equivalent office. The documents

provided shall represent the system baseline configuration agreed upon with government (IA) officials. This information will be maintained for the facilitation of telecommunication problem resolution.

11.6 Contractors Located On MTFs

11.6.1 Contractors located on a military installation who require direct access to government systems shall coordinate/obtain these connections with the local MTF and Base/Post/Camp communication personnel. These connections will be furnished by the government.

11.6.2 Contractors located on military installations that require direct connections to their networks shall provide an isolated IT infrastructure. They shall coordinate with the Base/Post/Camp communications personnel and the MTF in order to get approval for a contractor procured circuit to be installed and to ensure the contractor is within compliance with the respective organizational security policies, guidance and protocols.

Note: In some cases, the contractor may not be allowed to establish these connections due to local administrative/security requirements.

11.6.3 The contractor shall be responsible for all security certification documentation as required to support DoD IA requirements for network interconnections. Further, the contractor shall provide, on request, detailed network configuration diagrams to support DIACAP accreditation requirements. The contractor shall comply with DIACAP accreditation requirements. All network traffic shall be via TCP/IP using ports and protocols in accordance with current Service security policy. All traffic that traverses MHS, DMDC, and/or military Service Base/Post/Camp security infrastructure is subject to monitoring by security staff using Intrusion Detection Systems.

11.7 TMA/TED

11.7.1 Primary Site

The TED primary processing site is currently located in Oklahoma City, OK, and operated by the Defense Enterprise Computing Center (DECC), Oklahoma City Detachment of the DISA.

Note: The location of the primary site may be changed. The contractor shall be advised should this occur.

11.7.2 General

The common means of administrative communication between government representatives and the contractor is via telephone and e-mail. An alternate method may be approved by TMA, as validated and authorized by TMA. Each contractor on the telecommunication network is responsible for furnishing to TMA at the start-up planning meeting (and update when a change occurs), the name, address, and telephone number of the person who will serve as the technical POC. Contractors shall also furnish a separate computer center (Help Desk) number to TMA which the TMA computer operator can use for resolution of problems related to data transmissions.

11.7.3 TED-Specific Data Communications Technical Requirements

The contractor shall communicate with the government's TED Data Center through the MHS B2B Gateway.

11.7.3.1 Communication Protocol Requirements

11.7.3.1.1 File transfer software shall be used to support communications with the TED Data Processing Center. CONNECT:Direct is the current communications software standard for TED transmissions. The contractor is expected to upgrade/comply with any changes to this software. The contractor shall provide this product and a platform capable of supporting this product with the TCP/IP option included. Details on this product can be obtained from:

Sterling Commerce
4600 Lakehurst Court
P.O. Box 8000
Dublin, OH 43016-2000 USA
http://www.sterlingcommerce.com/solutions/products/ebi/connect/direct.html
Phone: 614-793-7000
Fax: 614-793-4040

11.7.3.1.2 For Ports and Protocol support, TCP/IP communications software incorporating the TN3270 emulation shall be provided by the contractor.

11.7.3.1.3 Transmission size is limited to any combination of 400,000 records at one time.

11.7.3.1.4 "As Required" Transfers

Ad hoc movement of data files shall be coordinated through and executed by the network administrator or designated representative at the source file site. Generally speaking, the requestor needs only to provide the POC at the remote site, and the source file name. Destination file names shall be obtained from the network administrator at the site receiving the data. Compliance with naming conventions used for recurring automated transfers is not required. Other site specific requirements, such as security constraints and pool names are generally known to the network administrators.

11.7.3.1.5 File Naming Convention

11.7.3.1.5.1 All files received by and sent from the TMA data processing site shall comply with the following standard when using CONNECT:Direct:

POSITION(S)	CONTENT
1 - 2	"TD"
3 - 8	YYMMDD Date of transmission
9 - 10	Contractor number
11 - 12	Sequence number of the file sent on a particular day. Ranges from 01 to 99. Reset with the first file transmission the next day.

11.7.3.1.5.2 All files sent from the TMA data processing site shall be named after coordination with receiving entities in order to accommodate specific communication requirements for the receivers.

11.7.3.1.6 Timing

Under most circumstances, the source file site shall initiate automated processes to cause transmission to occur. With considerations for timing and frequency, activation of transfers for each application shall be addressed on a case by case basis.

11.7.3.1.6.1 Alternate Transmission

Should the contractor not be able to transmit their files through the normal operating means, the contractor should notify TMA (EIDS Operations) to discuss alternative delivery methods.

11.8 TMA/MHS Referral And Authorization System

The MHS Referral and Authorization System is to be determined. Interim processes are discussed in the TOM.

11.9 TMA/TRICARE Duplicate Claims System

The DCS is planned to operate as a web application. The contractor is responsible for providing internal connectivity to the public Internet. The contractor is responsible for all systems and operating system software needed internally to support the DCS. (See the TOM, Chapter 9 for DCS Specifications.)

11.10 Payroll Allotment Systems

Enrollment fees/premium payments for specified TRICARE Programs may be paid by electronic monthly allotments from military payroll. The availability of this payment option is determined by the Program requirements and the service member's duty status and may not be available for all TRICARE Programs. Payroll allotment data is exchanged between military payroll centers and the TRICARE purchased care contractors. TRICARE contractors process allotment information exchanged with military payroll centers in accordance with the TOM, Chapter 6, Section 1 or as stated in the contract. The following allotment processing guidance is provided in accordance with the Memorandum of Understanding (MOU) established between the TMA and DFAS, the U.S. Coast Guard (USCG), and Public Health Service (PHS) for allotments from retired pay.

11.10.1 Exchange of Payroll Allotment Data

Contractors must exchange payroll allotment data with the DFAS and the USCG and PHS using a specified transmission protocol.

11.10.1.1 DFAS

Payroll allotment data for the U.S. Army, Air Force, Navy, and Marines must be transmitted to DFAS via the B2B Gateway using Secure File Transfer Protocol (SFTP) or a secure

internet file transfer, e.g., Multi-Host Internet Access Portal (MIAP). The use of the B2B or a Government identified secure file transfer requires compliance with all security requirements in this Chapter. Contractors are required to separately provide DFAS with a System Authorization Access Request (SAAR) DD Form 2875 requesting access to DFAS systems. This is in addition to what may have already been submitted for access to the B2B.

11.10.1.2 USCG and PHS

Payroll allotment data for the USCG and PHS must be transmitted via the SilkWeb (a secure Internet file transfer protocol) and *Titan* web application (see instructions in Addendum D D). All security and data handling requirements in this Chapter remain in effect. In addition, contractors are required to obtain user ids and passwords from the designated POC at the PHS.

11.10.2 Data Transmission Requirements

11.10.2.1 Contractors shall provide DFAS/USCG/PHS with a monthly file of retirees who have selected TRICARE Prime for their health benefit and elected monthly allotments as the methodology for paying enrollment fees. The dental contractor shall follow the same process for enrollees who have elected monthly alltotments as the means for paying their premiums. DFAS will return feedback files to contractors providing determinations of the actions, acceptance or rejection and whether the item is paid or unpaid.

11.10.2.2 Contractors shall provide DFAS/USCG/PHS with POCs for testing, system and ongoing business requirements. POC information shall be maintained and include: name, title, contractor name, address, electronic mail address and telephone number. Updated information shall be provided to DFAS when the POC or contact information changes.

11.10.2.3 DFAS/USCG/PHS will provide contractors with start/stop and change allotment requests received directly from TRICARE beneficiaries. Contractors will process these requests and submit an initial file containing information for all allotments selected in time for the first submission. Subsequent files will contain only new allotments and stops and/or changes.

11.10.2.4 The file (initial and subsequent) will be sent using the appropriate transmission protocol determined by the receiving payroll center, e.g., DFAS or USCG/PHS.

11.10.2.5 Contractors shall submit an electronic mail notification to DFAS/ USCG/PHS notifying them of the file transmission.

11.10.3 File Layout

11.10.3.1 Contractors shall exchange the following files with DFAS:

- Input data
- Reject Report
- Deduction Report

11.10.3.2 The file layout is provided at Addendum D. Contractors will be notified of any changes to the file layout by the CO.

11.10.3.3 Contractors shall submit files using the naming convention designated by DFAS.

11.10.4 Data Transmission Schedule

11.10.4.1 Data shall be transmitted by the contractor or their designated subcontractor on the business day immediately prior to the eighth day of each month (or on the previous Thursday, should the eighth fall on a Saturday or Sunday), for allotments due on the first day of the upcoming month. The only exception to this schedule is for the month of December when all data shall be transmitted so it is received on the first business day of December.

11.10.4.2 During months when no monthly beneficiary data exists, contractors shall continue to submit a file without data in accordance with the eighth day of the month rule. The file shall consist of a header and trailer record with no data in between. The electronic mail notification shall indicate the file contains no member data.

11.10.4.3 Within 24 hours of file processing by DFAS/USCG/PHS, contractors will receive a file from the pay center identifying all "rejected" submissions and the reasons for the rejection. The contractor shall research the rejected submissions and resubmit resolved transactions on the following month's file. The contractor shall also notify the beneficiary in accordance with TOM, Chapter 6, Section 1or as state in the contract.

11.10.4.4 Contractors will receive a file of the "deduct/no deduct" file that contains the "no deduct" reasons following processing of the "compute pay cycle" by the pay center. The contractor will research these items and resubmit resolved items, as appropriate, on the following month's file. The "deduct/no deduct" file is informational and will document all payments not collected as well as unfulfilled allotment requests (e.g., insufficient pay to cover deduction).

11.10.4.5 The contractor's banking institution will receive a Corporate Trade Exchange (CTX) "payment" file from DFAS on the first business day of the month following the submission of the files.

11.10.5 Data Transmission Start Up

11.10.5.1 The TMA Purchased Care Systems Integration Branch (PCSIB) will coordinate B2B Gateway and DFAS connectivity for all contractors.

11.10.5.2 PCSIB will also coordinate integration testing of the connectivity and data transmission. PCSIB and the contractor will collaborate with DFAS/USCG/PHS on the development of a test plan and schedule.

11.10.6 Transition

11.10.6.1 Upon reprocurement of a TRICARE contract, an incumbent contractor may succeed itself or a new contract company may be awarded the contract. Therefore, TMA will coordinate transition activities with the contractor and DFAS/USCG/PHS during the transition-in period (see the TOM, Chapter 1, Section 7 or as stated in the contract). When the contract is awarded to a new company, the following actions will be taken by the outgoing and incoming contractors.

11.10.6.2 The outgoing contractor shall send a "stop" (allotment) for any beneficiary whose transfer (disenrollment) has been processed by the sixth day of the month in which the file is being created.

11.10.6.3 The incoming contractor shall send a "start" (allotment) for any beneficiary whose transfer (enrollment) has been processed by the sixth of each month that the file is being created.

- END -

Chapter 3 Section 1.2

DEERS Concepts And Definitions

1.1 INTRODUCTION

1.2 All Defense Enrollment Eligibility Reporting System (DEERS) data provided by the Defense Manpower Data Center (DMDC) to the TRICARE Management Activity (TMA) for the use of determining medical eligibility, enrollment and medical claims payment are subject to the Privacy Act of 1974, as amended. DEERS data includes all data that is provided for test and/or production activities.

1.3 Release is made to you in accordance with the provisions of the Act allowing for intra-department release when an appropriate "need to know" exists. As such, the authorized organizations are responsible for using the protected Privacy Act data in accordance with the applicable provisions of the Act and DoD Personnel Security requirements. DEERS data is only accessible by personnel with at least an ADP/IT-II designation.

1.4 This includes:

1.4.1 Only personnel (military, civilian, contractor) with a need to know in the official performance of their duties may be given access, and

1.4.2 The data may only used for the specific purposes agreed to by DMDC and TMA.

1.4.3 The organization to which these data are provided must insure that sufficient physical and procedural safeguards are in place to satisfy the requirements of the Act.

1.4.4 These data should be returned to DMDC or destroyed when the approved use has been accomplished and no copies should be retained.

1.4.5 Any additional intended uses must first be submitted through TMA to DMDC for approval and are prohibited unless and until favorably coordinated with DMDC.

1.4.6 In addition, DMDC only provides the DEERS data for the specific purposes defined:

- Enrollment data is for the authorized enrollment of beneficiaries into valid health care plans as defined under the provisions of this Request For Proposal (RFP).
- Eligibility data is for reporting the eligibility of a beneficiary on DEERS as of the time of the eligibility inquiry.
- Claims data is for the processing and resolution of claims submitted for reimbursement of medical care received.

2.1 PURPOSE

2.2 The purpose of this chapter is to outline the systems and technical procedures to be followed in carrying out the data interchange between the DEERS and contractor systems for TRICARE benefit eligibility, enrollment, Other Health Insurance (OHI), and catastrophic caps and deductibles with DEERS.

2.3 This document provides specifications for the Managed Care Support Contractors' (MCSCs) and the Uniformed Services Family Health Plan (USFHP) interface with DEERS.

2.4 This document details the following:

- Terminology used within DEERS (see Appendix A)
- Methodology for identifying individuals within DEERS
- Functional events from the MCSCs and the USFHP that trigger a request to inquire and/or update data within DEERS

3.1 SYSTEM OVERVIEW

3.2 Program Description

3.2.1 DEERS serves as a centralized Department of Defense (DoD) data repository of personnel and medical data. The DEERS database contains detailed personnel eligibility information for benefits and entitlements distribution to Uniformed Services[1] members; United States (U.S.) sponsored foreign military members; DoD and Uniformed Services civilians; other personnel as directed by the DoD; and their eligible family members. DEERS supports essential day-to-day operations in a broad range of functional areas, including personnel, medical, and finance.

3.2.2 DEERS is updated by batch transactions from the Uniformed Services' automated personnel, finance, medical, and mobilization management systems, the Department of Veterans Affairs (DVA), and the Centers for Medicare and Medicaid Services (CMS). DEERS is also accessed and updated by online DEERS client applications, such as the Real-Time Automated Personnel Identification System (RAPIDS), and interfacing client systems of the Military Health System (MHS), such as the Composite Health Care System (CHCS). DEERS helps detect and prevent fraud and abuse in DoD benefits and entitlements distribution.

3.2.3 DEERS provides and receives updates to enrollment and eligibility verification data from existing DEERS' applications and interfacing information systems, as well as from other DoD, Uniformed Services, and non-DoD information systems, in accordance with DoD Directive 8000.1, "Defense Information Management (IM) Program," dated 27 October 1992. It provides statistical and demographic data to support DoD and Uniformed Services peacetime and wartime missions. DEERS maintains casualty identification data on members of the Uniformed Services, and other personnel as designated by DoD, to support casualty identification and verification of entitlement eligibility for surviving family members.

[1] The seven Uniformed Services are: U.S. Army, U.S. Navy, U.S. Marine Corps, U.S. Air Force, U.S. Coast Guard, their National Guard and Reserve components, U.S.Public Health Service (USPHS), and the National Oceanic and Atmospheric Administration (NOAA) Commissioned Corps.

4.0 DESCRIPTION

DEERS is a person-centric system that contains information about all DoD beneficiaries plus information about some people who are not eligible for DoD benefits. Within DEERS, interfaces with external systems are based on commercial standards where it supports the business requirements or standardized DEERS defined messages where needed. DEERS data provided by DMDC to TMA is also considered "protected health information" (PHI) as the term is defined in the Home Health System (HHS) Health Insurance Portability and Accountability Act (HIPAA) Privacy Final Rule and accordingly is subject to the requirements of DoD 6025.18-R which implements that rule for DoD and through the use of TMA business associate agreements to contractors and other non-DoD entities.

5.1 TYPES OF DATA DEERS USES AND STORES

DEERS stores different categories of information, including Person/Personnel, Beneficiary, and Health Care Benefit. Each is detailed below.

5.2 Person/Personnel Information

This is basic characteristic data about individuals, including both affiliations to DoD organizations or organizations designated by DoD, and affiliations within family units. Although historical data is available for longitudinal studies and demographic trend analysis, only current data is required for day-to-day clinical operations.

5.2.1 Person Data

- Primary (internal) identification - A mutually agreed-upon internal identifier shared between the repository and external interfacing systems
- Secondary (external) identification - Name, Social Security Number (SSN), and date of birth
- General characteristics - Sex, blood type, etc.
- Person-based programs - Organ donor
- Family association - Self, child, etc.
- Contact information - Address, telephone number

5.2.2 Personnel Data

- Personnel category - active duty, reserve, retired, etc.
- Service or organization - Army, Navy, DoD civilians, etc.
- Position - Rank
- Personnel readiness programs - DNA, blood type

5.2 Beneficiary Information

This information combines the underlying rules-based system that captures DoDI 1000.13 "Identification (ID) Cards for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals" and other applicable regulations and procedures with enrollment information, as maintained by the MHS community. This data is provided for past, current, and future periods from the inquiry date, and consists of specific Health Care Delivery Program (HCDP) information.

Examples of this information are:

- DoD HCDPs: DoD HCDPs are defined by DEERS as the methods of providing basic health benefits. Examples of these include TRICARE Prime, TRICARE Plus, and Continued Health Care Benefit Program (CHCBP).

- Other Government Programs (OGPs): OGP are defined by DEERS as programs or plans provided and supported by a U.S. Government agency other than the DoD.

- Other Health Insurance (OHI) (Commercial): OHI information is stored in DEERS to support third party collections.

5.3 Health Care Benefit Information

5.3.1 General Policy

Examples of medical benefit information that DEERS tracks on a policy level include:

- Deductible accumulation
- Enrollment fee accumulation and fee details (including fee exceptions)

5.3.2 Person Related

Examples of medical benefit information that DEERS tracks on a person level include:

- OHI
- Enrollment fee waiver information

6.1 SPECIFIC DEERS ROLES

6.2 Person Role

An individual exists within DEERS as a person who may have multiple roles, including but not limited to: a sponsor, a family member, a beneficiary, and a patient. This implies the existence of certain attributes tied to a person that do not normally change as his or her role within the system changes. For example, a person has a name, date of birth, weight, height, hair color, eye color, and an SSN. Both sponsor and family member are possible but not mutually exclusive roles of a person in the DEERS database. The family member role is supported by person association and condition data that is cross-referenced to the family member's sponsor.

6.3 Sponsor And Family Member Roles

A sponsor is any person who, as a direct affiliate or member of an organization within the DoD, is entitled to benefits from the DoD and who, through that affiliation or membership, may entitle his or her family members to benefits. Members of non-DoD organizations whose employees are authorized DoD benefits are also sponsors, and often accord eligibility to their family members.

Unremarried former spouses who meet eligibility requirements are considered as sponsors and are identified by their individual SSN. TRICARE entitlement for an unremarried former spouse is ended with the existence of an employer sponsored health plan. Contractors can identify an unremarried former spouse on the DEERS claims response from a discreet member category code that indicates the type of DoD Beneficiary. (See the DEERS Data Dictionary for Member Category Codes.) There is a unique member category code for each category of unremarried former spouse. If a DEERS claims response shows a person to be an unremarried former spouse (via the member category code) and the claim shows the possible existence of an employer sponsored health plan, the contractor shall proceed in accordance with the TRICARE Policy Manual (TPM).

Abused dependents also have a distinct member category code indicating their status. The presence of OHI does not remove an abused dependent's entitlement to TRICARE (see 32 CFR 199).

DEERS defines which relationships to sponsors make individual family members eligible for benefits. Some restrictions that influence the definition of a child family member include age, degree of support by the sponsor, physical disability, and educational status.

6.4 Beneficiary Role - Multiple Entitlements/Dual Eligibility

DEERS considers both sponsors and family members as beneficiaries (i.e., recipients of DoD benefits). The role of beneficiary is ambiguous, a person may be entitled to DoD benefits via his or her simultaneous association to more than one sponsor or by being a sponsor in one family while being a member of another. An example is a person that is a family member in two sponsored families at the same time. This situation occurs when both spouses in a family are sponsors. This condition is known as multiple entitlements. DEERS supports multiple entitlements by not only storing persons but any combination of their current and past associations.

Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and he or she becomes a sponsor. Becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

In some cases, the roles leading to multiple entitlements may change back and forth. For example, a child of married reservists who move in and out of active duty assignments may have transitory periods of entitlement to medical benefits under each sponsor. Each sponsor in this family has the potential to provide medical benefits for the family member (child) for various periods of time. Therefore, this multiple-entitled child may need to be changed back and forth between the two sponsor spouses as the situation changes. The concept of dual eligibility occurs when multiple entitlements are concurrent. This situation can occur when a sponsor is both a retired sponsor and a civil servant on overseas assignment. The beneficiary would have a coverage plan as the retired sponsor and another coverage plan as the civil servant. Hence, dual eligibility results when a person is associated with more than one DoD affiliation.

All instances of family membership and/or sponsorship are stored under unique identifiers. These identifiers are associated to a family as the DEERS Family Identifier (nine digit DEERS-assigned number) and each member of the family, including the sponsor, is further delineated by the DEERS Beneficiary Identifier (two digit DEERS-assigned number within each DEERS Family Identifier). All systems storing benefits or enrollment information about a beneficiary must do so by DEERS Family Identifier and DEERS Beneficiary Identifier (in combination known as the DEERS ID as well as the DoD Benefits Number (DBN) for a beneficiary). All information about TRICARE enrollments and policies to and from NED in DEERS and the regional contractors must be done using this Identifier. Updates of all other secondary attributes including SSN, Name, or Date of Birth are exchanged using this DEERS ID, which is also known as the DBN, as the primary means of identification.

6.5 Patient Role

The patient role results from an association or interaction between a person and a DoD Health Care delivery provider. It is important to note that a person is not required to be currently eligible for DoD benefits to be considered a patient. For example, the patient may have been a beneficiary in the past but is no longer eligible for DoD benefits. In certain cases, an individual who is not an authorized DoD beneficiary may be treated in an emergency situation at a DoD Military Treatment Facility (MTF), and is therefore a patient. Persons on the Person Data Repository (PDR) of DEERS and on clinical systems within the DoD are identified in the patient role by the Patient Identifier. All clinical and reporting data must be exchanged using this identifier. TRICARE contractors must store this identifier associated with each enrollee on their database.

6.6 Beneficiary Roles Within HCDPs

6.6.1 Subscriber Role

A subscriber is an individual who is the primary holder of a DoD policy (i.e., the primary holder of a DoD entitlement) for health care benefits based on his or her affiliation with the DoD. The subscriber is the sponsor.

6.6.2 Insured Role

An insured is an individual who is covered by a Uniformed Services health benefits program (i.e., an HCDP) for medical coverage. The individual is entitled to these programs based upon his or her association to a subscriber. A person may be both a subscriber and an insured. For example, under TRICARE Prime Individual Coverage for Retired Sponsors and Family Members, the sponsor is both the subscriber and an insured. However, other sponsors may be a subscriber and not be an insured. For example, a sponsor on active duty may be the subscriber for his or her family members that are insured under TRICARE Prime Family Coverage for Active Duty Family Members (ADFMs).

6.6 Sponsor, Subscriber, Beneficiary, And Insured Roles

As a sponsor, the person may also be the subscriber who holds the DoD “policy” for health care benefits. As a beneficiary, the person may also be an insured who is covered by a DoD “policy” for health care benefits.

6.7 Family Member, Beneficiary, And Insured Roles

As a sponsor, the person may also be the subscriber who holds the DoD policy for health care benefits. Another person, through associations and relationships, may be a family member to the sponsor, which implies a role as a beneficiary. As a beneficiary, the person may also be an insured who is covered by a DoD policy for health care benefits.

7.1 TRICARE POPULATIONS

The TRICARE programs serve a wide range of beneficiaries holding various statuses throughout their lifetime. The following information details the populations covered by the TRICARE benefit. The definition of the populations may be modified as legislation or TMA requires. These populations include:

- Active Duty Service Members (ADSMs) and ADFMs. These may include members from both the Active and Reserve components.
- Transitional Assistance Management Program (TAMP) Sponsors and Family Members
- Transitional Survivors of Active Duty Deceased Sponsors - Family members of an ADSM who died while on Active Duty. This also includes the family members of a Guard/Reserve sponsor who died while on active duty for more than 30 days.
- Survivors of Active Duty Deceased Sponsors - Spouses of an ADSM who died over three years ago while on active duty. This also includes the spouses of a Guard/Reserve sponsor who died over three years ago while on active duty for more than 30 days.
- Retired Sponsors and Family Members - Retirees eligible for retirement pay and their family members as well as Medal of Honor recipients.
- Transitional Survivors of Guard/Reserve Deceased Sponsors - Family members of a Guard/Reserve sponsor who died within the past three years, while on active duty for 30 days or less.
- Survivors of Guard/Reserve Deceased Sponsors - Family members of a Guard/Reserve sponsor who died in service over three years ago, while on active duty for 30 days or less.
- Selected Reserve members and their family members.

8.1 TYPES OF HCDP PLANS

Delivery programs are methods of providing basic health benefits. Coverage under these programs may be either individual or family, depending on the number of beneficiaries enrolled and beneficiaries' affiliation to the sponsor, as well as the program definition. There are two types of plans within DEERS: assigned and enrolled.

- Assigned plans represent the base entitlement of a beneficiary (e.g., TRICARE Standard). Assigned plans are based on a sponsor's affiliation to a DoD organization (e.g., Army Active Duty); therefore, when a sponsor's DoD affiliation changes (e.g., Army Active Duty

to Army Reserves), a new assigned plan is created for both the service member and family members.

- Enrolled plans represent another level of benefit into which the beneficiary has elected enrollment (e.g., TRICARE Prime).

- TRICARE Extra allows a beneficiary eligible for TRICARE Standard to seek care from a TRICARE network provider, thus obtaining a discount on services and reduced cost-share. Since TRICARE Extra acts like TRICARE Standard for DEERS purposes, DEERS does not track this option.

8.2 Medical Health Care Delivery Plans

The following sections detail the various types of health care plans currently available within the DoD. The Managed Care Support Contractor (MCSC)/USFHP provider is required to implement a system that allows changes to health care plans and HCDP plan coverage codes as legislation and regulation require. Refer to HCDP Plan Codes on the DEERS web site (https://www.dmdc.osd.mil/deers), for specific information related to each plan.

8.1.1 Assigned Plans

These plans are the defaults assigned by DEERS for beneficiaries based on their eligibility status. Assigned plans do not require enrollment actions.

8.1.1.1 Assigned Health Care Plan: ADSMs - TRICARE Prime, No Primary Care Manager (PCM) Selected

The Active Duty (AD) - TRICARE Prime, No PCM Selected HCDP is the default coverage assigned by DEERS for active duty sponsors. They are entitled to Direct Care (DC) and pharmacy benefits. This plan is the default for ADSMs who are not enrolled in a specific MTF or TRICARE Prime Remote (TPR). These enrollees are deemed Prime but do not have a PCM. (See Section 1.4.)

8.1.1.2 Assigned Health Care Plan: TRICARE Standard

The TRICARE Standard HCDP is the basic coverage assigned by DEERS for eligible beneficiaries and results when a beneficiary under the age of 65, or 65 and over but not Medicare eligible, is entitled to both DC and Civilian Health Care (CHC).

8.1.1.3 Assigned Health Care Plan: Direct Care Only

This plan identifies beneficiaries who are entitled only to DC in MTFs. Examples of the eligible population include dependent parents and parents-in-law, or beneficiaries who are eligible for the Medicare benefit that do not have both Medicare Parts A and B.

8.1.1.4 Assigned Health Care Plan: TRICARE For Life

Beneficiaries with Medicare Parts A and B are eligible for the TFL benefit.

8.1.1.5 Assigned Health Care Plans for DoD Affiliates

DoD affiliates are a conglomerate category of individuals entitled to DC or CHC at different levels than the groups defined in other HCDPs. The currently defined compositions of the DC categories are:

8.1.1.5.1 Assigned Health Care Plan: Direct Care For Continental United States (CONUS) For DoD Affiliates

This health care plan is available for the following population(s):

- North Atlantic Treaty Organization (NATO) Sponsored, Partnership for Peace, and NATO Non-Sponsored Foreign Military and their Family Members
- Non-NATO Sponsored Foreign Military and their Family Members

8.1.1.5.2 Assigned Health Care Plan: Direct Care For Outside The Continental United States (OCONUS) DoD Affiliates

This health care plan is available for the following population(s):

- NATO and Non-NATO Foreign Military and their Family Members
- Civilian Personnel of DoD and other government agencies and their accompanying family members
- Civilian contractors under contract to the DoD or the Uniformed Services
- Uniformed and non-uniformed full-time personnel of the Red Cross and their family members
- Area executives, center directors, and assistant directors of the USO and their family members
- United Seaman's Service (USS) personnel and their accompanying family members
- Military Sealift Command (MSC) Civil Service personnel

8.1.1.5.3 Enrolled Health Care Plan: TRICARE Standard For CONUS DoD Affiliates

This health care plan is available for the following population(s):

- Family Members of Sponsored and Non-sponsored NATO Foreign Military

8.1.2 Enrolled Plans

8.1.2.1 Enrolled Health Care Plan: TRICARE Prime - ADSM

ADSMs eligible for DC benefits are required to enroll into TRICARE Prime. Beneficiaries then select or are assigned a PCM in a MTF.

8.1.2.2 Enrolled Health Care Plan: TRICARE Prime Remote - ADSM (TPRADSM)

The National Defense Authorization Act (NDAA) of 1998 requires medical care coverage for active duty members of the armed forces assigned to remote locations. This coverage is provided through the TRICARE Prime Remote (TPR) Program.

Eligibility for this health care coverage requires that the ADSM's permanent duty location and residence be more than 50 miles or approximately one hour's drive from a MTF or designated clinic or in a authorized zip code. Under this program, the ADSM may enroll and select a civilian or USFHP PCM. Since in some locations PCMs are not available, Active Duty personnel may be enrolled in TPR without a PCM assignment.

8.1.2.3 Enrolled Health Care Plan: TRICARE Prime - ADFM

Beneficiaries who are eligible for TRICARE Standard as defined in paragraph 8.1.1.2 may elect to enroll into TRICARE Prime, with an MTF, a civilian network provider, or a USFHP coverage. Beneficiaries must enroll through an authorized enrolling organization. Beneficiaries then select or are assigned a PCM, and under some coverage plans may pay an annual fee for coverage. All the TRICARE Prime enrolled populations will share the same HCDPs and may be differentiated only by the network provider type code.

8.1.2.4 Enrolled Health Care Plan: TRICARE Prime Remote - ADFM (TPRADFM)

Eligibility for this health care coverage requires that the ADSM's permanent duty location and residence be more than 50 miles or approximately one hour's drive from an MTF or designated clinic, as determined by residential and daily work location zip codes; and that the family member has the same residential zip code as the sponsor. Resides with rules vary based on the status of the sponsor. Under this program the family members may enroll and select a civilian PCM. Since in some locations PCMs are not available, ADFMs may be enrolled in TPR without a PCM assignment.

8.1.2.5 Enrolled Health Care Plan: TRICARE Plus

The TRICARE Plus program is an MTF-based primary care program. There are two types of TRICARE Plus coverage to differentiate between those beneficiaries with a CHC entitlement and those without. Coverage is at the individual level; each enrolled person will have an individual policy.

8.1.2.6 Enrolled Health Care Plan: Uniformed Services Family Health Plan (USFHP)

The USFHPs cover beneficiaries age 65 and over that are Medicare-eligible, as well as dependent parent and parent-in-laws that have been grandfathered into the program. These beneficiaries are enrolled in separate USFHP plans for persons only having a DC entitlement. Other

categories of beneficiaries who enroll to the USFHP are enrolled into the appropriate TRICARE Prime plan with a USFHP network provider type code.

8.1.2.7 Enrolled Health Care Plan: Continued Health Care Benefit Program (CHCBP)

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

8.1.2.8 Enrolled Health Care Plan: TRICARE Reserve Select (TRS) Program

The TRS program is optional coverage to which Reserve Component (RC) members may subscribe while in the Selected Reserve.

8.1.2.9 Enrolled Health Care Plan: TRICARE Retired Reserve (TRR) Program

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

8.1.2.10 Health Care Plan: TRICARE Young Adult (TYA) Standard

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

8.1.2.11 Health Care Plan: TRICARE Young Adult (TYA) Prime

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

8.2 Special Health Care Programs

DEERS supports any special health care program mandated by the DoD. These special health care programs are programs into which a beneficiary can enroll or register concurrently with other assigned or enrolled health care coverage plans to which they are entitled. Information needed for claims processing purposes shall be returned as a Special Health Care Program within the Health Care Coverage Claims Response. Contractors may also utilize the web-based General Inquiry of DEERS (GIOD) application to obtain special program coverage information. See the TPM and the

TRICARE Operations Manual (TOM) for details regarding these programs.

8.2.1 TRICARE Extended Care Health Option (ECHO)

ECHO beneficiaries must be ADFMs, have a qualifying condition, and be registered to receive ECHO benefits on DEERS. MCSCs and USFHP providers are required to review appropriate documentation, including registration documents, and ascertain that individuals are ECHO eligible. Once a determination that an individual is ECHO eligible, MCSCs and USFHP providers must register the individual on DEERS. Registration will be performed through DOES and will include entering at least the following information: 1) ECHO, as a Special Health Care Coverage Plan Code and 2) Registration Start Date. If the Begin Date is not entered, DOES will enter a default date using the 20th of the month rule. (NOTE: Many ECHO enrollees may have received benefits and had claims under the Program for Persons with Disabilities (PFPWD) in the past.)

8.2.2 Community Based Health Care Organizations (CBHCO)

CBHCO is a program that allows Guard and Reserve members injured while on active duty to return home for continued health care while they are evaluated for return to duty, medical release, or medical board. CBHCO enrollees must also be enrolled in TRICARE Prime or TRICARE Prime Remote, depending on where they reside. Enrollment in the program requires approval by the member's service.

8.2.3 Medical Retention Processing Unit (MRPU)

MRPU is a program assigned to service members who are medically non-deployable but who are retained in the MTF's service area for medical reasons. MRPU enrollees must be enrolled to TRICARE Prime at that MTF that retained medical management.

8.2.4 Smoking Cessation

Smoking Cessation is a demonstration program restricted to certain states. This plan may be shown in eligibility history or claims responses.

8.2.5 TRICARE Dental Program (TDP)

The TDP offers worldwide coverage to all eligible family members of Uniformed Service active duty personnel and to members of the Selected Reserve and Individual Ready Reserve (IRR) and their eligible family members. ADSMs, former spouses, parents, in-laws, disabled veterans, foreign personnel, and retirees and their families are not eligible for the TDP. For purposes of this contract, the geographic area of coverage for the CONUS includes the 50 United States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. OCONUS service area includes Canada, all other countries, island masses and territorial waters.

8.2.6 TRICARE Retiree Dental Program (TRDP)

The TRDP offers coverage to all eligible personnel retired from the Uniformed Services, to unremarried surviving spouses, eligible dependents, former members of the armed forces who are Medal of Honor recipients and their immediate dependents. The TRDP currently has two programs: the Basc program which is closed to new enrollments and the Enhanced program to which all TRDP

enrollees shall be enrolled. The TRDP is a worldwide program. The TRDP Basic program offers coverage for dental services rendered in the 50 United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada. TRDP Enhanced program benefits are offered worldwide.

8.2.7 Active Duty Dental Program (ADDP)

The ADDP provides worldwide dental coverage to all ADSMs of the Uniformed Services, eligible members of the Reserves and National Guard, and those Foreign Force Members (FFMs) eligible for care pursuant to an approved agreement (e.g., reciprocal health care agreement, NATO Status of Forces Agreement (SOFA), Partnership for Peace (PFP) SOFA). The Uniformed Services include the U.S. Army, the U.S. Navy (USN), the U.S. Air Force (USAF), the U.S. Marine Corps (USMC), the U.S. Coast Guard (USCG), the Commissioned Corps of the NOAA, and the Commissioned Corps of USPHS. The Commissioned Corps of the USPHS is not included in this program. The ADDP shall supplement care provided in the DoD's Dental Treatment Facilities (DTFs), and shall provide care to those ADSMs living in regions without access to DTFs. The ADDP has two components:

- ADSMs referred from military DTFs for civilian dental care; and
- ADSMs having a duty location and residence greater than 50 miles from a DTF will be required to comply with the requirements and limitations of the Remote Active Duty Dental Program (RADDP) before receiving dental care.

9.1 IDENTIFICATION SCHEMA FOR ELECTRONIC DATA INTERCHANGE

9.2 Primary And Secondary Identifiers

Identification of persons in the DEERS database is established via primary identifiers and secondary identifiers. A primary identifier must be unambiguous, so that information systems and software can process it without the need for intervention by users. Secondary identifiers can be ambiguous and must be processed by users who match these secondary identifiers to persons in the DEERS database. More information on primary and secondary identifiers is explained in the next section of this document.

9.3 Beneficiary Identification

DEERS is the definitive system for person identification. Beneficiaries in the DEERS database are positively identified using a system-generated DEERS Identifier (DEERS ID). DEERS IDs are intended to be system-to-system identifiers and may not be assigned or altered by users. Each DEERS ID is formed by a combination of the following:

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

A person may have more than one DEERS ID, stemming from multiple entitlements. DEERS IDs positively identify each beneficiary. DEERS IDs serve as primary identifiers and are used by

information systems when passing data about individual beneficiaries and families.

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

- A person may be entitled to DoD benefits via his or her simultaneous association to more than one sponsor. For example, a person may be a family member in two sponsored families at the same time, such as when both spouses in a family are sponsors. This condition is known as multiple entitlements. While beneficiaries may have multiple entitlements in such situations, they may only receive benefits under one entitlement at any given moment in time.

- Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and becomes a sponsor. In this case, the person would have a DEERS ID as a family member and a second DEERS ID as a sponsor. However, becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

9.4 Patient Identification

All persons in DEERS have a primary identifier called the Electronic Data Interchange Person Identifier (EDIPI), which is a DEERS-assigned 10 digit number. This field is also known as the Electronic Data Interchange Person Number (EDIPN) or the Patient Identifier (PatID). The primary purpose is to reliably access patient and person level information.

9.5 Person Identification and Secondary Identification

Sources external to DEERS identify persons initially in the DEERS database using only secondary identifiers. The secondary identifiers are:

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

Any one secondary identifier, such as the sponsor SSN, could be duplicated across several beneficiaries. Therefore, each beneficiary must be positively identified using at least two secondary identifiers. Usually, a person may be positively identified by an end user by matching an SSN along with the first three characters of the last name and/or the date of birth. Data for both sponsors and individual family members may be accessed in this manner.

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

In order to obtain a DEERS ID for a beneficiary, a system interfacing with DEERS must provide secondary identification information in one of several forms. This ensures the correct beneficiary is found, received, and stored with a DEERS Identifier. In Figure 3.1.2-1, the "Inquiry Information" column describes required information entering DEERS, and the "Response" column describes information returned by DEERS.

FIGURE 3.1.2-1 SECONDARY IDENTIFICATION

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

9.6 Person Identification For Business Events

The following table identifies the options and type of data necessary to perform a DEERS/ Medical business event for system-to-system interactions. Legend (an "X" in a column indicates that the information may be used):

- Secondary identification: refer to the secondary identification section above.
- Individual (I)/Family (F): indicates if the business event can be done for an individual, a family, or both.

FIGURE 3.1.2-2 PERSON IDENTIFICATION FOR BUSINESS EVENTS

	X	X	I	Policy Notification
	X (Subscriber only)		I, F Depending on policy type	Enrollment Fee Payment
	X (Subscriber only)		I, F Depending on policy type	Disenrollment for failure to pay fees
X			I, F Depending on policy type	Enrollment Fee Payment
X			I, F	Health Care Coverage Inquiry for Claims
	X		I	Catastrophic Cap & Deductible Updates
X			I, F	Catastrophic Cap & Deductible Transaction History Request
	X		I, F	Catastrophic Cap & Deductible Totals Inquiry
		X	I, F	OHI Inquiry

FIGURE 3.1.2-2 PERSON IDENTIFICATION FOR BUSINESS EVENTS (CONTINUED)

		X	I, F	OHI Policy Add/Update
		X	I, F	OHI Cancellation

9.7 HCDP Enrollment Management Contractor (EMC) Identification

HCDP EMCs are entities that are authorized to enroll MHS-eligible sponsors and family members into DoD coverage plans and are responsible for maintaining an individual's HCDP policy. These organizations include MCSCs, USFHP providers, and the OCONUS TRICARE Area Organizations (TAOs). DEERS tracks the enrolling organization that is responsible for an individual's policy. A person only has one EMC that is responsible for managing their coverage at any given point in time. DEERS creates a system identifier for each enrolling organization, and distributes the identifier to each system. This system identifier is used to identify the enrolling organization system in system-to-system interactions with DEERS.

9.8 PCM Enrolling Division Identification

Within the MHS, enrollment locations are identified using the identifiers within Defense Medical Information System (DMIS). These DMISs may represent an actual physical location such as an MTF, or a grouping of providers within the DC, Civilian, or USFHP network. Examples include MTFs, satellite clinics of MTFs, and possibly clinics within the MTF, USFHPs, and designated administrative DMISs.

Downloads are available on the DMIS web site (www.dmisid.com).

9.9 PCM Identification

DEERS uses the NPI as the National Provider ID. The MCSC is responsible for assigning and providing it to DEERS. The MCSC is also responsible for maintaining a crosswalk from the MCSC provider ID to the national provider ID. MCSCs must not re-use PCM IDs.

9.10 Policy Identification

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

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

A sponsor can be a subscriber to multiple policies but may be enrolled as a beneficiary only to one.

- END -

Chapter 3 Section 1.3

Interface Overview

1.1 OPERATIONAL POLICIES AND CONSTRAINTS

The Defense Enrollment Eligibility Reporting System (DEERS) and its interfacing systems operate under the following policies and constraints:

- Standard Provider, Payer, and Patient IDs will be used, as legislated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when these IDs are mandated for implementation.

2.1 SYSTEM DESCRIPTION

2.2 Interface

DEERS supports various interfaces to systems within the Military Health System (MHS) and outside the MHS including the Center For Medicare and Medicaid Services (CMS) and the state Medicaid agencies.

Major communities that DEERS interfaces with include:

- Composite Health Care System (CHCS)
- DoD service personnel systems
- MHS clinical systems
- Clinical Data Repository (CDR)
- Managed Care Support Contractors (MCSCs)/claims processors
- Uniformed Services Family Health Plan (USFHP) Providers
- Beneficiary Services Officers worldwide via the General Inquiry of DEERS (GIQD) application
- Pharmacy Data Transaction System (PDTS)
- Continued Health Care Benefit Program (CHCBP) administrator
- TRICARE Dental contractors
- Department of Veterans Affairs (DVA)
- TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)
- Other organizations as identified

2.3 DEERS Operational Environment and Characteristics

The DEERS system environment consists of a Relational Database Management System (RDBMS), rules-based applications processing DoD entitlements and eligibility, a Transmission Control Protocol/Internet Protocol (TCP/IP) sockets listener, application servers that enforce business rules, and web servers.

DEERS provides applications, web applications, web services, and system to system interfaces.

2.2.1 Web Requirements

All Defense Manpower Data Center (DMDC) web-based applications require Microsoft® Internet Explorer 6.0 or higher using https. They are all government furnished equipment.

The contractor shall use the applications for their intended use only. The contractor shall not utilize screen scraping, html stripping, and any other technology or approach to manipulate or alter the intended use of the application or the application architecture.

The DEERS Online Enrollment System (DOES) supports enrollment activities and allows entry of fee information. DOES will show all fee payments for an existing policy, as well as for policies that have ended within the last 18 months.

PCM Research Application (PCMRS) allows users to view PCMs, their capacities, and their enrolled counts.

PCM Panel Reassignment (PCMRA) allows MCSCs to reassign beneficiaries by group to other PCMs. MTFs also use PCMRA to set up group moves for execution by the MCSCs.

General Inquiry of DEERS (GIQD) is used for research and customer service to display demographics, coverage and PCM assignment information. It also allows address updates.

The Catastrophic Cap and Deductible Research and Enrollment Fee Payment Transaction Research Application (CCD Web Research) supports research and allows limited updates on the history of CC&D and enrollment fee payment transactions posted to DEERS and stored on-line (current plus previous four fiscal years).

The OHI Maintenance Application is used by MCSCs, USFHP, pharmacy, and CHCS. It allows add, update, and cancellation of OHI policies as well as Standard Insurance Table (SIT) carrier adds, updates, cancellations and deactivations.

The SIT Verification Application is used exclusively by the TRICARE Management Activity (TMA) Uniform Business Office Verification Point of Contact (VPOC). The application queues all SIT transactions entered through the OHI Maintenance Application for review and verification by the VPOC.

The Security application is used by the MCSC/USFHP site security manager to establish users and grant access to applications and other privileges. The MCSC/USFHP is responsible for designating a primary site security manager and one backup to manage all users and their access to DEERS applications. The appointed Site Security Manager (SSM) and alternate are required to complete an on-line training certification at initial appointment and yearly thereafter. All SSMs are required to remove access to all DEERS systems immediately upon departure of an employee from performing the function.

The DMDC Support Office Web Request (DWR) application is used by the MCSCs/USFHP to report potential data problems or request historical enrollment corrections that cannot be

completed in DOES.

The DEERS Enrollment Reports application provides a number of reports at different intervals. These include:

- PCM Panel Downloads
- Enrollment and disenrollment reports
- Management reports for fees, cat cap, etc.

2.2.2 System Maintenance/Downtime

DMDC has routinely scheduled times for system maintenance and will schedule additional downtimes as required. The routinely scheduled downtimes are:

- Weekly: 2100 Eastern Saturday to 0600 Eastern Sunday
- Daily, if needed: 2355 Eastern to 0100 Eastern

When DMDC identifies a telecommunications, hardware, or software problem outside a scheduled maintenance window that results in downtime of the contractor interface for two contiguous or cumulative hours within a business day, DMDC must notify the TMA of the problem and approximately when it is expected to be corrected. TMA contractors reliant upon DEERS will be notified of the situation and provided guidance as appropriate.

In addition to the standard problem resolution procedures as referenced in DMDC documentation, when the contractor experiences downtime in the DEERS interface for two hours contiguously or cumulatively within a business day and has not been contacted by TMA, the contractor must report the downtime to the TMA representative and shall report an updated status every two hours until the problem is resolved. A final report upon resolution is also required.

2.2.3 DEERS System To System Interfaces/Interactions

FIGURE 3.1.3-1 SYSTEM TO SYSTEM INTERACTION

PCM Interface Sending node organizations send addition and modification records.	MCSC USFHP	DEERS	XML	Event Driver
Fee Payment/Failure To Pay Fees	MCSC TDP TRDP USFHP	DEERS	Fixed Length DEERS Defined	At least daily
Fee Gateway for BWE	DEERS	MCSC TDP TRDP USFHP	Fixed Length DEERS Defined	Event Driven

FIGURE 3.1.3-1 SYSTEM TO SYSTEM INTERACTION (CONTINUED)

Notification of Policy Information and Enrollment Information for Dental (EID) This message sends a new image of demographic, address, policy, PCM, fee, premium, and other pass through information.	DEERS	MCSC TDP TRDP USFHP provider	Variable Length DEERS Defined	Event Driven
Notification of Patient ID Change (This is a publish and subscribe model.)	DEERS	MCSC Rx TDP TRDP USFHP	XML	Weekly
DEERS Claims Web Services (DCWS) Inquiry	ADDP MCSC Rx TDP TRDP USFHP	DEERS	Fixed Length DEERS Defined	Event Driven
DCWS Response	DEERS	ADDP MCSC Rx TDP TRDP USFHP	Variable Length DEERS Defined	Event Driven
Partial Match Response to a DCWS Inquiry	DEERS	ADDP MCSC Rx TDP TRDP USFHP	Variable Length DEERS Defined	Event Driven
CC&D Totals Inquiry	MCSC Rx USFHP	DEERS	Variable Length DEERS Defined	Event Driven
CC&D Totals Response	DEERS	MCSC Rx USFHP	Variable Length DEERS Defined	Event Driven
CC&D Update	Claims Processor MCSC Rx USFHP	DEERS	Fixed Length DEERS Defined	Event Driven
OHI Policy Inquiry	CHCS Claims Processor MCSC Rx TDP TRDP	DEERS	XML	Event Driven

FIGURE 3.1.3-1 SYSTEM TO SYSTEM INTERACTION (CONTINUED)

OHI Policy Inquiry Response	DEERS	CHCS Claims Processor MCSC Rx TDP TRDP	XML	Event Driven
OHI Policy Add/Update/Cancellation	CHCS Claims Processor MCSC Rx TDP TRDP	DEERS	XML	Event Driven
SIT Add/Update/Cancellation/Deactivation	CHCS Claims Processor MCSC Rx TDP TRDP	DEERS	XML	Event Driven
SIT Add/Update/Cancellation/Deactivation	DEERS	CHCS Claims Processor MCSC Rx TDP TRDP	XML	Event Driven
Publish and Subscribe for the SIT Table Change Any change to the SIT Table (e.g., adds, deactivation, temp to perm on a Carrier ID, or updates) requires all holders of the SIT to download the SIT.	CHCS Claims Processor MCSC Rx TDP TRDP	DEERS	XML	Check Nightly
File of CMS Information	DEERS	TDEFIC	Fixed Length DEERS Defined	Monthly

2.3 DEERS Major System Components

Major components of DEERS include:

- Person repository
- National Enrollment Database (NED)
- Centralized CC&D repository
- PCM repository
- OHI repository
- SIT Database

2.4 External Systems

All system to system interfaces to DEERS must use TCP/IP, File Transfer Protocol (FTP), HTTP, or HTTPS as specified by DEERS.

- DEERS utilizes standard message protocols where appropriate.
- DEERS defines the content and format of messages between DEERS and the MCSC.
- DEERS, all contractors, and USFHP providers must utilize encryption for all messages that contain privacy level information.
- DEERS specifies the method of encryption and authentication for all external interfaces.
- All notifications are sent as full database images; they are not transaction-based. The contractor must accept and apply the full image sent by DEERS. The contractor shall add the information, if not present in their system. The contractor shall update their system, if the information is present, by replacing their information with what is newly received from DEERS. Notifications are only intended to synchronize the most current information between DEERS and the MCSC. They do not synchronize history between DEERS and the contractor.
- DMDC centrally enforces all business rules for enrollment and enrollment-related events.
- DEERS is the database of record for all eligibility and enrollment information.

2.5 Data Sequencing

Since DEERS is tasked with resolving data conflicts from external systems using rules-based applications, all contractors shall ensure proper data sequencing of transactions sent to DEERS. This aids in maintaining data validity and integrity.

- END -

Chapter 2 Section 1

General

1.1 POLICY

1.2 This chapter implements Department of Defense (DoD) Washington Headquarters Services (WHS) Administrative Instruction No. 15 (AI-15), hereafter referred to as AI-15, "Records Management, Administrative Procedures and Records Disposition Schedules." Contractors shall follow the AI-15, all applicable laws, regulations and instructions relating to Government records (regardless of media) and contractors must plan for the full life cycle of Government records, from creation through the required retention period to the authorized destruction date.

1.3 It is DoD policy, to limit the creation of records to those essential for the efficient conduct of official business and to preserve those of continuing value while systematically eliminating all others, and to ensure their management is in compliance with 44 United States Code (USC), 36 Code of Federal Regulations (CFR), 41 CFR and all AI-15 references.

1.4 No record of the U.S. Government is to be alienated (removed) or destroyed except in accordance with the provisions of the Federal Records Act and applicable regulations. Unauthorized destruction of records is punishable by fine, imprisonment, or both.

2.1 APPLICABILITY

2.2 The provisions of this chapter apply to all TRICARE Management Activity (TMA) contractors. Where "contractor" is referred to within this chapter, the provisions shall apply, when appropriate, to subcontractors providing services under the Prime contract.

2.3 No disposition of documents will be allowed without the prior written consent of the TMA Records Management Officer. Contractors are responsible for preventing the alienation or unauthorized destruction of records, including all forms of mutilation. Willful and unlawful destruction, damage or alienation of Federal records is subject to the fines and penalties imposed by 18 USC 2701. Records may not be removed from the legal custody of TMA or destroyed without regard to the provisions of the agency records schedules.

2.4 Contractors are required to obtain the TMA Contracting Officer's (CO's) approval prior to engaging in any contractual relationship (subcontractor) in support of this contract requiring the disclosure of information, documentary material and/or records generated under, or relating to, this contract. Contractors are required to abide by Government and TMA guidance for protecting sensitive and proprietary information.

3.1 RESPONSIBILITY

- Contractors will comply with Federal and TMA records management policies, including those policies associated with the safeguarding of records covered by the Privacy Act of

1974, Freedom of Information Act (FOIA), and Health Insurance Portability and Accountability Act (HIPAA) statute. These policies include the preservation of all records created or received regardless of format [paper, electronic, etc.] or mode of transmission [e-mail, fax, etc.] or state of completion [draft, final, etc.].

- Contractors shall treat all deliverables under the contract as the property of the U.S. Government for which TMA shall have unlimited rights to use, dispose of, or disclose such data contained therein as it determines to be in the public interest.

- Contractors shall not retain, use, sell, or disseminate copies of any deliverable that contains information covered by the Privacy Act of 1974, the HIPAA Statute or that which is generally protected by the FOIA.

- Contractors shall not create or maintain any records containing any TMA records that are not specifically tied to or authorized by the contract.

- TMA owns the rights to all data/records produced as part of this contract.

3.2 TMA

TMA is responsible for:

3.1.1 The development and implementation of standards and policies for the economical management of records for the TMA Program.

3.1.2 Providing effective control over the creation, organization, maintenance, use, and disposition of records including records containing adequate and proper documentation of the contractor's administration and procedures.

3.1.3 Providing annual records training for contractors.

3.1.4 Notifying contractors of records freezes.

3.1.5 Inspecting the contractor's records management practices and procedures during the contractor's normal business hours.

3.2 Contractors

Records related to beneficiary health care and/or claims and supporting documentation which are received or developed under the TMA contracts are, by contract, the property of the U.S. Government unless specifically excluded. Contractors are required at a minimum to:

3.2.1 Maintain all government records in accordance with the requirements of the AI-15.

3.2.2 Appoint an individual as the contractor's Records Management Officer to perform the records management function and serve as accountable records custodians in their organization and to act in liaison with the TMA Records Management Officer. The individual shall have knowledge of applicable laws, regulations, and published industry standards governing records management. This appointment shall be made in writing and furnished to the TMA Records

Management Officer. All appointment letters will specify the offices supported by the individual. Appointment letters will be updated upon the departure or change of the individual.

3.2.3 Apply current laws, regulations, standards, procedures, and techniques to ensure the most economical, efficient, and reliable means for creation, retrieval, maintenance, preservation, and disposition of their records, regardless of media.

3.2.4 Maintain a file plan of all active and inactive Federal records in TMA format in accordance with the requirements of the AI-15. In addition, maintain documentation on any Federal records that have been retired to the Federal Records Center (FRC) or destroyed.

3.2.5 Annually review and approve the file plans for each office within their purview to ensure that records are accurately identified; these file plans will be reviewed and approved and signed by the contractor's Records Management Officer. These file plans will be made available to the Government as requested.

3.2.6 Perform self-evaluations of their records management program every two years to ensure compliance with applicable records management laws, regulations, standards and guidance. These evaluations will be made available to the Government as requested.

3.2.7 Evaluate current and potential information systems to identify record information being created or received during the conduct of business and ensure the preservation of Federal records as specified in AI-15. Record information created in information systems and not identified in the AI-15 Disposition Schedule shall be brought to the attention of the TMA Records Management Officer.

3.2.8 Inform and caution all employees not to destroy records in their custody and ensure they are made aware of their legal responsibility to report to the appropriate official any actual, impending, or threatened unlawful removal, alteration, or destruction of Federal records.

3.2.9 Establish a records management program covering all media. The contractor will use the standard classification and filing system outlined in AI-15. This allows for the maximum uniformity and ease in maintaining and using Government records and facilitating the locating, charge-out, refiling and disposing of records.

3.2.10 All records are maintained in a current and easily retrievable manner.

3.2.11 A vital records program is developed and implemented in case of disaster.

3.2.12 Provide TMA, it's delegated audit agencies and the Comptroller General of the United States, access to and the right to examine those books, records, documents, and other supporting data which will permit adequate evaluation of the cost or pricing data submitted by the contractor, along with the computations and projections used. The purpose of the examination shall be to verify that cost or pricing data submitted in conjunction with the negotiation of the agreement, including changes, and any fiscal report of settlement is accurate, complete, and current. The right to examination of records shall continue for six years and three months after final payment to the contractor has been made or until such time as the final audit is completed.

3.2.13 It is the responsibility of the contractor to ensure that records in its jurisdiction are retrievable within five working days of request by the Government. Adequate management controls and procedures to ensure timely retrieval of Federally stored records shall be established. The Government's right of access to these records shall not interfere with the contractor's ability to maintain an effective records management program. However, the contractor's records management program shall make allowance for the Government's right of access to records.

3.2.14 Routinely transfer inactive TMA electronic records from contractor systems to TMA's designated National Archives and Records Administration (NARA) Electronic Federal Records Center (eFRC). In the event of Transition, additional records transfer requirements will apply.

4.1 DEFINITIONS

4.2 Active Records

Active records are those used to conduct current TMA business. They may also be referred to as "open." Active records are generally maintained in office space or on-line in an electronic system. Events in this phase of the life cycle include creating or receiving records and capturing them in a document or content management system or recordkeeping system.

4.3 Case or Project Files

A case or project file contains material on a specific action, transaction, event, person, project, or other subject. As an example, case files may cover one or several subjects that relate to a particular case. A contract file maintained by an agency contracting office may contain proposals, bids, addenda, inspection reports, payment authorizations, correspondence, and legal papers.

4.4 Contractor Records

Data produced and/or maintained by a contractor for TMA and required to provide adequate and proper documentation of TMA's programs and to manage them effectively.

4.5 Disposition

Actions taken regarding records no longer needed for the conduct of the regular current business of TMA. An instruction for the cut off, transfer, retirement or destruction of record documents. Specific guidance and techniques for using or applying disposition instructions are located in the AI-15.

4.6 Documentation

Documentation concerns the creation of records and the assembly or consolidation of this information; this applies to records in all media (paper, electronic, microfilm, etc.).

4.7 Electronic Information Systems

Records generated in systems created to perform mission related functions (payroll, finance, personnel, acquisition, etc.) and used by office and/or organizational personnel, computer operators, programmers, and systems administrators. These systems are usually identified by a

specific name or acronym and contain structured data. Information produced by these systems will have to be evaluated for its legal, administrative, and fiscal values. The same information that may be scheduled for databases applies to electronic information systems. In addition, inputs received from other systems or information transmitted to other systems needs to be evaluated.

4.8 Electronic Mail

A document created or received on an agency electronic mail system including brief notes, more formal or substantive documents, and any attachments and routing information which may be transmitted with the message. May be a record or a non-record.

4.9 Electronic Recordkeeping

The creation, maintenance, use and disposition of records created and stored by using a computer. Electronic recordkeeping is part of the solution to manage, preserve, and provide access to electronic records.

4.10 Electronic Recordkeeping System

An electronic recordkeeping system collects, organizes, and categorizes electronic records in their native file form instead of requiring the user to print and file them in a manual filing system, Such a system automates the preservation, retrieval, use, and disposition of the electronic record.

4.11 Electronic Records

Records stored in a form that only a computer can process and satisfies the definition of a Federal Record, also referred to as machine-readable records or automatic data processing records.

4.12 Electronic 135 (e135)

The e135 is modeled after the transmittal document Standard Form 135 (SF 135) designed for metadata about the paper records. The e135 is a web screen that collects the metadata necessary to transfer electronic records to the eFRC. The metadata collected by the e135 will be the key identifiers used to search and retrieve the electronic record.

4.13 Frozen Records (FRs)

Those temporary records that cannot be destroyed on schedule because special circumstances, such as a court order, require a temporary extension of the approved retention period.

4.14 Inactive Records

Inactive records are documents which are no longer referenced on a regular basis (yearly) and tend to be stored in a less accessible place since they are not used frequently. Many times records become inactive when they reach their cut-off as defined on a Records Retention Schedule. Inactive records may also be referred to as “closed” records.

4.15 Life Cycle of Records

The concept that records pass through the following stages: receipt, capture, active use, in-active use, distribution, storage, transfer, migration, disposition, and archiving of the official record.

4.16 Master Files

Relatively long-lived computer files containing an organized and consistent set of complete and accurate data. Usually updated periodically.

4.17 Medium/Media

The physical form of recorded information. Includes paper, film, disc, magnetic tape, and other materials on which information can be recorded.

4.18 Metadata

Data about a record. The attributes of electronic records -- structure, content, and context (including office of origin, file codes, dates sent/received, disposition, security classification, etc.). For example, if a record can be viewed as a letter, then metadata is found on the envelope, e.g., date stamp, return address, addressee, etc. Associated metadata is data that is linked to or associated with a specific electronic record or record object.

4.19 Migration

The techniques and strategies used to move electronic information from one storage medium to another over time to prevent the loss of needed information because of technological obsolescence.

4.20 Non-Records

Government materials, including duplicate record material with no real evidentiary or informational value or of only short term value. Consists of processed or printed material maintained for reference or distribution. The following non-record materials are excluded by statute:

- Library and museum materials
- Extra convenience copies
- Supplies of publications and blank forms
- Personal papers
- Drafts and worksheets
- Routing slips, transmittal sheets, and envelopes
- Duplicate copies
- Catalogs, trade journals and publications

4.21 Optical Disc (OD)

A non-contact, random-access disc tracked by optical laser beams and used for mass storage and retrieval of digitized text and graphics. Sometimes called an optical digital disc or optical

digital data disc. Types include WORM (write once read many), CD-ROM (compact disc-read only memory), and CD-I (compact disc-interactive), DVD, and erasable optical discs.

4.22 Processing Files

Files, aside from master files, which comprise the life cycle of most computerized records prior to the production of a given master file. Processing files, from work files and input or source files to some valid transaction files, are employed to create and use a master file.

4.23 Record Object

A record object is a container (typically, a computer file) for a group of related information. The information can be formatted as either text or images, and the computer file-type indicates the format of the information. For example, scanned images are typically stored in Tagged Imaged File Format (TIFF) or as Portable Document Format (PDF) files.

Note: For the purpose of electronic records management, a record object is not necessarily a row of data in a database.

4.24 Records

According to 44 USC 3301, the term "records" includes all books, papers, maps, photographs, electronic records, or other documentary materials, regardless of physical form or characteristics, made or received by an agency of the U.S. Government under Federal law or in connection with the transaction of public business and preserved or appropriate for preservation by that agency or it's legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the Government, or because of the informational nature of data in them. Library and museum material made or acquired and preserved solely for reference, and stocks or publications and of processed documents are not included.

4.25 Records Management

That area of general administrative management concerned with achieving economy and efficiency in the creation, use/maintenance, and disposition of records.

4.26 SmartScan

Smart Scan is a feature of the Archives and Records Centers Information System (ARCIS) that provides a service of scanning the paper records requested and having them e-mailed to the requestor. For more specific details about the service check the NARA ARCIS web page.

4.27 Transfer

The term "transfer" has replaced the older term "accession" for temporary records. Like an accession, a transfer is a unique identifier used by NARA to track the records transferred using the transmittal document either SF135 for paper, or e135 for electronic records.

4.28 Transmission and Receipt Data

4.27.1 Transmission data. Information in electronic mail systems regarding the identities of sender and addressee(s), and the date and time messages were sent.

4.27.2 Receipt data. Information in electronic mail systems regarding date and time of receipt of a message, and/or acknowledgment of receipt or access by the addressee(s).

4.28 Vital Records (Sometimes Called Essential Records)

Records essential to the continued functioning or reconstitution of an organization during and after an emergency and also those records essential to protecting the rights and interests of that organization and of the individuals directly affected by its activities (includes both emergency-operating and rights-and-interests records). Vital records considerations are part of an agency's records disaster prevention and recovery program.

5.1 E-MAIL RECORDKEEPING REQUIREMENTS

The same records management principles apply to e-mail records. Contractors shall, at a minimum:

5.2 Write and implement e-mail instructions based on the requirements of the AI-15. Instructions at a minimum shall address: what is a record vs. a nonrecord, how the contractor will preserve the data, the names on distribution lists or directories, when to request receipts and how to preserve the receipts, external e-mail systems, and circulated drafts. The contractor must minimize the risk of unauthorized additions, deletions, or alterations to e-mail records (integrity).

5.3 Assign an individual to be responsible for the maintenance of the e-mail recordkeeping system. This individual is also required to annually monitor the use of the e-mail system to assure recordkeeping instructions are being followed.

5.4 Train all e-mail users and provide on-going training for any new users on e-mail record keeping requirements in compliance with AI-15 and NARA requirements. This training shall include: defining what is a record vs. a nonrecord; how to put records into record keeping systems; preserving data; preserving names on distribution lists or directories, when to request receipts and how to preserve the receipts; how to deal with circulated drafts; and external e-mail systems.

6.1 RECORDS MAINTAINED BY CONTRACTORS

6.2 The records identified in Section 2 shall be maintained by all contractors. Inactive records shall be routinely transferred to the NARA FRC designated by TMA in accordance with Section 4.

6.3 In the event of a contract transition, the outgoing contractor shall transfer either a TIFF, Group 4 or higher or searchable PDF copy of the records with associated metadata for the full retention time required by AI-15 disposition instructions, to an incoming contractor and to the NARA Records Center designated by TMA. FRs shall be taken into consideration. Records to be maintained and transferred include, but are not limited to:

- TMA Claims

- Claims Supporting Documentation (including any documentation that either supports or denies payment of a claim)
- Adjustment Records
- Adjustment Supporting Documentation (including any documentation that either supports or denies payment of the adjustment)
- Checks
- Explanation of Benefits (EOB) Forms and Summary Payment Vouchers

For additional detailed requirements pertaining to TMA records and transition, reference the DoD TMA Records Management web site.

- END -

Chapter 2 Section 2

Record Series Subject And Description Of Government Records

1.1 GENERAL

1.2 The following TRICARE Management Activity (TMA) records shall be maintained by all contractors regardless of media. If this section does not contain a description of a record created by the contractor for the Government, contact the TMA Records Management Officer for instructions. Follow Washington Headquarters Services (WHS) Administrative Instruction No. 15 (AI-15) for indexing requirements (if not specified), the record series number and disposition for each of the record categories.

1.3 The AI-15 TMA's Records Manual is the legal authority for managing all TMA records. If TMA contractors cannot locate a record description in the spreadsheet provided on the TMA Records Management web site, consult the AI-15 for additional record descriptions. The record descriptions are provided on the TMA Records Mangement web site.

- END -

Chapter 2 Section 3

Digital Imaging (Scanned) And Electronic (Born-Digital) Records Process And Formats

1.1 GENERAL

1.2 The success of a document conversion operation, receipt or creation of electronic records in native formats, or output of data as electronic records depend upon a strict standardization process. A standardized process that is repeatable and consistently followed will result in authentic and reliable records. It also provides for quality, creation, capture, conversion in the case of scanning, output, processing, indexing, storage, search, retrieval, migration, and reproduction of TRICARE Management Activity (TMA) records.

1.3 All TMA contractors shall routinely provide TMA with the following records in either Tagged Imaged File Format (TIFF) or searchable Portable Document Format (PDF) formats, with required metadata as defined by the TMA Records Office (see Addendum B for format, metadata and transfer requirements):

- TMA Claims.
- Claim Supporting Documentation (including any documentation that either supports or denies payment of a claim).
- Adjustment Records.
- Adjustment Supporting Documentation (including any documentation that either supports or denies payment of the adjustment).
- Checks.
- Explanation of Benefit (EOB) Forms and Summary Payment Vouchers (if not electronically generated).

2.1 STANDARDS

2.2 Contractors shall adhere to the National Institute of Standards and Technology (NIST), Federal Information Processing Standards (FIPS).

2.3 TMA records that are imaged will follow the Association for Information and Image Management (AIIM) Standards for imaging. All scanned documents converted to digital images will at a minimum be 300 pixels per inch/dots per inch and output as TIFF or saved as searchable PDF files. Refer to the Department of Defense (DoD) TMA Records Management web site for specific output requirements.

2.3.1 Imaged copies of TMA records shall be certified, reproducible, and legible. The contractor's image capture and storage system shall be able to reproduce legible copies of TMA records from the storage medium. If any record or set of records is not of a standard to produce legible copies, the contractor shall recover the originals and re-image them, making certain the new stored image is reproducible as legible documents.

2.3.2 The contractor shall provide an automated indexing system that can be used independently of the contractor's data system in the event of a transition. An automated indexing system **must not** be subject to proprietary hardware or software constraints. The automated indexing system shall be able to identify the retrieval location of the original claim and all related documentation, adjustment claims (including correspondence on which the decision to adjust was based) and all related supporting documentation.

Example 1: If back-end filming or imaging is done, the back-end document number assigned shall be cross-referenced to the original claim number on the index.

Example 2: If the Internal Control Number (ICN) assigned to the adjustment claim is different than the original claim number, the contractor shall cross reference the adjustment claim ICN to the ICN of the original claim being adjusted on the index. The index shall be available for TMA on-site review.

2.4 The following minimum requirements are applicable to digital images (scanned), electronic records (born-digital), and electronic data or records output in PDF format:

2.4.1 PDF File Specification For All PDF Records

2.4.1.1 PDF records shall comply with PDF versions 1.0 through 1.4 (i.e., be compatible PDF file formats in existence on the approval date of this guidance), and meet conversion requirements as outlined below.

2.4.1.2 TMA shall periodically update the list of acceptable PDF versions provided in this guidance, as appropriate.

2.4.1.3 The automated indexing system requirements identified in paragraph 2.2 apply to all PDF records.

2.4.2 General Requirements For All PDF Records

2.4.2.1 Security Requirements

2.4.2.1.1 PDF records shall not contain security settings (e.g., self-sign security, user passwords, and/or permissions) that prevent TMA or National Archives and Records Administration (NARA) from opening, viewing, or printing the record.

2.4.2.1.2 All PDF records shall have all security settings deactivated (e.g., encryption, master passwords, and/or permissions) prior to transfer to TMA, NARA, or for transit reasons. Deactivating security settings from PDFs ensures TMA has the ability to support long term migration and preservation efforts, especially records affected by legal holds.

2.4.2.2 Review Of Special Features

Complexities associated with certain PDF features that may be a requirement for contractors shall require pre-authorization from the TMA Records Management Officer prior to enabling any special feature. Examples of special features, include but are not limited to: digital signatures; links to other documents, files or sites; embedded files (including multimedia objects); form data; comments and/or annotations.

2.4.3 Reference the DoD TMA Records Management web site for requirements that are specific to digital records converted to PDF from native formats.

2.4.4 Data output from electronic information systems as TMA records shall be in searchable PDF format. Refer to the DoD TMA Records Management web site for these requirements.

3.1 METADATA

3.2 Metadata is a critical element of TMA records in electronic format. All TMA electronic records require mandatory metadata to be associated or linked to them throughout their active and inactive life cycle. Metadata enables TMA to meet the federally mandated life cycle and recordkeeping requirements while ensuring eRecords remain accessible and searchable to TMA business owners and authorized users. There are several different layers of metadata associated with electronic records as they move through their life cycle from active to inactive, then are transferred to the designated NARA Federal Records Center (FRC). See Addendum B and the DoD TMA Records Management web site for the requirements for federal records created or generated in support of the claims processing and for a description of other metadata layers and requirements associated with each.

3.3 Metadata can be captured or generated throughout or as part of the business process. For specific metadata requirements reference the DoD TMA Records Management web site. For example, document and record series metadata for a TMA Contractor Claims Records, Record Series 911-01, may include but is not limited to the following metadata:

- Date
- Subject
- Name
- Status
- Social Security Number (SSN)
- Claim#
- Dates of Service
- Provider Name
- Taxpayer Identification Number (TIN)

4.1 PROCEDURES

The contractor shall develop and follow a system for imaging two-sided documentation and output to electronic formats required by TMA to include written procedures for Government inspection detailing the entire process. Documentation, at a minimum, must include the following:

4.2 Planning for further technological developments.

4.3 Providing for the ongoing functionality of system components.

4.4 Assuring the imaging system and electronic information systems have inherent flexibility and has a non-proprietary design that accepts future hardware and software upgrades.

4.5 Monitoring and limiting the deterioration of optical media and digital data disk storage.

4.6 Document preparation.

4.7 Imaging/Conversion Operations (flowchart or other graphical depiction of the imaging process from start to finish).

4.8 Indexing, Retrieval, and Cross-Referencing (method of indexing all portions of the claim; i.e., mother claim, adjustments, related correspondence, any documentation that substantiates the settlement of the claim, explanation of benefits, check number, etc.). Ensuring that claims retrieval software is Structured Query Language (SQL) compliant.

4.9 Quality Control (must ensure 100% accuracy of readability of all imaged documents, how each original will be imaged, what will occur if errors are made, equipment failures, skewed margins, loss of data, etc.) as well as comparable quality control process and procedures for data output as electronic records in PDF format.

4.10 Disaster Recovery (shall be in place to ensure 100% recovery capability, how content and media will be protected, the protection of the vital records, and the location of the duplicate copies of the images, indexes, and PDF records).

4.11 Disposition of Original Records (how, when, where will the original documents be destroyed in accordance with applicable laws and regulations, i.e., Washington Headquarters Services (WHS) Administrative Instruction No. 15 (AI-15), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Act of 1974.

4.12 Imaging and Output Storage Requirements (a detailed description of equipment and software which utilizes Write Once-Read Many (WORM) technology).

5.1 TRANSITION

5.2 Maintain a complete set of documentation, including source code with flow diagrams, object code, and operations and maintenance manuals to be turned over to an incoming contractor and the NARA electronic Federal Records Center (eFRC) as designated by TMA, in the event of a transition.

5.3 Upon direction from TMA, the incumbent shall also be prepared to present the incoming contractor with standard TIFF claim images, searchable PDF records, and a non-proprietary program to sort and retrieve these TMA records by ICN. This program or programs shall be compatible with a current Microsoft® Desktop Operating System. Valid alternatives may be negotiated with TMA.

5.4 Once Transition of records and materials has been accomplished, outgoing contractors are responsible for destroying all copies to include backup data in accordance with DoD policy after full

Transition and acceptance of Transition materials and information has been completed. Contractors are not authorized to dispose or destroy any copies or backup data prior to formal, written notification from the TMA Contracting Office or TMA Records Management Office. A formal record of destruction or certificate must be provided to the TMA Contracting Office documenting what was destroyed, the date(s) destroyed and by whom. This certificate of destruction will be provided to the TMA Records Management Officer.

5.5 Reference Chapter 2, Section 4 and the DoD TMA Records Management web site for details regarding transfers associated with a Transition Event.

6.1 LEGAL ADMISSABILITY

6.2 The contractor shall be familiar with how the rules of evidence apply to Federal records, and ensure that procedural controls that protect their integrity are in place and adhered to for the life cycle management of all Government records.

6.3 The contractor shall implement current industry standards, using digital-imaging processes, proven technologies, and optical media for the conversion of paper documents to digital form, their initial creation in digital form, or digital to digital conversion.

- END -

Chapter 2 Section 4

Electronic Records Disposition, Storage, And Transfer

1.0 GENERAL

Contractors shall adhere to current industry standards in regards to electronic records (i.e., International Organization for Standardization guidelines regarding electronic storage and transfer of records). Contractors shall follow the procedure outlined in Addendum B, in Washington Headquarters Services (WHS) Administrative Instruction No. 15 (AI-15) and National Archives and Records Administration (NARA) requirements in regards to electronic storage and transfer of records.

2.1 STANDARDS

2.2 The contractor shall ensure electronic records are:

- Accessible
- Identifiable
- Retrievable
- Understandable
- Authentic

2.3 Contractors shall ensure they maintain accurate, reliable, and trustworthy electronic document-based information. This means ensuring the following: it can be read and correctly interpreted by a computer application; it is available in natural language format; it has logical and physical structure, substantive content, and context that were apparent at the time of creation or receipt.

2.4 If a contractor chooses to use an Electronic Records Management Software application, the software must be Department of Defense (DoD) 5015.2 compliant.

2.5 Contractors shall ensure that all on- and off-site records storage areas are compliant with the NARA Records Storage Facility Standards Toolkit. These standards can be found on the TRICARE Management Activity (TMA) Records Management web site.

2.4.1 Physical Media Transfer and Storage

2.4.1.1 Federal records must be stored properly, either on-line or off-line. Industry standards will be applied to on-line storage processes, procedures, archiving, data back-up and recovery, and vital records.

2.4.1.2 Contractors are responsible for managing electronic Federal records in accordance with the NARA Code of Federal Regulations (CFR) - 36 CFR 1234, Subpart B—Facility Standards. These standards can be found on the TMA Records Management web site. Section 1234.30 outlines

responsibilities regarding the selection and maintenance of electronic records storage media. Section 1234.32 describes responsibilities for retention and disposition of electronic records. Additional guidance for storing temporary records on physical media, reference NARA's Frequently Asked Question(s) (FAQ(s)) on storing temporary records on Compact Discs (CDs) and Digital Versatile Discs (DVDs) can be found on the TMA Records Management web site.

2.4.2 If a contractor chooses to use an optical digital data disk system, they shall, at a minimum:

2.4.2.1 Regularly monitor trends in the technological environment that conform to open systems standards.

2.4.2.2 Specify existing and emerging non-proprietary technology standards in system design.

2.4.2.3 Evaluate possible data degradation of information stored on optical digital data disks and system functionality on a regular basis using media error monitoring and reporting tools outlined in proposed and evolving standards (i.e., American National Standards Institute (ANSI)/Association for Information and Image Management (AIIM) MS59-199X).

2.4.2.4 Support the ongoing development of non-proprietary standards for data exchange and interoperability.

3.1 ROUTINE TRANSFER OF TMA eRECORDS

3.2 Routine, annual transfer of inactive TMA eRecords from contractor systems is required. In accordance with current record dispositions identified in AI-15, TMA records will be closed-out at the end of each calendar year, held for one additional year on-sight, then transferred.

3.2.1 Contractors shall routinely transfer inactive electronic records with associated metadata to TMA's designated electronic records repository hosted by NARA's electronic Federal Records Center (eFRC). Access the TMA Records Management web site for current transfer package instructions and transfer requirements.

3.2.2 Transfer documentation must include required NARA e135 and Standard Form (SF) 135 with corresponding indexes.

3.2.3 Where possible, contractors shall submit required documentation in an electronic format that conforms to NARA requirements. For data files and databases, documentation must include record layouts, data element definitions, and code translation tables (code books) for coded data. Data element definitions, codes used to represent data values and interpretations of these codes must match the actual format and codes as transferred.

3.3 Formats and storage media for transfer will be coordinated with the TMA Records Management Officer. The contractor may not transfer electronic records that are in a format dependent on specific hardware and/or software.

3.4 The contractor shall follow transfer procedures provided by the TMA Records Management Officer and made available from the TMA Records Management web site. The contractor shall use the designated validation software and process provided by the TMA Records Management Officer

for the quality assurance requirement for preparing electronic records for transfer. (See Addendum B.)

3.4.1 The contractor shall follow the specific guidelines provided by the TMA Records Management Officer in preparing the electronic SF 135 transfer document that will include the indexing information provided as metadata.

3.4.2 The contractor shall follow the specific transfer protocol procedures provided by the TMA Records Management Officer for proper shipment of electronic records. The contractor shall use the recommended storage media designated by the TMA Records Management Officer. The contractor shall use encryption software approved by TMA Records Management Officer for sensitive data Personal Identifiable Information (PII)/Personal Health Information (PHI).

3.4 The contractor shall prepare the electronic transfer package to include the following items:

- e135 or SF 135 in Portable Document Format (PDF) format, which can be found on the TMA Records Management web site. The transmittal document SF 135 shall be used as a communication and documentation tool when requesting electronic records transfer. The sample SF 135 illustrates how to use this document that was designed for paper records and change some key information that is specific for the electronic records. For example, in #6, Volume (d), list the storage size of the transfer; Agency Box Numbers (e), list the total rows of data in the metadata file; and the Series Description (f), list the metadata elements and data types included in the metadata file. The SF 135 PDF file will be sent via e-mail to the TMA Records Management Office to start the request for an electronic records transfer. The TMA Records Management Office will use the information on the SF 135 to populate the e135 web page with the metadata information. The TMA Records Management Office will require the SF 135 PDF file on the media that is used to transfer the electronic records as a documentation tool.

- eXtensible Markup Language (XML) file provided to contractor from TMA.

- Delimited data file to include required document type (i.e., DOC, PDF, TIFF, XLS) and version information of the software that produced the document type.

- Record Object documents.

- Validation Audit Log.

4.1 TRANSFER OF RECORDS IN THE EVENT OF TRANSITION

4.2 In the event of a contract change, active and eligible inactive TMA eRecords with their associated metadata will be transferred to the incoming contractor and to the NARA eFRC.

4.3 In addition to following the procedures for routine eRecords transfers, the contractor shall prepare and provide electronic records documentation which, at a minimum, must maintain a complete set of documentation, including business rules implemented in source code with flow diagrams, object code, and operations and maintenance manuals to be turned over to an incoming contractor and to NARA.

4.4 The documentation must be adequate to identify, service, and interpret electronic records that have been designated for storage by TRICARE and the documentation must be transferred with the records.

- END -

Chapter 2 Section 5

Transferring Records (Federal Records Centers (FRCs) And Transitions)

1.0 FEDERAL RECORDS CENTERS (FRCs)

FRCs are established and maintained by the National Archives and Records Administration (NARA) at locations throughout the United States for the storage, processing, and servicing of noncurrent records for federal agencies. When a government record (regardless of media) becomes inactive, it shall be transferred to a FRC designated by TRICARE Management Activity (TMA). If necessary, the contractor may transfer active records to their designated FRC in the case of storage issues, etc.

2.1 FRC RELATIONS

The contractor shall:

2.2 Deal only with the FRC designated by the TMA.

2.3 Contact TMA Records Management Officer for assistance in arranging for the retirement and storage of records. The arrangements concern only the details of transfer and recall of records.

2.4 Designate a specific individual as a Point Of Contact (POC) to deal with the transfer of records. The name and address of the individual, and any change in designation, shall be forwarded, as soon as possible, to:

Records Management Officer
TRICARE Management Activity
16401 East Centretech Parkway
Aurora, Colorado 80011-9066

2.5 Refer all problems or excessive delays encountered with the FRC to:

Records Management Officer
TRICARE Management Activity
16401 East Centretech Parkway
Aurora, Colorado 80011-9066

3.1 TRANSFER TO OTHER CONTRACTORS/RECORDS CENTER

In circumstances when it is necessary to transfer records to another TRICARE contractor (i.e., transition situations) or NARA Records Center, the contractors shall carefully follow the media transferring procedures located in Addendums A and Addendum B.

3.2 Transfer Of Paper Records

See Addendum A for paper record transfer procedures.

3.3 Transfer of Electronic Records

See Addendum B for electronic record transfer procedures.

3.3.1 Transfer of electronic records will be determined in transition meetings for records being transferred to another TRICARE contractor.

3.3.2 When transferring electronic records to other than a contractor, the transfer of electronic records will be in accordance with current NARA Temporary Records Transfer procedures.

- END -

Chapter 2 Section 6

Destruction Of Records

1.1 POLICY

Contractors are required to use the following procedures in destroying Government records:

1.2 Paper records and other media: Since the bulk of the Government records created/ maintained and received by the contractor contain protected health information and personal identifying information, the contractor shall be required at a minimum to cross shred paper documents. Other acceptable disposal methods include: burning, melting, chemical decomposition, pulping, pulverizing, or mutilation. These methods are considered adequate, if the personal data is rendered unrecognizable or beyond reconstruction. Magnetic tapes or other magnetic media shall be cleared by degaussing, overwriting, or erasing.

1.3 If a contractor uses a shred company, the destruction shall be witnessed by a contractor employee. The shred company shall be bonded, insured, and furnish the contractor with a Certificate of Destruction. The Certificate(s) of Destruction shall provide a description of the records that were destroyed (i.e., general correspondence and claim documents for Calendar Year (CY) 2006). The Certificate(s) of Destruction shall be made available to the Government upon request.

- END -

Chapter 2 Addendum A

Paper Record Transfer Procedures

1.0 GENERAL

The standard Federal records carton (or its equivalent) will be used to ship records to the Federal Records Center (FRC). It is the responsibility of the contractor to acquire cartons from outside sources. When records are shipped in cartons that the FRC cannot accommodate, the records will be returned to the contractor for repacking at the contractors expense. Cartons that meet standards for shipping records to the FRC are:

Standard-Size Record Box
(for standard and legal files)
14-3/4" x 12" x 9-1/2" (inside dimensions)
15" x 12" x 10" (outside dimensions)

Small Material Box
(for checks)
14-3/7" x 9-1/2" x 4-7/8" (outside dimensions)

Microfiche Box
14-3/4" x 11-3/4" x 11-3/4" (outside dimensions)

2.1 PACKING AND LABELING OF RECORDS

2.2 An important aspect of preparing records for transfer to FRC is proper packing. Improper packing may result in damage to records and may make them difficult to use in the future.

2.3 Records shall not be forced into the cartons; leaving a 1/2 inch space in each carton will permit easy withdrawal of individual records for reference. If interfiles are expected in the future, enough space shall be left to accommodate them. Records shall be packed upright, with letter-size records facing the front of the carton and legal-size records facing the left side of the carton (see the FRC Toolkit, which can be found on the TRICARE Management Activity (TMA) Records Management web site). Records shall be shipped in manila file folders or expandable folders separating the various records specified in Section 2. Under no circumstances shall records be placed one on top of another in a carton.

2.4 After the records are boxed, the cartons shall be numbered sequentially (1/10, 2/10, 3/10, etc.) with permanent black marker in the upper right front corner (see Figure 2.A-1).

2.5 Detailed lists of the contents of cartons, indexes to records, and other specialized finding aids shall be attached to the Standard Form (SF) 135 (Records Transmittal and Receipt) and be retained by the contractor so that documents needed for future reference can be identified clearly by requesting officials.

3.1 PREPARING TRANSMITTAL DOCUMENT

3.2 When transferring records to the FRC, the contractor shall prepare and forward the original and two copies of the SF 135 (which can be found on the TMA Records Management web site under National Archives and Records Administration (NARA) Records Transmittal and Receipt, SF 135) to the TMA Records Management Officer prior to shipping records. In the FROM block (Block 5) the contractor shall enter the following: TRICARE Management Activity, ATTN: Records Management, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9066. The contractor shall insert its own address below the TMA address. The contractor shall state in the Series Description Block the description of the records, the contract number and region. Instructions for completing the remainder of the form are printed on the reverse side of the SF 135. A detailed listing of the contents of each carton shall be attached to the SF 135. If a continuation form is required, use SF 135-A (Records Transmittal and Receipt (Continuation)) or on 8-1/2" x 11" bond paper.

3.3 When records are transferred, they must be scheduled for disposal using the applicable disposition schedule (see Section 2 for schedules). When the disposal authority is not cited, the SF 135 will be returned for completion.

3.4 Upon receipt of the SF 135, the FRC reviews it for completeness for transfer. If approved, the FRC assigns a transfer number on the form.

3.5 The original SF 135 is retained by the FRC; one copy of the annotated SF 135, showing transfer number(s) will be returned to the contractor, indicating the FRC's approval of the shipment.

3.6 After receiving the copy of the approved SF 135, the contractor shall mark each carton in the shipment with the assigned transfer number. The transfer number shall be put in the upper left front of the carton (see Figure 2.A-1). The contractor shall place one copy of the SF 135 with the index in Box 1 of each transfer and the records will be shipped to the FRC. A copy of the SF 135 and index shall be retained by the contractor for its use.

3.7 The shipment of records shall be accomplished as soon as possible after the contractor receives the annotated copy of the SF 135. If shipment cannot be made within 90 days of receipt, the contractor must notify the FRC, or the SF 135 may be cancelled and returned by the FRC.

3.8 Upon receipt of the records in the FRC, the SF 135 will be signed and returned to the contractor. The FRC Archives and Records Centers Information System (ARCIS) web application tracks the location of boxes with bar codes and location numbers are no longer returned to TMA.

3.9 Records boxes will be palletized as shown in Figure 2.A-2. If transferring to the Pittsfield FRC, use Figure 2.A-2. If transferring records to another FRC, contact the TMA Records Management Officer for guidance.

4.1 SHIPPING RECORDS

4.2 The contractor shall advise the TMA Records Management Officer that a Commercial Bill of Lading (CBL) is required for shipment of records. The information must be provided at least two

weeks prior to the estimated shipment date. The information required when requesting a CBL includes:

Number of boxes/pallets	Point of Contact Name/Telephone number
Estimated weight	Pick up address
Estimated date of shipment	Destination Address
Pickup Date for Shipment	

4.3 A line-haul carrier will be assigned by the Government and stated in the CBL. Only the carrier designated on the CBL will be used. The contractor shall be responsible for arranging for the date and time of pickup and delivery. The TMA office will notify the contractor at least 24 hours in advance of scheduled pickup date. If a contractor location is open other than normal days/hours, that information should be included on the CBL request, so that the pickup can be scheduled during those times. The contractor shall comply with the following instructions:

- Boxes will be strapped or shrink-wrapped onto pallets.
- Pallets will not be double stacked.
- The shipment will be loaded and off-loaded sequentially (see the FRC Toolkit, which can be found on the TMA Records Management web site).

4.4 The FRC has the right to refuse any shipment of records. Their basis for refusal is based on the requirements of this chapter not being met. When deficiencies are identified with the contents of a shipment, the FRC will send a letter to the contractor stating the deficiencies found. The FRC will notify the TMA Records Management Officer of any deficiencies found in shipments including corrective actions to be taken by the contractor or the basis for a return of the shipment.

4.5 TMA will pay for the actual shipment of records to the FRC by use of the CBL. However, if the shipment is found unacceptable at the FRC, the cost to send the shipment back to the contractor and reship to the FRC will be the responsibility of the contractor. If the FRC must perform work on the shipment to make it acceptable, i.e., putting box or transfer numbers on boxes, repacking damaged boxes (caused by improper packing), etc., that cost will also be the responsibility of the contractor.

5.1 RETRIEVING RECORDS

5.2 The FRC provides reference services which include the loan or return of records, preparation of authenticated reproductions of documents, and furnishing of information from records. Requests for the return of retired records by the contractor shall be approved by the TMA Records Management Officer.

5.3 Recall of a record from the FRC may constitute a reactivation of the case if the record will be retained on the basis of a current transaction (permanent recall). The record shall be transferred as part of a new shipment of records to the FRC after the new retention period has been met. A record is not reactivated if used only for reference (temporary recall) and may be returned to the FRC for refile.

5.4 The best method to recall records from the FRC is with the use of the Optional Form 11 (OF-11) (see the Reference Request - Federal Records Center). When multiple OF-11s are transmitted to the FRC, they shall be arranged in transfer number order, by FRC location and contractor box number. Use one OF-11 per request. If OF-11s are unavailable, request files on letter-size paper, providing one copy for each requested document to be used by the FRC as a charge-out document.

5.5 The following information shall always be furnished when preparing a reference request:

- Accession Number
- FRC Location
- Contractor Box Number
- Description of Records or Information Requested
- Name, Address, and Telephone Number of Requester

5.6 Phone request shall be limited to emergency situations. The FRC normally processes requests within eight hours of receipt. All telephone requests for records (priority requests) must go through the TMA Records Management Officer at (303) 371-8677. Emergency phone requests are defined as:

- Freedom of Information Act (FOIA) requests
- Privacy Act requests
- Congressional inquiries
- Pending court actions
- High-level interest cases

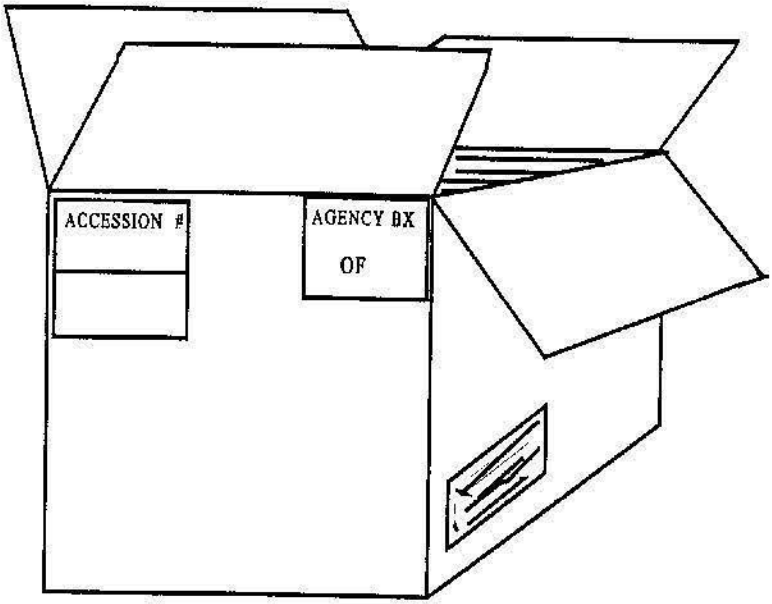
5.7 ARCIS Smart Scan requests shall be limited to emergency situations. The FRC normally processes these requests within eight hours of receipt. All Smart Scanned and e-mail documents should not contain Personally Identifiable Information (PII) or Personal Health Information (PHI) unless approved encryption is applied. Contact your TMA Records Management Officer on guidance on approved encryption. All Smart Scanned electronic documents shall be treated as transitory and convenience copy. All Smart Scan requests for records (priority requests) must go through the TMA Records Management Officer at (303) 371-8677. Smart Scan requests are defined as:

- FOIA requests
- Privacy Act requests
- Congressional inquiries
- Pending court actions
- High-level interest cases

5.8 All records requested from storage shall go to the individual (office) requesting them. Records shall not be sent to outside sources such as the U.S. Department of Justice (DOJ) or Defense Criminal Investigating Service (DCIS). Records shall be sent only to TMA contractors or the TMA Records Management Officer.

5.9 Requests for records (OF-11) shall be in FRC location order if 25 or more requests are sent together. There is no limit on the number of requests the FRC will process at one time.

FIGURE 2.A-1 MARKING AND PACKING INSTRUCTIONS



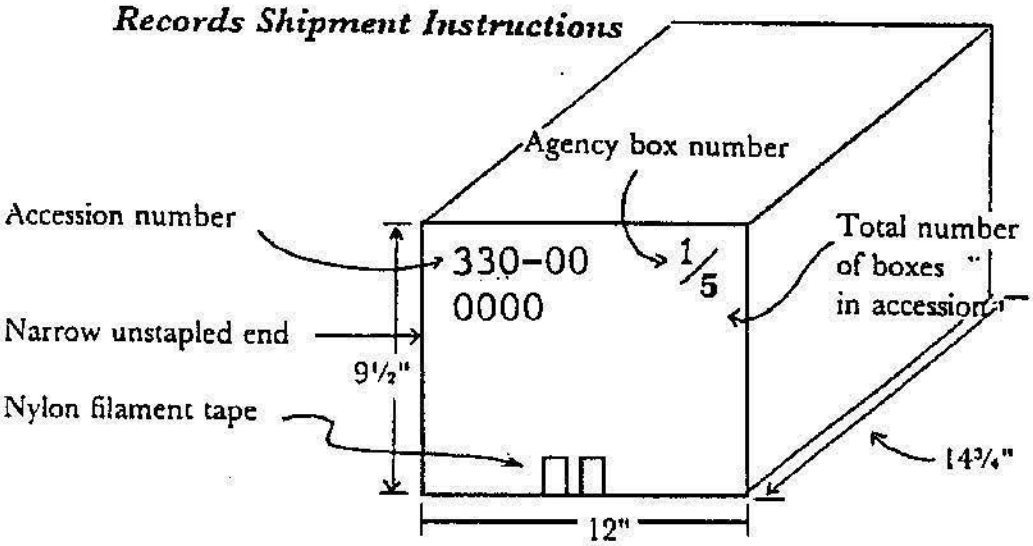
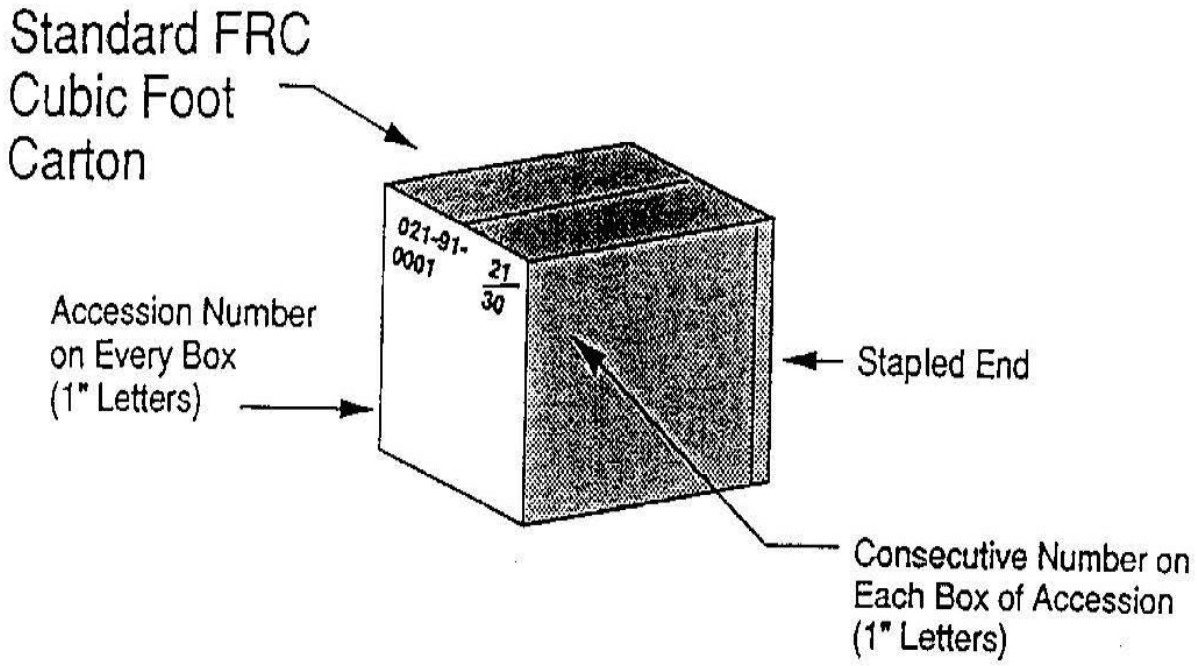
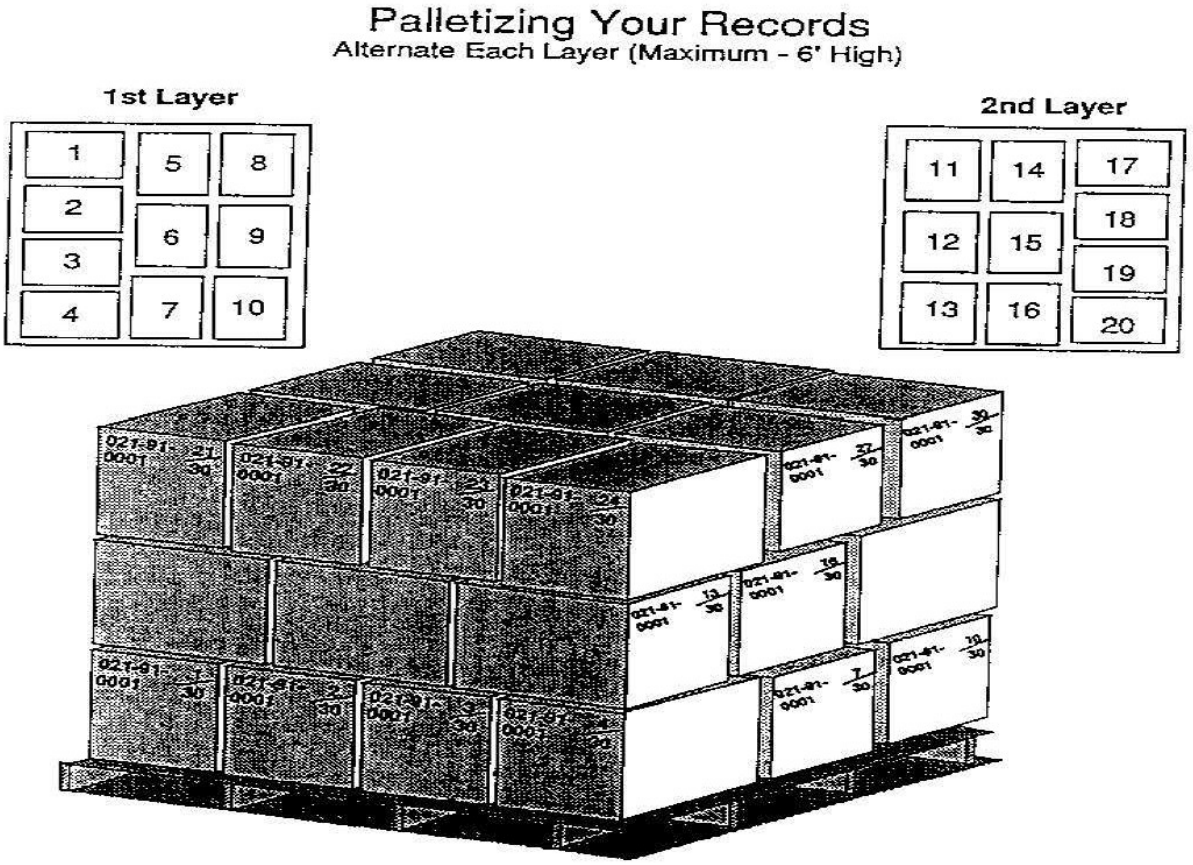


FIGURE 2.A-2 ARRANGEMENT OF BOXES ON PALLETS





- END -

Chapter 2 Addendum B

Electronic Record Transfer Procedures

1.1 GENERAL

1.2 Electronic records are transferred to TRICARE Management Activity (TMA) on acceptable storage media. Acceptable storage media for electronic transfers are Compact Disc-Read Only Memory (CD-ROM) or Digital Versatile Disk-Recordable (DVD-R). Contact the TMA Records Management Officer if you have a need for other storage media not identified.

1.3 The contractor will use the existing electronic Standard Form (SF)-135 (Records Transmittal and Receipt) which can be found on the TMA Records Management web site, to communicate the specific transfer information for electronic records. The SF-135 is specific to paper records however with minor changes the same form can be used to initiate the request to transfer electronic records. The TMA Records Management Officer will receive the SF-135 Portable Document Format (PDF) form via e-mail from the contractor. Once the transfer is approved the TMA Records Management Officer will send the annotated SF-135 PDF form via e-mail to the contractor. The contractor shall include the e-copy of the SF-135 PDF form in the transfer package.

1.4 The Validator software and documentation can be downloaded from the TMA Privacy Office web site. This Validator software shall be run by the contractor prior to shipment of the transfer package to TMA. The purpose of the Validator software is to provide the quality assurance necessary to insure trustworthy electronic records. The Validator will produce an audit log to document the success of transfer package validation and this log is required as part of the final package. More specific details can be obtained from the TMA Privacy Office web site from the Data Transfer Specification document.

2.1 TRANSFER PACKAGE PREPARATION AND LABELING OF ELECTRONIC RECORDS

2.2 An important aspect of preparing electronic records for transfer to the Electronic Federal Records Center (eFRC) is proper preparation. Improper preparation of the transfer package may result in the transfer package being rejected by TMA Records Management Officer.

2.3 Transfer package consists of the following files:

- eXtensible Markup Language (XML) Transfer Specification file
- Metadata file (txt format)
- Record objects
- e-Copy of SF-135 (PDF format)
- Audit Log of Validation

When preparing to transfer files for validation and the eventual transfer to the media device, the user creates a folder on their computer and transfers the XML Transfer Specification file and

Metadata file to that folder. Specific instructions and details can be referenced from the TMA Privacy Office web site from the eFRC Data Transfer Specification document.

2.4 After the electronic records are stored on the media device, the CD-ROM or DVD-R shall be numbered sequentially (1 of 10, 2 of 10, 3 of 10, etc.) on the label. For more specific guidance on labeling of storage media contact the TMA Records Management Officer.

2.5 A list of the required metadata elements that will be included in the metadata file shall be listed on the electronic SF-135 (e135). A list of the minimum required metatdata elements can be located in Section 2. An electronic copy shall be retained by the contractor so that documents needed for future reference can be identified clearly by requesting officials. Specific instructions and details can be referenced from the TMA Privacy Office web site from the eFRC Process User Manual.

3.1 PREPARING TRANSMITTAL DOCUMENT

3.2 When transferring electronic records to the eFRC, the contractor shall prepare and e-mail the e135 which can be found on the TMA Records Management web site, to the TMA Records Management Officer prior to shipping the electronic transfer package. In the FROM block (Block 5) the contractor shall enter the following: TRICARE Management Activity, ATTN: Records Management, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9066. The contractor shall insert its own address below the TMA address. The contractor shall state in the Series Description Block the description of the records, the contract number, region, record series, and specific metadata elements that will be in the metadata file of the transfer package. The contractor shall state in the volume, and agency box number columns the storage size, and total number of rows in the metadata file respectively. Instructions for completing the remainder of the form are printed on the reverse side of the SF 135.

3.3 When records are transferred, they must be scheduled for disposal using the applicable disposition schedule (see Section 2 for schedules). When the disposal authority is not cited, the e135 will be returned for completion.

3.4 Upon receipt of the e135, the TMA and eFRC staff review it for completeness for transfer. If approved, the eFRC annotates the official transfer number on the form and returns it to the TMA Records Office for continued processing.

3.5 The original e135 is retained by the eFRC; one copy of the annotated e135, showing transfer number(s) will be e-mailed to the contractor, indicating the eFRC's approval of the transfer.

3.6 After receiving the copy of the approved e135 PDF document, the contractor shall prepare the transfer package. The transfer number shall be included on the label of each physical media device. The contractor shall place the electronic copy of the e135 PDF document on the first media device of each transfer and the records will be shipped to the TMA Records Management Officer in accordance with Personal Health Information (PHI)/ Personal Identifiable Information (PII) guidance. A copy of the e135 PDF document shall be retained by the contractor for its reference and use.

3.7 The shipment of the transfer package of electronic records shall be accomplished as soon as the contractor has successfully run the Validator Program. The contractor can download the

Validator Installation program from the TMA Privacy Office web site. Install instructions shall be available from the TMA Privacy Office web site. The eFRC Data Transfer Specification document has specific guidelines for this process and is available on the TMA Privacy Office web site. Contact the TMA Records Management Officer for additional guidance for the required validation process.

4.1 SHIPPING RECORDS

4.2 Sensitive data shall follow the transfer protocol instructions available on the TMA Privacy Office web site. All sensitive data that includes PII or PHI shall be encrypted on the media device prior to shipping the transfer package to TMA or eFRC. Contact the TMA Records Office for guidance on the approved encryption software to use for sensitive data. The contractor shall comply with the following instructions:

- Double Wrapping shall be used for shipment.
- Prepare for U.S. Postal Service.
- Always send by registered mail.
- Use opaque envelopes or containers.
- Inner envelope/container has full address for TMA Records Management Officer.
- Inner envelope/container has classification and handling markings (i.e., Unclassified, For Official Use Only (FOUO)).
- Outer envelope/container has full address for TMA Records Management Officer.
- Outer envelope/container has no classification markings.

4.3 Non-sensitive data can be shipped to TMA Records Management Officer using normal shipment methods and sensitive data transfer protocol are not necessary.

5.1 RETRIEVING RECORDS

5.2 The eFRC provides reference services which include search, retrieval, and providing authorized requesters with a copy of the electronic records stored in the repository.

5.3 Recall of an electronic record from the eFRC does not include a permanent recall. The copy of an electronic record shall be managed as a convenience copy and destroyed when no longer needed. Remember if the content of the recalled record is re-utilized for other business purposes, it becomes a new record and is managed and maintained as such.

5.4 The best method to recall records from the eFRC is with the use of the Optional Form (OF) 11, (Reference Request-Federal Records Center) which can be found on the TMA Records Management web site. Use the electronic form OF 11 per request and e-mail to the TMA Records Management Officer.

5.5 The following information shall always be furnished when preparing a reference request:

- Transfer Number
- eFRC Location (for all transfers going to the eFRC, annotate "eFRC" as the FRC Location.
- Metadata elements used for Search Criteria
- Record Series
- Description of Records or Information Requested
- Name, Address, and Telephone Number of Requester

- END -

SECTION J, ATTACHMENT J-10

CONTRACT HT9402-13-C-0006
TRICARE RETIREEE DENTAL PROGRAM

DELTA DENTAL of CALIFORNIA
SMALL BUSINESS SUBCONTRACTING PLAN
Dated September 18, 2012

6.1 SUBCONTRACTING PLAN [L.5.3, M.8]

6.2 Introduction

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