Chapter 2 Section 1

Cost-Shares And Deductibles

Issue Date: December 16, 1983
Authority: 32 CFR 199.4, 32 CFR 199.5, 32 CFR 199.17, and 32 CFR 199.18

Revision:

1.0 POLICY

1.1 General

1.1.1 TRICARE Standard program deductible and cost-share amounts are defined in 32 CFR 199.4. They are identical to those applied under TRICARE Basic.

1.1.2 TRICARE Extra program deductible and cost-share amounts are defined in 32 CFR 199.17.

1.1.3 TRICARE Prime program enrollment fees and copayments are defined under the Uniform Health Maintenance Organization (HMO) Benefit Schedule of Charges in 32 CFR 199.18. For information on fees for Prime enrollees choosing to receive care under the Point of Service (POS) option, refer to 32 CFR 199.17.

1.1.4 Fees under the Extended Care Health Option (ECHO) are defined in 32 CFR 199.5.

1.1.5 Addendum A contains a complete listing of cost-share and deductible information.

1.1.6 Waiver of Cost-Sharing and Deductible

1.1.6.1 Operation Desert Shield/Desert Storm

1.1.6.1.1 The Operation Desert Shield/Desert Storm Supplemental Appropriations Act of 1991, Public Law 102-28, April 10, 1991, allowed medical providers to voluntarily waive the patient cost-share and/or deductible for medical services provided family members of active duty personnel from August 2, 1990, until the date the "Persian Gulf conflict" ends as prescribed by Presidential proclamation or by law.

1.1.6.1.1.1 Operation Desert Storm. Operations of the United States (U.S.) Armed Forces conducted as a consequence of the invasion of Kuwait by Iraq (including operations known as Operation Desert Shield and Operation Desert Storm).

1.1.6.1.1.2 Persian Gulf Conflict. The period beginning on August 2, 1990, and ending thereafter on the date prescribed by Presidential proclamation or by law.

1.1.6.1.1.3 A Civilian Health Care (CHC) provider may voluntarily waive, in whole or in part, the cost-share and/or deductible of Active Duty Family Members (ADFMs) if the provider certifies in writing that the amount charged the federal Government for such health care was not increased above the amount that the health care provider would have charged the federal Government for such health care had the payment not been waived.

1.1.6.1.1.3.1 The legislation only provides a temporary exemption to the cost-sharing provisions. Once the President officially proclaims an end to the "Persian Gulf conflict", the cost-sharing provision will be reinstated.

1.1.6.1.1.3.2 The legislation does not require modification of the existing claims processing guidelines. The contractors shall process the claims normally, reflecting the appropriate deductible, cost-share, and catastrophic cap on the claims history, payment records, TRICARE Explanation of Benefits (EOB), etc. The waiver of cost-sharing is between the ADFM and the provider and does not affect the contractor's claims processing procedures, except as prescribed in the Program Integrity provisions in the TRICARE Operations Manual (TOM), Chapter 13.

1.1.6.1.1.3.3 The waiver of cost-sharing is based on the dates of care/service.

1.1.6.1.1.3.4 The waiver applies to both the Basic Program and the ECHO and is applicable to both inpatient and outpatient care.

1.1.6.1.1.3.5 The waiver of cost-sharing only applies to family members of active duty personnel. The other categories of TRICARE beneficiaries are still subject to the cost-sharing and deductible requirements set forth in 10 USC 1079 and 1086.

1.1.6.1.2 The exception to the cost-sharing requirements is effective for services rendered from August 2, 1990, until the date the "Persian Gulf conflict" ends as prescribed by Presidential proclamation or by law.

1.1.6.2 Operation Joint Endeavor

1.1.6.2.1 Under legislation passed for Operation Joint Endeavor, the TRICARE Standard deductible has been waived for family members of certain reserve members called to active duty. However, this provision does not provide for voluntary waiver of cost-shares or the deductibles by providers allowed under Operation Desert Storm. If the family is enrolled in TRICARE Prime, the deductible for POS is not waived for this provision.

1.1.6.2.2 The exception to the deductible requirements under Operation Joint Endeavor for TRICARE Standard and Extra is effective for services rendered from December 8, 1995 until such time as Executive Order 12982 expires.

1.1.6.3 Operation Noble Eagle/Operation Enduring Freedom

1.1.6.3.1 The TRICARE Standard and Extra deductible is waived for family members of members of the reserves or National Guard who have been ordered to active duty in support of operations that result from the terrorist attacks on the World Trade Center (WTC) and the Pentagon on September 11, 2001.

1.1.6.3.2 The cost-share is partially waived in certain cases for these beneficiaries. On claims from non-participating professional providers for services rendered to Standard beneficiaries, the allowable amount is the lesser of the billed charge or the balance billing limit (115%) of the CHAMPUS Maximum Allowable Charge (CMAC)). In these cases, the cost-share is 20% of the lesser of the CMAC or the billed charge, and the cost-share for any amounts over the CMAC that are allowed is waived. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

1.1.6.4 For Certain Reservists

The Defense Health Agency (DHA) may waive the individual or family deductible for family members of a Reserve Component (RC) member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a RC member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 United States Code (USC) 101(a)(13). Also, for this purpose a family member is a lawful husband or wife of the member or an eligible child.

1.2 TRICARE Prime

1.2.1 Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See Addendum A for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act, Public Law 106-398, for services provided on or after April 1, 2001, a $0 copayment shall be charged to TRICARE Prime ADFMs of Service members who are enrolled in TRICARE Prime. Pharmacy copayments and POS charges are not waived by the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2001.

1.2.2 In instances where the CMAC or allowable charge is less than the copayment shown on Addendum A, network providers may only collect the lower of the allowable charge or the applicable copayment.

1.2.3 The TRICARE Prime copayment requirement for emergency room services is on a PER VISIT basis; this means that only one copayment is applicable to the entire emergency room episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers.

1.2.4 Prime enrollees have no copayments for the ancillary services in the categories listed below (normal referral and authorization provisions apply). Current Procedural Terminology (CPT) code ranges are given; however, these codes are not all-inclusive. The most up-to-date codes should be utilized to identify services within each category, in accordance with the TOM, Chapter 1, Section 4. Additionally, listing the code ranges does not imply coverage; the codes just provide the broad range of services that are not subject to copayments under this provision:

1.2.4.1 Diagnostic radiology and ultrasound services included in the CPT procedure code range from 70010-76999, or any other code for associated contrast media;

1.2.4.2 Diagnostic nuclear medicine services included in the CPT procedure code range from 78012-78999;

1.2.4.3 Pathology and laboratory services included in the CPT procedure code range from 80047-89398; G0461-G0462 (during 2014); and

1.2.4.4 Cardiovascular studies included in the CPT procedure code range from 93000-93355.

1.2.4.5 Venipuncture included in the CPT procedure code range from 36400-36425.

1.2.4.6 Collection of blood specimens in the CPT procedure codes 36591 and 36592.

1.2.4.7 Fetal monitoring for CPT procedure codes 59020, 59025, and 59050.

Note: Multiple discounting will not be applied to the following CPT procedure codes for venipuncture, fetal monitoring, and collection of blood specimens; 36400-36425, 36591, 36592, 59020, 59025, and 59050.

1.2.5 Point of Service option. See Section 3.

1.3 Basic Program: TRICARE Standard

1.3.1 Deductible Amount: Outpatient Care

1.3.1.1 Active Duty Sponsor in Pay Grade E-4 or Below

1.3.1.1.1 Deductible, Individual: Each beneficiary is liable for the first fifty dollars ($50.00) of the allowable amount on claims for care provided in the same fiscal year.

1.3.1.1.2 Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed one hundred dollars ($100.00).

1.3.1.2 All TRICARE Beneficiaries Except Family Members of Active Duty Sponsors in Pay Grade E-4 or Below

1.3.1.2.1 Deductible, Individual: Each beneficiary is liable for the first $150.00 of the allowable amount on claims for care provided in the same fiscal year.

1.3.1.2.2 Deductible, Family: The total deductible amount for all members of a family with the same sponsor during one fiscal year shall not exceed $300.00.

1.3.1.3 TRICARE-Approved Ambulatory Surgery Centers (ASCs), Birthing Centers, or Partial Hospitalization Programs (PHPs)

1.3.1.4 No deductible shall be applied to allowable amounts for services or items rendered to ADFMs or authorized North Atlantic Treaty Organization (NATO) family members.

1.3.1.5 Allowable Amount Does Not Exceed Deductible Amount. If fiscal year allowable amounts for two or more beneficiary members of a family total less than $100.00 (or $300.00 if paragraph 1.3.1.2, applies), and no one beneficiary's allowable amounts exceed $50.00 (or $150.00 if paragraph 1.3.1.2 applies), neither the family nor the individual deductible will have been met and no TRICARE benefits are payable.

1.3.1.6 In the case of family members of an active duty member of pay grade E-5 or above, with Persian Gulf conflict service who is, or was, entitled to special pay for hostile fire/imminent danger authorized by 37 USC 310, for services in the Persian Gulf area in connection with Operation Desert Shield or Operation Desert Storm, the deductible shall be the amount specified in paragraph 1.3.1.2.

Note: The provisions of paragraph 1.3.1.6, also apply to family members of Service members who were killed in the Gulf, or who died subsequent to Gulf service; and to Service members who retired prior to October 1, 1991, after having served in the Gulf war, and to their family members.

1.3.1.7 Adjustment of Excess. Any beneficiary identified under paragraphs 1.3.1.5 and 1.3.1.6 who paid any deductible in excess of the amounts stipulated is entitled to an adjustment of any amount paid in excess against the annual deductible required under those paragraphs.

1.3.1.8 The deductible amounts identified in this section shall be deemed to have been satisfied if the catastrophic cap amounts identified in Section 2 have been met for the same fiscal year in which the deductible applies.

1.3.2 Deductible Amount: Inpatient Care

None.

1.3.3 Cost-share Amount

1.3.3.1 Outpatient Care

1.3.3.1.1 ADFM or Authorized NATO Beneficiary. The cost-share for outpatient care is 20% of the allowable amount in excess of the annual deductible amount. This includes the professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC or Birthing Center.

1.3.3.1.2 Other Beneficiary. The cost-share applicable to outpatient care for other than active duty and authorized NATO family member beneficiaries is 25% of the allowable amount in excess of the annual deductible amount. This includes: partial hospitalization for alcohol rehabilitation; professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC.

1.3.3.2 Inpatient Care

1.3.3.2.1 ADFM: Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the daily charge the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater. (Please reference daily rate chart below.)

FIGURE 2.1-1 UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

PERIOD	DAILY CHARGE
October 1, 2011 - September 30, 2012 (for ADFMs not enrolled in Prime)	$17.05
October 1, 2012 - September 30, 2013 (for ADFMs not enrolled in Prime)	$17.35
October 1, 2013 - September 30, 2014 (for ADFMs not enrolled in Prime)	$17.65
October 1, 2014 - September 30, 2015 (for ADFMs not enrolled in Prime)	$17.80
Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.	

1.3.3.2.2 Other Beneficiaries: For services exempt from the DRG-based payment system and the mental health per diem payment system and services provided by institutions other than hospitals (i.e., Residential Treatment Centers (RTCs)), the cost-share shall be 25% of the allowable charges.

1.3.3.3 Cost-Shares: Maternity

1.3.3.3.1 Determination. Maternity care cost-share shall be determined as follows:

1.3.3.3.1.1 Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded.

Note: Inpatient cost-share formula applies to prenatal and postnatal care provided in the office of a civilian physician or certified nurse-midwife in connection with maternity care ending in childbirth or termination of pregnancy in, or on the way to, a Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) inpatient childbirth unit. ADFMs pay a per diem charge (or a $25.00 minimum charge) for an admission and there is no separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

1.3.3.3.1.2 Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted, and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

1.3.3.3.1.3 Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

1.3.3.3.1.4 Otherwise covered medical services and supplies directly related to "complications of pregnancy", as defined in the Regulation, shall be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

1.3.3.3.2 Otherwise authorized services and supplies related to maternity care, including maternity related prescription drugs, shall be cost-shared on the same basis as the termination of pregnancy.

1.3.3.3.3 Claims for **pregnancy testing** shall be cost-shared on an outpatient basis when the delivery is on an inpatient basis.

1.3.3.3.4 Where the beneficiary delivers in a **professional office birthing suite** located in the office of a physician or certified nurse-midwife (which is not otherwise a TRICARE-approved birthing center) the delivery shall be adjudicated as an at-home birth.

1.3.3.3.5 Claims for **prescription drugs** provided on an outpatient basis during the maternity episode but not directly related to the maternity care shall be cost-shared on an outpatient basis.

1.3.3.3.6 Newborn cost-share. Effective for all inpatient admissions occurring on or after October 1, 1987, separate claims must be submitted for the mother and newborn. The cost-share for inpatient claims for services rendered to a beneficiary newborn is determined as follows:

1.3.3.3.6.1 In a DRG hospital:

1.3.3.3.6.1.1 Same newborn date of birth and date of admission:

- For ADFMs, there shall be no cost-share during the period the newborn is deemed enrolled in Prime.
- For newborn family members of other than active duty members, unless the newborn is deemed enrolled in Prime, the cost-share shall be the lower of the number of hospital days minus three multiplied by the per diem amount, OR 25% of the total billed charges (less duplicates and DRG non-reimbursables such as hospital-based professional charges).

1.3.3.3.6.1.2 Different newborn date of birth and date of admission:

- For ADFMs, there shall be no cost-share during the period the newborn is deemed enrolled in Prime.
- For all other beneficiaries, the cost-share shall be applied to all days in the inpatient stay unless the newborn is deemed enrolled in Prime.

1.3.3.3.6.2 In DRG exempt hospital:

1.3.3.3.6.2.1 Same newborn date of birth and date of admission:

- For ADFMs, there shall be no cost-share during the period the newborn is deemed enrolled in Prime.
- For family members of other than active duty members, the cost-share shall be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

1.3.3.3.6.2.2 Different newborn date of birth and date of admission:

- For ADFMs, there shall be no cost-share during the period the newborn is deemed enrolled in Prime.
- For family members of other than active duty members, the cost-share shall be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

1.3.3.3.7 Maternity Related Care. Medically necessary treatment rendered to a pregnant woman for a non-obstetrical medical, anatomical, or physiological illness or condition shall be cost-shared as a part of the maternity episode when:

- The treatment is otherwise allowable as a benefit; and
- Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated; and
- The illness or condition is, or increases the likelihood of, a threat to the life of the mother; or
- The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness; or
- The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

1.3.3.4 Cost-Shares: DRG-Based Payment System

1.3.3.4.1 General

These special cost-sharing procedures apply only to claims paid under the DRG-based payment system.

1.3.3.4.2 TRICARE Standard

1.3.3.4.2.1 Cost-shares for ADFMs.

1.3.3.4.2.1.1 Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

1.3.3.4.2.1.2 Inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission.

1.3.3.4.2.2 Cost-shares for beneficiaries other than ADFMs.

1.3.3.4.2.2.1 The cost-share shall be the lesser of:

1.3.3.4.2.2.1.1 An amount based on a single, specific per diem amount which will not vary regardless of the DRG involved. The following is the DRG inpatient TRICARE Standard cost-sharing per diems for beneficiaries other than ADFMs.

- For FY 2012, the daily rate is $708.
- For FY 2013, the daily rate is $698.
- For FY 2014, the daily rate is $744.
- For FY 2015, the daily rate is $764.

1.3.3.4.2.2.1.1.1 The per diem amount will be calculated as follows:

- Determine the total allowable DRG-based amounts for services subject to the DRG-based payment system and for beneficiaries other than ADFMs during the same database period used for determining the DRG weights and rates.
- Add in the allowance for Capital and Direct Medical Education (CAP/DME) which have been paid to hospitals during the same database period used for determining the DRG weights and rates.
- Divide this amount by the total number of patient days for these beneficiaries. This amount will be the average cost per day for these beneficiaries.
- Multiply this amount by 0.25. In this way total cost-sharing amounts will continue to be 25% of the allowable amount.
- Determine any cost-sharing amounts which exceed 25% of the billed charge (see paragraph 1.3.3.4.2.2.1.2) and divide this amount by the total number of patient days in paragraph 1.3.3.4.2.2.1.1). Add this amount to the amount in paragraph 1.3.3.4.2.2.1.1. This is the per diem cost-share to be used for these beneficiaries.

1.3.3.4.2.2.1.1.2 The per diem amount shall be required for each actual day of the beneficiary's hospital stay which the DRG-based payment covers except for the day of discharge. When the payment ends on a specific day because eligibility ends on a short-stay outlier day, the last day of eligibility is to be counted for determining the per diem cost-sharing amount. For claims involving a same-day discharge which qualify as an inpatient stay (e.g., the patient was admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.)

1.3.3.4.2.2.1.2 Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

1.3.3.4.2.2.2 Under no circumstances can the cost-share exceed the DRG-based amount.

1.3.3.4.2.2.3 Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

1.3.3.4.3 TRICARE Extra

1.3.3.4.3.1 Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

1.3.3.4.3.2 Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is $250.

1.3.3.4.4 TRICARE Prime

There is no cost-share for ADFMs. For beneficiaries other than ADFMs, the cost-sharing provision is the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of $11, whichever is greater.

1.3.3.4.5 Maternity Services

See paragraph 1.3.3.3, for the cost-sharing provisions for maternity services.

1.3.3.5 Cost-Shares: Inpatient Mental Health Per Diem Payment System

1.3.3.5.1 General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the procedures in paragraph 1.3.3.2 or 1.3.3.4 are to be followed.

1.3.3.5.2 Cost-shares for ADFMs. Inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission. This $20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any RTC, any Substance Use Disorder Rehabilitation Facility (SUDRF), and any PHP providing mental health or substance use disorder rehabilitation services. For Prime ADFMs cost-share is $0 per day. See Addendum A for further information.

1.3.3.5.3 Cost-shares for beneficiaries other than ADFMs.

1.3.3.5.3.1 Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25% of the hospital specific per diem amount.

1.3.3.5.3.2 Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of paragraphs 1.3.3.5.3.2.1 or 1.3.3.5.3.2.2:

1.3.3.5.3.2.1 A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the **Federal Register** along with the per diems published

pursuant to Chapter 7, Section 1. This fixed daily amount will also be furnished to contractors by DHA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

- Fiscal Year 2012 - $208 per day.
- Fiscal Year 2013 - $213 per day.
- Fiscal Year 2014 - $218 per day.
- Fiscal Year 2015 - $224 per day.
- Fiscal Year 2016 - $229 per day.

1.3.3.5.3.2.2 Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

1.3.3.5.4 Claims which span a period in which two separate per diems exist. A claim subject to the inpatient mental health per diem payment system which spans a period in which two separate per diems exist shall have the cost-share computed on the actual per diem in effect for each day of care.

1.3.3.5.5 Cost-share whenever leave days are involved. There is no patient cost-share for leave days when such days are included in a hospital stay.

1.3.3.5.6 Claims for services that are provided during an inpatient admission which are not included in the per diem rate shall be cost-shared as an inpatient claim if the contractor cannot determine where the service was rendered and the status of the patient when the service was provided. The contractor shall examine the claim for place of service and type of service to determine if the care was rendered in the hospital while the beneficiary was an inpatient of the hospital. This would include non-mental health claims and mental health claims submitted by individual professional providers rendering medically necessary services during the inpatient admission.

1.3.3.6 Cost-Shares: Partial Hospitalization

Cost-sharing for partial hospitalization is on an inpatient basis. The inpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers will have to identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing can be applied. The cost-share for ADFMs enrolled in Prime for inpatient mental health services is $0. For retirees and their family members, the cost-share is 25% of the allowed amount. Since inpatient cost-sharing is being applied, no deductible is to be taken for partial hospitalization regardless of sponsor status. The cost-share for ADFMs shall be taken from the PHP claim.

1.3.3.7 Cost-Shares: Ambulatory Surgery

1.3.3.7.1 Non-Prime ADFMs or Authorized NATO Beneficiary. For all services reimbursed as ambulatory surgery, the cost-share shall be $25 and shall be assessed on the facility claim. No cost-share shall be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are provided in a freestanding ASC, a hospital outpatient department or a hospital emergency room. So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim shall be cost-shared as ambulatory surgery as required by this section.

1.3.3.7.2 Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, the cost-share shall be taken from all ambulatory surgery claims.

For professional services, the cost-share is 25% of the allowed amount. For the facility claim, the cost-share is the lesser of:

1.3.3.7.2.1 Twenty-five percent (25%) of the applicable group payment rate (see Chapter 9, Section 1); or

1.3.3.7.2.2 Twenty-five percent (25%) of the billed charges; or

1.3.3.7.2.3 Twenty-five percent (25%) of the allowed amount as determined by the contractor.

1.3.3.7.2.4 The special cost-sharing provisions for beneficiaries other than ADFMs will ensure that these beneficiaries are not disadvantaged by these procedures. In most cases, 25% of the group payment rate will be less, but because there is some variation within each group, 25% of billed charges could be less in some cases. This will ensure that the beneficiaries get the benefit of the group payment rates when they are more advantageous, but they will never be disadvantaged by them. If there is no group payment rate for a procedure, the cost-share shall simply be 25% of the allowed amount.

1.3.3.8 Cost-Shares and Deductible: Former Spouses

1.3.3.8.1 Deductible. In accordance with the FY 1991 Appropriations and Authorization Acts, Sections 8064 and 712 respectively, beginning April 1, 1991, an eligible former spouse is responsible for payment of the first one hundred and fifty dollars ($150.00) of the reasonable costs/charges for otherwise covered outpatient services and/or supplies provided in any one fiscal year. Although the law defines former spouses as family members of the member or former member, there is no legal familial relationship between the former spouse and the member or former member. Moreover, any TRICARE-eligible children of the former spouse will retain a legal familial relationship with the member or former member and shall be included in the member's or former member's family deductible. The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of that of any TRICARE-eligible children. In other words, a former spouse must independently meet the $150.00 deductible in any fiscal year.

1.3.3.8.2 Cost-Share. An eligible former spouse is responsible for payment of cost-sharing amounts identical to those required for beneficiaries other than ADFMs.

1.3.3.9 Cost-Share Amount: Under Discounted Rate Agreements

Under managed care, where there is a negotiated (discounted) rate agreed to by the network provider, the cost-share shall be based on the following:

1.3.3.9.1 For non-institutional providers providing outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share (20%) for outpatient care to ADFMs, 25% for care to all others) shall be applied to (after duplicates and noncovered charges are eliminated), the lowest of the billed charge, the prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge.

1.3.3.9.2 For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The single, specific per diem supplied by DHA after the application of the agreed upon discount rate; OR
- Twenty-five percent (25%) of the billed charge.

1.3.3.9.3 For institutional providers subject to the Mental Health Per Diem Payment System (high volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be 25% of the hospital per diem amount after it has been adjusted by the discount.

1.3.3.9.4 For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for beneficiaries other than ADFMs shall be the LOWER OF EITHER:

- The fixed daily amount supplied by DHA after the application of the agreed upon discount rate; OR
- Twenty-five percent (25%) of the billed charge.

1.3.3.9.5 For RTCs, the cost-share for other than ADFMs shall be 25% of the TRICARE rate after it has been adjusted by the discount.

1.3.3.9.6 For institutions and for institutional services being reimbursed on the basis of the TRICARE-determined reasonable costs, the cost-share for beneficiaries other than ADFMs shall be 25% of the allowable billed charges after it has been adjusted by the discount.

Note: For all inpatient care for ADFMs, the cost-share shall continue to be either the daily charge or $25 per stay, whichever is higher. There is no change to the requirement for the ADFM's cost-share to be applied to the institutional charges for inpatient services. If the contractor learns that the participating provider has billed a beneficiary for a greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement. (Also see paragraph 1.3.3.4.) For Prime ADFMs, the cost-share is $0 for care provided on or after April 1, 2001.

1.3.3.10 Preventive Services

1.3.3.10.1 No copayments or authorizations are required for the following preventive services as described in the TRICARE Policy Manual (TPM), Chapter 7, Section 2.1 and 2.5:

1.3.3.10.1.1 Colorectal cancer screening.

1.3.3.10.1.2 Breast cancer screening.

1.3.3.10.1.3 Cervical cancer screening.

1.3.3.10.1.4 Prostate cancer screening.

1.3.3.10.1.5 Immunizations.

1.3.3.10.1.6 Well-child visits for children under six years of age.

1.3.3.10.1.7 Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5. If one or more of the procedure codes described in the TPM, Chapter 7, Section 2.1 for those preventive services listed in paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5 is billed on a claim, then the cost-share shall be waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

1.3.3.10.2 A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

1.3.3.10.3 This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

1.3.3.10.4 Appropriate cost-sharing and deductibles shall apply for all other preventive services under TRICARE Standard. See Chapter 7, Section 2.1 and 2.5.

1.4 TRICARE Extra

1.4.1 For Extra deductibles and cost-shares, see Addendum A.

1.4.2 If non-enrolled TRICARE beneficiary receives care from a network provider out of the region of residence, and if the beneficiary has not met the fiscal year catastrophic cap, the beneficiary shall pay the Extra cost-share to the provider. The contractor for the beneficiary's residence shall process the claim under TRICARE Extra claims processing procedures if the TRICARE Encounter Provider Record (TEPRV) shows the provider to be contracted.

1.4.3 Preventive Services

1.4.3.1 No copayments or authorizations are required for the following preventive services as described in the TPM, Chapter 7, Section 2.1 and 2.5:

1.4.3.1.1 Colorectal cancer screening.

1.4.3.1.2 Breast cancer screening.

1.4.3.1.3 Cervical cancer screening.

1.4.3.1.4 Prostate cancer screening.

1.4.3.1.5 Immunizations.

1.4.3.1.6 Well-child visits for children under six years of age.

1.4.3.1.7 Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in paragraphs 1.4.3.1.1 through 1.4.3.1.5. If one or more of the

procedure codes described in the TPM, Chapter 7, Section 2.1 for those preventive services listed in paragraphs 1.4.3.1.1 through 1.4.3.1.5 are billed on a claim, then the cost-share shall be waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit shall be subject to appropriate cost-sharing and deductibles.

1.4.3.2 A beneficiary is not required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied the deductible for that year.

1.4.3.3 This waiver does not apply to any TRICARE beneficiary who is a Medicare-eligible beneficiary.

1.4.3.4 Appropriate cost-sharing and deductibles shall apply for all other preventive services under TRICARE Standard. See Chapter 7, Section 2.1 and 2.5.

1.5 Cost-Shares: Ambulance Services

1.5.1 For the basis of payment of ambulance services, see Chapter 1, Section 14.

1.5.2 Outpatient. The following are beneficiary copayment/cost-sharing requirements for medically necessary ambulance services when paid on an outpatient basis:

1.5.2.1 TRICARE Prime

1.5.2.1.1 For care provided for pay grades E-1 through E-4, $0. See Addendum A for further information.

1.5.2.1.2 For care provided for pay grades E-5 and above, $0. See Addendum A for further information.

1.5.2.1.3 For retirees and their family members, $20.

1.5.2.2 TRICARE Extra

1.5.2.2.1 A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

1.5.2.2.2 A cost-share of 20% of the fee negotiated by the contractor for retirees, their family members, and survivors.

1.5.2.3 TRICARE Standard

1.5.2.3.1 A cost-share of 20% of the allowable charge for ADFMs.

1.5.2.3.2 A cost-share of 25% of the allowable charge for retirees, their family members, and survivors.

1.5.2.4 Inpatient: Non-Network Providers

1.5.2.4.1 ADFMs. No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

1.5.2.4.2 Other Beneficiary. The cost-share applicable to inpatient care for beneficiaries other than ADFMs is 25% of the allowable amount.

1.5.2.5 Exceptions

1.5.2.5.1 Inpatient Cost-share Applicable To Each Separate Admission

A separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

1.5.2.5.1.1 Any admission which is not more than 60 days from the date of the last inpatient discharge shall be treated as one inpatient confinement with the last admission for cost-share amount determination.

1.5.2.5.1.2 Certain heart and lung hospitals are excepted from cost-share requirements. See Chapter 1, Section 27, entitled "Legal Obligation To Pay".

1.5.2.5.2 Inpatient Cost-Share: Maternity Care

See paragraph 1.3.3.3. All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share shall be applied to the first institutional claim received.

1.5.2.5.3 Special Cost-Share Provisions

1.5.2.5.3.1 For services provided prior to International Classification of Diseases, 10th Revision (ICD-10) implementation. Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This shall not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of:

- That calculated according to paragraph 1.3.3.2.2; or
- That calculated according to paragraph 1.3.3.4.2.

1.5.2.5.3.1.1 Child Bone Marrow Transplant (BMT)

All services related to discharges involving BMT for a beneficiary less than 18 years old with International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) principal or secondary diagnosis code V42.8 and ICD-9-CM procedure codes 41.0 through 41.04, 41.06, and 41.91.

1.5.2.5.3.1.2 Child Human Immunodeficiency Virus (HIV) Seropositivity

All services related to discharges involving HIV seropositive beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis codes 042, 079.53, and 795.71.

1.5.2.5.3.1.3 Child Cystic Fibrosis

All services related to discharges involving beneficiary less than 18 years old with

ICD-9-CM principal or secondary diagnosis code 277.0 (cystic fibrosis).

1.5.2.5.3.2 For services provided on or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**. Effective October 1,1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This shall not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of:

- That calculated according to paragraph 1.3.3.2.2; or
- That calculated according to paragraph 1.3.3.4.2.

1.5.2.5.3.2.1 Child BMT

All services related to discharges involving BMT for a beneficiary less than 18 years old with International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10- CM) principal or secondary diagnosis code Z94.81 and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) procedure codes 30230G0-30263Y0 through 30230X0-30263X0 and 079T3ZZ-07DS3ZZ.

1.5.2.5.3.2.2 HIV Seropositivity

All services related to discharges involving HIV seropositive beneficiary less than 18 years old with ICD-10-CM principal or secondary diagnosis codes B20, B97.35, and R75.

1.5.2.5.3.2.3 Child Cystic Fibrosis

All services related to discharges involving beneficiary less than 18 years old with ICD-10-CM principal or secondary diagnosis code E84 (cystic fibrosis).

1.5.2.5.4 Cost-Sharing for Family Members of a Member who Dies While on Active Duty

Those in Transitional Survivor status, are not distinguished from other ADFMs for cost-sharing purposes. After the Transitional Survivor status ends, eligible TRICARE beneficiaries may be placed in Survivor status and will be responsible for retiree cost-shares. See the Transitional Survivor Status policy in the TPM, Chapter 10, Section 7.1.

1.6 Catastrophic Loss Protection

See Section 2.

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