Chapter 2 Section 2

Cost-Shares And Deductibles For TRICARE Services Received On Or After January 1, 2018

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1.0 BACKGROUND

1.1 National Defense Authorization Act for Fiscal Year 2017 (NDAA FY 2017), Section 701, made significant changes to the TRICARE program, especially to TRICARE Prime; TRICARE Extra, which is replaced by TRICARE Select; and to the third option, TRICARE Standard, which was terminated as of December 31, 2017, and is also replaced by TRICARE Select. TRICARE Select is a self-managed, Preferred Provider Option (PPO) under the TRICARE program, and replaces the TRICARE Extra and Standard programs and adopts a number of improvements, including fixed copayments rather than percentage copays for covered benefits provided by a civilian network provider. It also features freedom of choice of providers, with reduced beneficiary out-of-pocket costs for covered care received from a civilian network provider. The NDAA also included the continuation of TRICARE Prime as a managed care, Health Maintenance Organization (HMO)-like option under the TRICARE Program. TRICARE Prime adopts a number of changes to conform to specifications in the new law, including categories of health care services applicable to the determination of copayment amounts. Other features of the NDAA include preservation of benefits for active duty dependents and TRICARE For Life (TFL) beneficiaries and conforming changes to the TRICARE Young Adult (TYA), TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (TRR).

1.2 With respect to beneficiary cost-sharing, the NDAA FY 2017 introduced a new split of beneficiaries into two groups: one group (Group A or grandfathered beneficiaries) consists of sponsors and their family members who first became affiliated with the military through enlistment or appointment before January 1, 2018, and the second group (Group B or non-grandfathered beneficiaries) who first became affiliated on or after that date.

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

1.4 Fees for services received by TFL beneficiaries are set forth in Section 1 and Addendum A. In accordance with 10 United States Code (USC) section 1075(f), TFL beneficiaries will continue to have their cost-sharing requirements calculated for services received on or after January 1, 2018, as if the beneficiary were enrolled in TRICARE Standard as if TRICARE Standard and Extra were still being carried out by the Department of Defense (DoD). Therefore, cost-shares and deductibles for services received by TFL beneficiaries on or after January 1, 2018, are not addressed in this section.

1.5 Non-network care for Select beneficiaries. Although the cost-share percentages for non-network care provided to Select beneficiaries are listed in this section for ease, the authority for these cost-shares is in 32 CFR 199.4 and Section 1.

1.6 Fees under the TRICARE Pharmacy Benefits Program are defined in 32 CFR 199.21 and Addendum B.

1.7 Cost-shares are updated each calendar year in accordance with 32 CFR 199.17, and are available at http://www.health.mil/rates in advance of the beginning of the calendar year.

2.0 POLICY

2.1 Review And Annual Updates

All fees (including enrollment fees, deductibles, and cost-shares) are subject to review and annual updating on the calendar year, in accordance with 10 USC sections 1075 and 1075a.

2.1.1 This section provides the policy regarding fees and the Calendar Year (CY) 2018 amounts. Annual updates thereafter will be published on the Defense Health Agency (DHA) web site at http://www.health.mil/rates.

2.1.2 Each fee for Group B beneficiaries shall be annually indexed to the amount by which retired pay is increased (i.e., the cost-of-living adjustment (COLA)) under 10 USC section 1401a, rounded to the next lowest multiple of $1. The remaining amount above such multiple of $1 shall be carried over to, and accumulated with, the amount of the increase for the subsequent year and made when the aggregate amount of increases carried over for a year is $1 or more.

2.2 TRICARE Prime

2.2.1 TRICARE Prime program enrollment fees and copayments are defined in 10 USC sections 1075 and 1075a. For information on fees for Prime enrollees choosing to receive care under the Point of Service Option (POS), refer to 32 CFR 199.17 and Section 5.

2.2.1.1 TRICARE Prime Active Duty Family Members (ADFMs) have no annual enrollment fee in CY 2018 or subsequent calendar years.

2.2.1.2 TRICARE Prime Group A Retirees have a CY 2018 enrollment fee of $XXX.XX for an individual or $XXX.XX for a family. Annual updates are available at http://www.health.mil/rates.

2.2.1.3 TRICARE Prime Group B Retirees have a CY 2018 enrollment fee of $350 for an individual or $700 for a family. Annual updates are available at http://www.health.mil/rates.

2.2.1.4 Effective March 26, 1998, the TRICARE Prime enrollment fee is waived for those beneficiaries who are both eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare and are otherwise eligible to enroll in TRICARE Prime.

2.2.1.5 Effective FY 2012, Group A Prime beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their family members, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying

Prime plan. (This does not include TYA plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year through December 31, 2017 or calendar year commencing CY 2018, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime. The fee for the family member(s) of a medically retired Uniformed Services member shall not change if the family member(s) is later re-classified a survivor.

2.2.1.6 Group B Prime Retiree beneficiary enrollment fees are not frozen nor waived.

2.2.2 TRICARE Select

TRICARE Select enrollment fees and copayments are defined in 10 USC sections 1075 and 1075a.

2.2.2.1 TRICARE Select ADFMs have no enrollment fees.

2.2.2.2 TRICARE Select Group A retirees have no enrollment fees until CY 2021.

2.2.2.3 When enrollment fees implemented for TRICARE Select Group A Retirees. Retirees who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their family members, have no enrollment fees in CY 2018 or in any subsequent calendar year. (This does not include TYA plans). The fee for the family member(s) of a medically retired Uniformed Services member shall not change if the family member(s) is later re-classified a survivor.

2.2.2.4 TRICARE Select Group B Retirees have enrollment fees of $450 per individual or $900/family for CY 2018. These fees shall be updated annually in accordance with paragraph 2.1. Annual updates shall be posted at http://www.health.mil/rates.

2.3 Deductibles

2.3.1 TRICARE Prime ADFMs and Retirees. Group A and Group B Prime ADFMs and Prime retirees have no deductible under TRICARE Prime for health care services obtained in accordance with Prime rules and procedures. If otherwise covered health care services are not obtained in accordance with Prime rules and procedures, the services may be covered under the POS option (Section 6) including a deductible of $300 per individual or $600 per family.

2.3.2 TRICARE Select. TRICARE Select beneficiaries have calendar year deductibles that must be fully met before TRICARE benefits are payable. Once the deductible has been met, the cost-shares in paragraph 2.4 apply. The TRICARE Select deductible applies to the catastrophic cap.

2.3.3 Collection of deductible amounts. Contractors shall require network providers to collect, at a minimum, the copayment at the time of service and the Explanation Of Benefits (EOB) shall inform the provider and beneficiary of additional amounts owed to satisfy the deductible. Additionally, the contractor may provide deductible information to network providers in advance so they may also be collected at the time of the service, at the discretion of both the contractor and network providers in their network agreements.

2.3.4 Deductibles when beneficiaries move between regions. See the TRICARE Operations Manual (TOM), Chapter 2, Section 2, regarding portability.

2.3.5 Beneficiaries who transfer to Prime, and again to Select during the same calendar year. The deductible for these beneficiaries does not reset to zero. The amount of the deductible fulfilled shall carry forward if a beneficiary moves to Prime, and back to Select during the same CY.

2.3.6 Figure 2.2-1 contains the deductibles that apply to TRICARE Select beneficiaries for CY 2018. These fees shall be updated annually in accordance with paragraph 2.2 and shall be posted at http://www.health.mil/rates.

FIGURE 2.2-1 TRICARE SELECT DEDUCTIBLES FOR CY 2018

<table>
<tr><th rowspan="2">TRICARE SELECT**</th><th colspan="2">GROUP A ADFM</th><th colspan="2">GROUP B ADFM</th><th>GROUP A</th><th>GROUP B</th></tr>
<tr><th>E1-E4</th><th>E-5 & ABOVE</th><th>E1-E4</th><th>E-5 & ABOVE</th><th>RETIREES</th><th>RETIREES</th></tr>
<tr><td>In-Network</td><td rowspan="2">$50/$100</td><td rowspan="2">$150/$300</td><td rowspan="2">$50/$100</td><td rowspan="2">$150/$300</td><td rowspan="2">$150/$300</td><td>$150/$300</td></tr>
<tr><td>Out-Of-Network</td><td>$300/$600*</td></tr>
</table>

* Group B Retirees have a separate out-of-network deductible. The out-of-network deductible is separate from the in network deductible and must be paid in addition to the in network deductible. For example, if a Group B retiree beneficiary had met their $150 network deductible, and then chooses to see an out-of-network provider, the beneficiary must pay the additional $300 out-of-network deductible before TRICARE will cost-share out-of-network care.
** If a beneficiary has a partially-fulfilled deductible, and the next service will meet the deductible, the beneficiary must meet their deductible and then may be subject to the additional copayment, if the remaining deductible was less than the applicable copayment:

Example 1: An E1 Group B ADFM has met $25 of their $50 deductible. They visit their primary care physician, and the visit has an allowable charge of $100. The beneficiary is responsible for $25 of the service, and has thus met their deductible.

Example 2: The same Group B ADFM has met $45 of their $50 deductible. They visit their primary care physician, and the visit has an allowable charge of $100. The beneficiary is responsible for the remaining $5 plus the $15 copayment, for a total of $20.
*** Out-of-network deductibles apply to the catastrophic cap.

2.4 Cost-Shares and Copayments

2.4.1 This paragraph provides an overview of the establishment and general applicability of TRICARE cost-shares and copayments for each TRICARE plan and category of beneficiary.

2.4.2 TRICARE Prime Group A and Group B ADFM Enrollees. Prime enrollees have $0.00 copayment for covered health care services obtained in accordance with Prime rules and procedures. If otherwise covered health care services are not obtained in accordance with Prime rules and procedures, the services may be covered under the POS option (Section 5), including a separate deductible of $300 per individual or $600 per family. This would include any non-emergency out of network care obtained by a Prime beneficiary without following applicable referral requirements. Pharmacy copayments are in addition to any TRICARE Prime copayments.

2.4.3 TRICARE Select Group A ADFM and Retiree Enrollees.

2.4.3.1 Care received from network providers. The cost-sharing amounts for covered health care services obtained from a network provider are fixed dollar amounts for each specified category of care and are set prospectively for each calendar year with the annual updates available at http://www.health.mil/rates.

2.4.3.2 Care received from non-network providers. The cost-sharing amounts for covered health care services obtained from a non-network provider are as provided in 32 CFR 199.4 and Section 1.

2.4.4 TRICARE Select Group B ADFM and Retiree Enrollees. The cost-sharing amounts for covered health care services for CY 2018 are established by 10 USC 1075 and shall be updated annually in accordance with paragraph 2.1, with the annual updates available at http://www.health.mil/rates. The cost-sharing amounts are unique for Group B ADFMs and for Group B Retirees and include different cost-sharing amounts within each beneficiary category depending on whether the covered health care services are obtained from a network provider or from a non-network provider.

2.4.5 CHAMPUS Maximum Allowable Charge (CMAC) impact on cost-sharing. In instances where the CMAC or allowable charge is less than the copayment established by this section and published on the DHA website, network providers may only collect the lower of the allowable charge or the applicable copayment.

2.4.6 Services with Set Copayments. Copayments apply only after any applicable deductibles have been satisfied, except for preventive care, which is available (when all conditions of coverage are met) with no copayment from network physicians, regardless of whether or not applicable deductibles have been satisfied.

2.5 Cost-shares for services are as follows:

2.5.1 Preventive Care Outpatient Visits Under TRICARE Prime and Select

2.5.1.1 TRICARE Prime enrollees may receive Prime clinical preventive services from any network provider within their region of enrollment without referral or authorization. See the TRICARE Policy Manual (TPM), Chapter 7, Section 2.2 for a list of these services. If a Prime clinical preventive service is not available from a network provider, an enrollee may receive the service from a non-network provider with a referral from the Primary Care Manager (PCM) and authorization from the contractor. If an enrollee uses a non-network provider without first obtaining a referral from their PCM and authorization from the contractor, payment is made under the POS option only for services that are otherwise covered under the TRICARE Basic Program and described in the TPM, Chapter 7, Section 2.1. Payment shall not be made under the POS option for clinical preventive services that are not otherwise covered under the TRICARE Basic Program.

2.5.1.2 TRICARE Select enrollees may receive Prime clinical preventive services when furnished by a network provider. If a TRICARE Select enrollee uses a non-network provider, payment is made only for clinical preventive services that are otherwise covered under the TRICARE Basic Program.

2.5.1.3 No copayments or cost-shares are required for additional clinical preventive services authorized under 32 CFR 199.4(e)(28) and described in the TPM, Chapter 7, Sections 2.1, 2.2, and 2.5

whether received from network or non-network providers. However, TRICARE Prime beneficiaries are required to obtain services in accordance with the rules and procedures of Prime to avoid POS charges.

2.5.1.4 No copayments or authorizations are required for covered clinical preventive services not normally provided as part of the TRICARE Basic program under 32 CFR 199.4(e)(28) when provided to Prime and Select enrollees by network providers. These specific set of services shall be established by the Director, DHA, and announced annually before the open season enrollment period. Such preventive care outpatient visits may include: laboratory and imaging tests; cancer screenings; immunizations; periodic health promotion and disease prevention exams (e.g., well-child care); blood pressure screening; hearing exams; sigmoidoscopy or colonoscopy; serologic screening; and appropriate education and counseling services as specified by the Director, DHA. A beneficiary is not required to pay any portion of the cost of covered, in-network preventive services even if the beneficiary's deductible has not yet been fulfilled.

FIGURE 2.2-2 TRICARE PRIME COST-SHARES FOR PREVENTIVE CARE VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Prime Preventive Care Visits (CY 2018), In-Network	$0	$0	$0	$0
Basic Preventive Care Visits (CY 2018), Out-Of-Network* when obtained in accordance with established rules	$0	$0	$0	$0
* Those services listed in the TPM, Chapter 7, Section 2.1, paragraph 3.1 are exempt from cost-share requirements.				

FIGURE 2.2-3 TRICARE SELECT COST-SHARES FOR PREVENTIVE CARE VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Select Preventive Care Visits (CY 2018), In-Network	$0	$0	$0	$0
Basic Preventive Care Visits (CY 2018), Out-Of-Network*	$0	$0	$0	$0
* Those services listed in the TPM, Chapter 7, Section 2.1, paragraph 3.1 are exempt from cost-share requirements.				

2.5.2 Primary Care Outpatient Visits

Primary care outpatient visits to include any PCM as designated in TPM, Chapter 1, Section 7.1. Includes the services of the individual professional provider as well as all medical supplies used within the office and ancillary services and the treatment room.

FIGURE 2.2-4 TRICARE PRIME COST-SHARES FOR PRIMARY CARE OUTPATIENT VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Primary Care Outpatient Visits (CY 2018), In-Network	$0	$0	$20	$20

FIGURE 2.2-5 TRICARE SELECT COST-SHARES FOR PRIMARY CARE OUTPATIENT VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Primary Care Outpatient Visits (CY 2018), In-Network	$27	$15	$35	$25
Primary Care Outpatient Visits (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.3 Specialty Care Outpatient Visits

This category applies to outpatient care provided by provider specialties other than those listed under primary care outpatient visits. Includes the services of the individual professional provider as well as all medical supplies used within the office and ancillary services and the treatment room. This category also includes partial hospitalization services, intensive outpatient treatment, and opioid treatment program services. The per visit fee shall be applied on a per day basis on days services are received, with the exception of opioid treatment program services reimbursed in accordance with 32 CFR 199.14(a)(2)(ix)(A)*(3)(i)* which per visit fee will apply on a weekly basis.

FIGURE 2.2-6 TRICARE PRIME COST-SHARES FOR SPECIALTY CARE OUTPATIENT VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Specialty Care Outpatient Visits (CY 2018)	$0	$0	$30	$30

FIGURE 2.2-7 TRICARE SELECT COST-SHARES FOR SPECIALTY CARE OUTPATIENT VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Specialty Care Visits (CY 2018), In-Network	$34	$25	$45	$40
Specialty Care Visits (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.4 Ancillary Care

2.5.4.1 TRICARE 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. When Prime rules and procedures are not followed, POS charges may apply. 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:

- Diagnostic radiology and ultrasound services included in the CPT procedure code range from 70010-76999, or any other code for associated contrast media;
- Diagnostic nuclear medicine services included in the CPT procedure code range from 78012-78999;

- Pathology and laboratory services included in the CPT procedure code range from 80047- 89398; G0461-G0462 (during 2014); and
- Cardiovascular studies included in the CPT procedure code range from 93000-93355.
- Venipuncture included in the CPT procedure code range from 36400-36425.
- Fetal monitoring for CPT procedure codes 59020, 59025, and 59050.
- Collection of blood specimens in the CPT procedure codes 36591 and 36592.

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.

2.5.4.2 TRICARE Select enrollees have no copayments for ancillary services (defined in paragraph 2.5.4.1) provided by network providers. Ancillary services for TRICARE Select beneficiaries are cost-shared as follows:

FIGURE 2.2-8 TRICARE SELECT COST-SHARES FOR ANCILLARY SERVICES

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Ancillary Services (CY 2018), In-Network	$0	$0	$0	$0
Ancillary Services (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.5 Other Radiology Services

Radiology Services are considered ancillary services for TRICARE Prime enrollees and all Prime rules and procedures apply. TRICARE Select enrollees who obtain radiology services from network providers have no cost-share. TRICARE Select enrollees who receive other radiology services from non-network providers are subject to the following cost-shares:

FIGURE 2.2-9 TRICARE SELECT COST-SHARES FOR OTHER RADIOLOGY SERVICES

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Radiology Services (CY 2018), In-Network	$0	$0	$0	$0
Radiology Services (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.6 Eye Examinations

2.5.6.1 TRICARE Prime. One routine examination per year for TRICARE Prime family members of active duty sponsors. One routine examination every other year for TRICARE Prime retirees and their family members per the TPM, Chapter 7, Section 2.2.

FIGURE 2.2-10 TRICARE PRIME COST-SHARES FOR EYE EXAMINATIONS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Eye Examinations (CY 2018)	$0	$0	$0	$0

2.5.6.2 TRICARE Select. Eye examinations received from in-network and out-of-network providers by TRICARE Select ADFMs may be cost-shared as follows. Eye examinations for TRICARE Select retirees are not a TRICARE benefit. See the TPM, Chapter 7, Section 6.1.

FIGURE 2.2-11 TRICARE SELECT COST-SHARES FOR EYE EXAMINATIONS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Eye Examinations (CY 2018), In-Network	$0	$0	NA	NA
Eye Examinations (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	NA	NA

2.5.7 Emergency Room (ER) Visits

Emergency care obtained on an outpatient basis in network or non-network facilities, in-region or out-of-region.

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

2.5.7.2 POS charges do not apply to emergency care. See the TOM, Chapter 8, Section 5, paragraph 2.6.

FIGURE 2.2-12 TRICARE PRIME COST-SHARES FOR EMERGENCY ROOM (ER) VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
ER Visits (CY 2018)	$0	$0	$60	$60

FIGURE 2.2-13 TRICARE SELECT COST-SHARES FOR EMERGENCY ROOM (ER) VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
ER Visits (CY 2018), In-Network	$87	$40	$116	$80

FIGURE 2.2-13 TRICARE SELECT COST-SHARES FOR EMERGENCY ROOM (ER) VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
ER Visits (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.8 Urgent Care Center (UCC) Visits

The usual TRICARE Prime referral requirement may be waived for some or all urgent care visits for TRICARE Prime enrollees other than active duty members. This is similar to the current pilot program, which waives the referral requirement (other than for active duty members) for up to two urgent care visits per year. The specific number of urgent care visits without a referral will be determined annually prior to the beginning of the open season enrollment period. See the TOM, Chapter 18, Section 5, for TRICARE Urgent Care Pilot.

FIGURE 2.2-14 TRICARE PRIME COST-SHARES FOR URGENT CARE CENTER (UCC) VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
UCC Visits (CY 2018)	$0	$0	$30	$30

FIGURE 2.2-15 TRICARE SELECT COST-SHARES FOR URGENT CARE CENTER (UCC) VISITS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
UCC Visits (CY 2018), In-Network	$27	$20	$35	$40
UCC Visits (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.9 Ambulatory Surgery

Authorized hospital-based or freestanding ambulatory surgical center that is TRICARE certified. Also includes prenatal care, outpatient delivery, and postnatal care provided by a TRICARE authorized birthing center. No cost-share shall be deducted from a claim for professional services related to ambulatory surgery. This applies whether the services are performed in a Freestanding Ambulatory Surgical Center (FASC), or a Hospital Outpatient Department (HOPD). So long as at least one procedure on the claim is reimbursed as ambulatory surgery, the claim shall be cost-shared as ambulatory surgery.

FIGURE 2.2-16 TRICARE PRIME COST-SHARES FOR AMBULATORY SURGERY (INCLUDING BIRTHING CENTERS)

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Ambulatory Surgery (CY 2018)	$0	$0	$60	$60

FIGURE 2.2-17 TRICARE SELECT COST-SHARES FOR AMBULATORY SURGERY (INCLUDING BIRTHING CENTERS)

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Ambulatory Surgery (CY 2018), In-Network	15% of allowable charge	$25	20% of allowable charge	$95
Ambulatory Surgery (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.10 Ambulance Services

Ambulance services, when medically necessary as defined in the TPM and when the service is a covered benefit. POS charges do not apply to emergency care; see the TOM, Chapter 8, Section 5, paragraph 2.6.

FIGURE 2.2-18 TRICARE PRIME COST-SHARES FOR AMBULANCE SERVICES (INCLUDING BIRTHING CENTERS)

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Outpatient Ground Ambulance (CY 2018)	$0	$0	$40	$40
Outpatient Air Ambulance (CY 2018)	$0	$0	$20	$20
Inpatient, Non-Network Providers (Transfers rendered in conjunction with an inpatient stay.) (CY 2018)	$0	$0	25% of allowable charge	25% of allowable charge

FIGURE 2.2-19 TRICARE SELECT COST-SHARES FOR AMBULANCE SERVICES

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Outpatient Ground Ambulance (CY 2018), In-Network	$79	$15	$106	$60
Outpatient Ground Ambulance (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge
Outpatient Air Ambulance (CY 2018), In-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge
Outpatient Air Ambulance (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge
Inpatient, Non-Network Providers (Transfers rendered in conjunction with an inpatient stay.) (CY 2018), In- and Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.11 Durable Medical Equipment (DME)

DME, hearing aids for ADFMs, and medical supplies prescribed by an authorized provider which are covered benefits, if dispensed for use outside of the office or after the home visit.

FIGURE 2.2-20 TRICARE PRIME COST-SHARES FOR DURABLE MEDICAL EQUIPMENT (DME)

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
DME (CY 2018)	$0	$0	20% of allowable charge	20% of allowable charge

FIGURE 2.2-21 TRICARE SELECT COST-SHARES FOR DURABLE MEDICAL EQUIPMENT (DME)

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
DME (CY 2018), In-Network	15% of allowable charge	10% of allowable charge	20% of allowable charge	20% of allowable charge
DME (CY 2018), Out-Of-Network	20% of allowable charge	20% of allowable charge	25% of allowable charge	25% of allowable charge

2.5.12 Inpatient Hospital Admission

Semiprivate room (when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services, meals including special diets, drugs, and medication while an inpatient, operating and recovery room, anesthesia, laboratory tests, x-ray and other radiology services, necessary medical supplies and appliances, blood and blood products. Also, includes maternity hospital and professional services (prenatal, delivery, postnatal). Includes inpatient hospital admissions in all acute care, specialty (i.e., cancer and children's hospitals), and mental health hospitals.

2.5.12.1 For inpatient hospital admissions subject to the inpatient mental health per diem payment system, the following special rules apply:

2.5.12.1.1 Lower volume hospitals and units: For care paid on a regional per diem, the cost-share shall be calculated in accordance with Section 1, paragraph 1.3.3.5.3.2.

2.5.12.1.2 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.

2.5.12.1.3 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.

2.5.12.1.4 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.

2.5.12.2 All final claims reimbursed under the TRICARE Diagnosis Related Group (DRG)-based payment system are to be priced using the rules, weights and rates in effect as of the date of discharge. Interim claims with "end date of care" shall be priced using the rules, weights and rates in effect as of the "end date of care." See Chapter 6, Section 3, paragraph 3.3.1.

FIGURE 2.2-22 TRICARE PRIME COST-SHARES FOR INPATIENT HOSPITALIZATIONS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Inpatient Hospitalization (CY 2018)	$0	$0	$150/ admission	$150/admission

FIGURE 2.2-23 TRICARE SELECT COST-SHARES FOR INPATIENT HOSPITALIZATIONS

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
Inpatient Hospitalization (CY 2018), In-Network	Subsistence charge per day, minimum $25/admission*	$60/ admission	$250/day or 25% of the hospital's total charges (based on the fee schedule negotiated by the contractor) whichever is less, plus 20% of separately billed professional charges	$175/ admission
Inpatient Hospitalization (CY 2018), Out-Of-Network	Subsistence charge per day, minimum $25/admission*	20% of allowable charge	DRG per diem or 25% of the hospital's billed charges for institutional services, whichever is less, plus 25% of separately billed professional charges	25% of allowable charge
* See Section 1, Figure 2.1-1				

2.5.13 Inpatient Skilled Nursing/Inpatient Rehabilitation

This category includes a Residential Treatment Center (RTC) or Substance Use Disorder Rehabilitation Facility (SUDRF) residential treatment program. For Skilled Nursing Facility (SNF) care, this is the same benefit as Medicare except there is no limitation as to the number of days of coverage. Benefit includes semiprivate room; regular nursing services; meals including special diets; physical, occupational, and speech therapy; drugs furnished by the facility; necessary medical supplies; and appliances.

FIGURE 2.2-24 TRICARE PRIME COST-SHARES FOR SKILLED NURSING/REHABILITATION FACILITIES

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
SNF/Rehab Facilities (CY 2018)	$0	$0	$30/day	$30/day

FIGURE 2.2-25 TRICARE SELECT COST-SHARES FOR SKILLED NURSING/REHABILITATION FACILITIES

	ADFM		RETIREE	
	GROUP A	GROUP B	GROUP A	GROUP B
SNF/Rehab Facilities (CY 2018), In-Network	Subsistence charge per day, minimum $25/admission*	$25/day	$250/day up to 25% of the hospital's total charge plus 20% of separately billed services	$50/day
SNF/Rehab Facilities (CY 2018), Out-Of-Network	Subsistence charge per day, minimum $25/admission*	$50/day	25% of allowable charge	Lesser of $300/day or 20% of allowable charge
* See Section 1, Figure 2.1-1.				

2.5.14 Home Health and Hospice

Home Health Care (HHC) provided by a Home Health Agency (HHA) and reimbursed in accordance with Chapter 12 has no cost-share for all beneficiary categories. Hospice care provided in accordance with Chapter 11 has no cost-share for all beneficiary categories.

2.5.15 Maternity Care

Maternity care shall be cost-shared as follows:

2.5.15.1 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. 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.

2.5.15.2 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.

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

2.5.15.4 Otherwise covered medical services and supplies directly related to "complications of pregnancy", as defined in the Regulation, will 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.

2.5.15.5 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.

2.5.15.6 Claims for pregnancy testing are cost-shared on an outpatient basis when the delivery is on an inpatient basis.

2.5.15.7 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 is to be adjudicated as an at-home birth.

2.5.15.8 Claims for prescription drugs provided on an outpatient basis during the maternity episode but not directly related to the maternity care are cost-shared on an outpatient basis.

2.5.15.9 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.

2.5.15.10 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:

2.5.15.10.1 The treatment is otherwise allowable as a benefit; and

2.5.15.10.2 Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated; and

2.5.15.10.3 The illness or condition is, or increases the likelihood of, a threat to the life of the mother; or

2.5.15.10.4 The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness; or

2.5.15.10.5 The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

2.5.16 Newborn Care

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:

2.5.16.1 Same newborn date of birth and date of admission. For care where a cost-share is determined on a per diem basis, the cost-share shall be calculated in accordance with this section; however, the number of days shall be reduced by three.

2.5.16.2 Different newborn date of birth and date of admission. The cost-share shall be applied to all days in an inpatient stay.

2.6 Cost-Shares and Deductibles: Former Spouses

2.6.1 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 (effective January 1, 2018, in any one calendar 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 (effective January 1, 2018, in any calendar year).

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

2.7 Cost-Share Amount

Under discounted rate agreements. In cases where the cost-share is calculated as a percentage rather than a fixed amount, the percentage 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. 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.

2.8 Exceptions

2.8.1 Inpatient Cost-Share: Applicable To Each Separate Admission

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

2.8.1.1 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.

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

2.8.2 Inpatient Cost-Share: Maternity Care

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.

2.8.3 See Section 6 for waivers of cost-shares and deductibles.

2.9 Exclusions

TFL. See Section 1.

3.0 CATASTROPHIC LOSS PROTECTION

See Section 4.

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