Chapter 2 Section 1

Cost-Shares And Deductibles For TRICARE Services Received Prior To January 1, 2018 And For TRICARE Services Received On Or After January 1, 2018 By TRICARE For Life (TFL) Beneficiaries

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

1.0 POLICY

1.1 General

1.1.1 National Defense Authorization Act for Fiscal Year 2017 (NDAA FY 2017), Section 701, made significant changes to the TRICARE Program including establishing new health plans, new classifications for beneficiary eligibility for the health plans, and unique cost-shares, deductibles, and catastrophic loss protection applicable to services received on or after January 1, 2018 (see Section 2). This section sets forth the cost-shares and deductibles applicable to TRICARE services received on or after January 1, 2018 by TFL beneficiaries and, certain other beneficiaries otherwise as specified in Section 2.

1.1.2 For services received prior to January 1, 2018, deductibles and catastrophic loss protection are applicable on a fiscal year basis. For services received on or after January 1, 2018, deductibles and catastrophic loss protection are applicable on a calendar year basis. In order to transition deductibles and catastrophic loss protection from a fiscal year to a calendar basis, the deductible and catastrophic loss protection amounts for FY 2017 will be applicable to services received during the 15-month period of October 1, 2016, through December 31, 2017.

1.1.3 Special Transition Rules for October 1, 2017 through December 31, 2017.

1.1.3.1 A Prime beneficiary's enrollment fee for this period is one-fourth the enrollment fee for FY 2017.

1.1.3.2 The deductible amounts and catastrophic cap amounts for FY 2017 shall be applicable to the 15-month period of October 1, 2016 through December 31, 2017.

1.1.4 Effective January 1, 2018, beneficiaries enrolled in TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA), and the Continued Health Care Benefit Program (CHCBP) have Group B cost-shares, Catastrophic Cap and Deductibles (CCDs) regardless of when the sponsor initially enlisted or was appointed in a Uniformed Service. The CCD amounts are for Active Duty Family Member (ADFM) or retiree as appropriate to the sponsor's status and plan

selected. Cost-shares for care received prior to January 1, 2018 follow the rules for TRICARE Standard/Extra.

1.1.5 Effective January 1, 2018, family members of active duty members of the armed forces of North Atlantic Treaty Organization (NATO) and Partnership for Peace (PfP) foreign nations who are eligible for outpatient care under TRICARE per the Defense Enrollment Eligibility Reporting System (DEERS) have the cost- shares and deductibles of Group B TRICARE Select ADFMs. See TRICARE Policy Manual (TPM), Chapter 1, Section 1.1. There is no catastrophic protection (see Section 4). Cost-shares for care received prior to January 1, 2018 follow the rules for TRICARE Standard/Extra.

1.1.6 Applicable Terms and Conditions

1.1.6.1 TRICARE Standard means the TRICARE program made available prior to January 1, 2018, with program deductible and cost-share amounts identical to those applied under the TRICARE Basic program in 32 CFR 199.4. Although TRICARE Standard is generally terminated as of January 1, 2018, under NDAA FY 2017, Section 701(e), in accordance with 10 United States Code (USC) Section 1075(f), a TFL beneficiary 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 were still being carried out by the Department of Defense (DoD).

1.1.6.2 TRICARE Extra means the preferred-provider option of the TRICARE program made available prior to January 1, 2018, under which TRICARE Standard beneficiaries obtained discounts on cost sharing as a result of using TRICARE network providers.

1.1.6.3 TRICARE Prime means the managed care option of the TRICARE program. For enrollment fees and copayments applicable to services received prior to January 1, 2018, see Addendum A. TRICARE Prime enrollees choosing to receive care under the Point of Service (POS) option, refer to Section 5.

1.1.6.4 TFL means the Medicare wraparound coverage option of the TRICARE program made available to the beneficiary by reason of 10 USC Section 1086(d).

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

1.1.6.6 Fees under the TRICARE Pharmacy Benefits Program are defined in 32 CFR 199.21.

1.1.6.7 Addendum A contains a complete listing of cost-share and deductible information applicable to services received prior to January 1, 2018, as well as those applicable to services received by TFL beneficiaries as if they were enrolled in TRICARE Standard on or after January 1, 2018.

1.1.6.8 Addendum B contains a listing of fee information applicable to the TRICARE Pharmacy Benefits Program.

1.1.6.9 Waiver of Cost-Sharing and Deductible. See Section 6.

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, Public Law 106-398, for services provided on or after April 1, 2001, a $0 copayment shall be charged to TRICARE Prime ADFMs of active duty service members (ADSMs) who are enrolled in TRICARE Prime. Pharmacy copayments and POS charges are not waived by the NDAA for 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 Effective for care provided on or after March 26, 1998, Prime enrollees shall have no copayments for ancillary services in the categories listed below (normal referral and authorization provisions apply). 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 of 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[1] 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[1] procedure code range from 78012-78999;

1.2.4.3 Pathology and laboratory services included in the CPT[1] procedure code range from 80047-89398; G0461-G0462 (during 2014); and

1.2.4.4 Cardiovascular studies included in the CPT[1] procedure code range from 93000-93355.

1.2.4.5 Venipuncture included in the CPT[1] procedure code range from 36400-36425.

1.2.4.6 Collection of blood specimens in the CPT[1] procedure codes 36591 and 36592.

1.2.4.7 Fetal monitoring for CPT[1] procedure codes 59020, 59025, and 59050.

Note: Multiple discounting will not be applied to the following CPT[1] procedure codes for venipuncture, fetal monitoring, and collection of blood specimens; 36400-36425, 36591, 36592, 59020, 59025, and 59050.

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1.2.5 Point of Service (POS) option. See Section 5.

1.3 Basic Program: TRICARE Standard

1.3.1 Deductible Amount: Outpatient Care

1.3.1.1 For care rendered all eligible beneficiaries prior to April 1, 1991, or when the active duty sponsor's pay grade is E-4 or below, regardless of the date of care:

1.3.1.1.1 Deductible, Individual: Each beneficiary is liable for the first fifty dollars ($50.00) of the TRICARE-determined 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 For care rendered on or after April 1, 1991, for all TRICARE beneficiaries except family members of active duty sponsors of pay grade E-4 or below.

1.3.1.2.1 Deductible, Individual: Each beneficiary is liable for the first $150.00 of the TRICARE-determined 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). No deductible shall be applied to allowable amounts for services or items rendered to ADFMs. For family members of active duty members of the armed forces of NATO/PfP foreign nations who are eligible for outpatient care under TRICARE, see paragraph 1.1.5 for deductible and cost-share information.

1.3.1.4 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.

1.3.1.5 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, for care rendered after October 1, 1991.

Note: The provisions of paragraph 1.3.1.5, 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.

1.3.1.6 Effective December 8, 1995, the annual TRICARE deductible has been waived for family members of selected reserve members called to active duty for 31 days or more in support of Operation Joint Endeavor (the Bosnia peacekeeping mission). Under a nationwide demonstration, TRICARE may immediately begin cost-sharing in accordance with standard TRICARE rules. These beneficiaries will be eligible to use established TRICARE Extra network providers at a reduced cost-share rate. Additionally, in those areas where TRICARE is in full operation, selected reserve members called to active duty for 31 days or more will have the option of enrolling their families in TRICARE Prime.

Note: This demonstration is effective December 8, 1995, and is in effect until such time as Executive Order 12982 expires. TRICARE eligible beneficiaries other than family members of reservists called to active duty in support of Operation Joint Endeavor are not eligible for participation. This demonstration is limited to the annual TRICARE Standard and Extra deductible; other TRICARE cost-sharing continues to apply. All current TRICARE rules, unless specifically provided otherwise, will continue to apply.

Note: Initially the option to enroll in TRICARE Prime was limited to family members of selected reserve members who were called to active duty for 179 days or more. This changed to 31 days or more as of March 10, 2003.

Note: Claims for these beneficiaries are to be paid from financially underwritten funds and reported as such. Defense Health Agency (DHA) periodically will calculate and reimburse the contractors for the additional costs incurred as a result of waiving the deductibles on these claims.

1.3.1.7 Adjustment of Excess. Any beneficiary identified under paragraphs 1.3.1.4, 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 3 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 The cost-share for ADFMs 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. For family members of active duty members of the armed forces of NATO/PfP foreign nations who are eligible for outpatient care under TRICARE per DEERS, see paragraph 1.1.5.

1.3.3.1.2 Other Beneficiary. The cost-share applicable to outpatient care for other than active duty and authorized NATO/PfP 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.

Note: Per paragraphs 1.3.3.10 and 1.4.3, annual deductible amounts do not apply to the preventive care services described in the TPM, Chapter 7, Sections 2.1 and 2.5.

1.3.3.2 Inpatient Care

1.3.3.2.1 ADFM: For services prior to October 3, 2016, except in the case of mental health and Substance Use Disorder (SUD) 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.) For services on or after October 3, 2016, the following applies to all services (to include mental health services) for ADFMs or their sponsors.

FIGURE 2.1-1 UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

PERIOD	DAILY CHARGE
October 1, 2015 - September 30, 2016 (for ADFMs not enrolled in Prime)	$18.00
October 1, 2016 - September 30, 2017 (for ADFMs not enrolled in Prime)	$18.20
October 1, 2017 - September 30, 2018 (for ADFMs not enrolled in Prime)	$18.60
October 1, 2018 - December 31, 2019 (for ADFMs not enrolled in Prime)	$19.05
January 1, 2020 - December 31, 2020 (for ADFMs not enrolled in Prime)	$19.55
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 1: 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) 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, 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.

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** are 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 is to 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 are 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 will 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 will 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 will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For all other beneficiaries, the cost-share is 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 will 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 will 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 will 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 will 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. 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.

1.3.3.4.2.2 Cost-shares for beneficiaries other than ADFMs.

1.3.3.4.2.2.1 The cost-share will 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 2005, the daily rate is $512.
- For FY 2006, the daily rate is $535.
- For FY 2007, the daily rate is capped at the FY 2006 level of $535, per Section 704 of NDAA FY 2007.
- For FYs 2008, 2009, 2010, and 2011, the daily rate is $535.
- 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.
- For FY 2016 and beyond, the daily rate is posted to the DHA web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement.

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 will 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 either a long-stay or 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.) Where long-stay outlier days are subsequently determined to be not medically necessary by a Peer Review Organization (PRO), no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

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. For dates of service prior to October 3, 2016, inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission. This $20 per day cost-share 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 SUD rehabilitation services. For Prime ADFMs, cost-share is $0 per day. See Addendum A for further information.

1.3.3.5.3 For dates of service on or after October 3, 2016, the inpatient cost-sharing for mental health services is that described in paragraph 1.3.3.2.1. The cost-share applies to admissions to any hospital for mental health services, any RTC, and any SUDRF. For Prime ADFMs, the cost-share is $0 per day. See Addendum A for further information.

1.3.3.5.4 Cost-shares for beneficiaries other than ADFMs.

1.3.3.5.4.1 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.

1.3.3.5.4.2 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 paragraph 1.3.3.5.4.2.1 or paragraph 1.3.3.5.4.2.2:

1.3.3.5.4.2.1 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 on the DHA web site at http://www.health.mil/rates. 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 2019 - $248 per day.
- Fiscal Year 2020 - $255 per day.
- Fiscal Year 2021 - $261 per day.

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

1.3.3.5.5 Claim which spans 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.

1.3.3.5.6 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.

1.3.3.5.7 Claims for services that are provided during an inpatient admission which are not included in the per diem rate are to 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 would need to 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 And Intensive Outpatient Programs (IOPs)

1.3.3.6.1 For care rendered prior to October 3, 2016, a 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. Effective for care on or after October 1, 1995, the cost-share for ADFMs for inpatient mental health services is $20 per day for each day of the inpatient admission. For care provided on or after April 1, 2001, 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 is to be taken from the PHP claim.

1.3.3.6.2 For care rendered on or after October 3, 2016, cost-sharing for PHPs and IOPs is on an outpatient basis. The outpatient cost-share also applies to the associated psychotherapy billed separately by the individual professional provider. These providers shall identify on the claim form

that the psychotherapy is related to PHP or IOP care so the proper outpatient cost-sharing can be applied. Cost-shares for standard beneficiaries can be found in paragraph 1.3.3.1; cost-sharing requirements for prime beneficiaries can be found in paragraph 1.2.

1.3.3.7 Cost-Shares: Ambulatory Surgery

1.3.3.7.1 For non-TRICARE Prime ADFMs, for all services reimbursed as ambulatory surgery, the cost-share will be $25 and will be assessed on the facility claim. No cost-share is to 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 is to be cost-shared as ambulatory surgery as required by this section. For family members of active duty members of the armed forces of NATO/PfP foreign nations who are eligible for outpatient care under TRICARE per DEERS, see paragraph 1.1.5.

1.3.3.7.2 Other Beneficiaries. Since the cost-share for other beneficiaries is based on a percentage rather than a set amount, it is to 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 will 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 be included in the member's or former member's family deductible. Therefore, 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 Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TPM, Chapter 7, Sections 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 is waived for the visit.

1.3.3.10.2 In addition to the services listed in paragraph 1.3.3.10.1, effective January 1, 2017, cost-shares are eliminated for the services listed in the TPM, Chapter 7, Section 2.1, paragraphs 1.1.1.1.2 and 1.1.5.1 through 1.1.5.12. Effective January 1, 2018, cost-shares are eliminated for the services listed in TPM, Chapter 7, Section 2.1, paragraph 1.1.5.13.

1.3.3.10.3 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.

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

1.3.3.10.5 Appropriate cost-sharing and deductibles will apply for all other preventive services described in the TPM, Chapter 7, Section 2.1, paragraph 1.2 and Section 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 Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TPM, Chapter 7, Sections 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 is billed on a claim, then the cost-share is waived for the visit.

1.4.3.2 In addition to the services listed in paragraph 1.4.3.1, effective January 1, 2017, cost-shares are eliminated for the services listed in the TPM, Chapter 7, Section 2.1, paragraphs 1.1.1.1.2 and 1.1.5.1 through 1.1.5.12. Effective January 1, 2018, cost-shares are eliminated for the services listed in the TPM, Chapter 7, Section 2.1, paragraph 1.1.5.13.

1.4.3.3 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.

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

1.4.3.5 Appropriate cost-sharing and deductibles will apply for all other preventive services described in the TPM, Chapter 7, Section 2.1, paragraph 1.2 and Section 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 prior to April 1, 2001, for ADFMs in pay grades E-1 through E-4, $10. For care provided on or after April 1, 2001, for ADFMs in pay grades E-1 through E-4, $0. See Addendum A for further information.

1.5.2.1.2 For care provided prior to April 1, 2001, for ADFMs in pay grades E-5 and above, $15. For care provided on or after April 1, 2001, for ADFMs in 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

Prior to January 1, 2018, for TRICARE ADFMs only, a separate cost-share amount is applicable to each separate beneficiary for each inpatient admission EXCEPT:

1.5.2.5.1.1 Any readmission to an acute care hospital 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 will 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 will 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 as classified in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

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 will 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 as classified in International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).

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.

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

1.6 Catastrophic Loss Protection

See Section 3.

1.7 COVID-19 Testing

For cost-shares and copayments related to Coronavirus 2019 (COVID-19) testing, see Section 7.

2.0 EFFECTIVE DATE

October 3, 2016, PHP and IOP as outpatient mental health and SUD services.

- END -