# 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: October 20, 2017
Authority: 32 CFR 199.4, 32 CFR 199.5, and 32 CFR 199.17
Copyright: CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.
Revision: C-61, August 5, 2021

## 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 (FY) basis. For services received on or after January 1, 2018, deductibles and catastrophic loss protection are applicable on a Calendar Year (CY) basis. To transition deductibles and catastrophic loss protection from a FY to a CY basis, the deductible and catastrophic loss protection amounts for FY 2017 are 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 TRICARE Prime beneficiary's enrollment fee for this period is one-fourth the enrollment fee for FY 2017.

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

**1.1.4** Effective January 1, 2018, the contractor shall use Group B cost-shares, Catastrophic Cap and Deductibles (CCDs) for beneficiaries enrolled in TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA), and the Continued Health Care Benefit Program (CHCBP),

regardless of when the sponsor initially enlisted or was appointed in a Uniformed Service. The contractor shall use CCD amounts for Active Duty Family Member (ADFM) or retiree as appropriate to the sponsor's status and plan selected. The contractor shall follow the rules for TRICARE Standard/Extra for cost-shares for care received prior to January 1, 2018.

**1.1.5** The contractor shall use Group B TRICARE Select ADFM cost-shares and deductible for 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). See TRICARE Policy Manual (TPM), Chapter 1, Section 1.1. The contractor shall not apply catastrophic protection (see Section 4) to this group. The contractor shall follow the rules for TRICARE Standard/Extra for cost-shares for care received prior to January 1, 2018.

**1.1.6 Applicable Terms And Conditions**

**1.1.6.1** Although TRICARE Standard is generally terminated as of January 1, 2018, under Section 701(e) of the NDAA FY 2017, in accordance with section 1075(f) of title 10, United States Code (USC), the contractor shall continue to apply cost-sharing requirements for services received on or after January 1, 2018, by TFL beneficiaries 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** Fees under the Extended Care Health Option (ECHO) are defined in 32 CFR 199.5.

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

**1.1.6.4** 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.

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

**1.1.6.6** 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 updates. See Addendum A for additional information on the benefits and costs. In accordance with NDAA FY 2001, Section 752, Public Law 106-398, for services provided on or after April 1, 2001, the contractor shall charge a $0 copayment to TRICARE Prime ADFMs of Service members who are enrolled in TRICARE Prime. NDAA FY2001 did not waive pharmacy copayments and Point of Service (POS) charges.

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

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

**1.2.4** The contractor shall not charge TRICARE Prime enrollees 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 contractor shall use the most up-to-date codes to identify services within each category, in accordance with the TRICARE Operations Manual (TOM), Chapter 1, Section 4. Additionally, listing the code ranges does not imply coverage; the code ranges 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:** The contractor shall not apply multiple discounts 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** POS option. See Section 5.

**1.3 Basic Program: TRICARE Standard**

**Note:** For the FY ending in September 2017, provisions of the following paragraphs for claims in that year were extended three months beyond the end of the FY (through December 2017).

### 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: The contractor shall charge each beneficiary for the first fifty dollars ($50.00) of the allowable amount on claims for care provided in the same FY prior to January 1, 2018.

**1.3.1.1.2** Deductible, Family: The contractor shall not charge a total deductible amount for all members of a family with the same sponsor during one FY more than one hundred dollars ($100.00) for claims of care provided prior to January 1, 2018.

#### 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: The contractor shall charge each beneficiary for the first $150.00 of the allowable amount on claims for care provided in the same FY prior to January 1, 2018.

**1.3.1.2.2** Deductible, Family: The contractor shall not charge a total deductible amount for all members of a family with the same sponsor during one FY more than $300.00 for claims of care provided prior to January 1, 2018.

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

**1.3.1.3.1** TRICARE-Approved ASCs, BCs, or PHPs. The contractor shall not apply a deductible 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 the TRICARE Program, see paragraph 1.1.5 for deductible and cost-share information.

**1.3.1.3.2** Allowable Amount Does Not Exceed Deductible Amount. If FY allowable amounts (CY for services provided after December 31, 2017) 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 has been met and the contractor shall not pay toward the care.

**1.3.1.3.3** 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 contractor shall apply the deductible amount specified in paragraph 1.3.1.2.

**Note:** The contractor shall apply provisions of paragraph 1.3.1.3.3, 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.

**1.3.1.3.4** Adjustment of Excess. The contractor shall adjust any amount paid in excess against the annual deductible required under paragraphs 1.3.1.3.2 and 1.3.1.3.3 for any beneficiary identified under those paragraphs.

**1.3.1.3.5** The contractor shall consider the deductible amounts identified in this section as satisfied if the catastrophic cap amounts identified in Section 2 have been met for the same FY (CY for claims of care provided after December 31, 2017) 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 contractor shall apply a 20% cost-share of the allowable amount in excess of the annual deductible amount for ADFM outpatient care. The contractor shall include the professional charges of an individual professional provider for services rendered in a non-TRICARE-approved ASC or BC. For family members of active duty members of the armed forces of NATO/PfP foreign nations who are eligible for outpatient care under the TRICARE Program per DEERS, see paragraph 1.1.5.

**1.3.3.1.2** Other Beneficiary. The contractor shall apply a cost-share to outpatient care for other than active duty and authorized NATO/PfP family member beneficiaries of 25% of the allowable amount in excess of the annual deductible amount. The contractor shall include: 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, the contractor shall not apply annual deductible amounts 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 Military Treatment Facility (MTF), whichever is greater. (Please reference daily rate chart below.) For services on or after October 3, 2016, the contractor shall apply the following chart to all services (to include mental health and SUD services) for ADFMs or their sponsors.

**FIGURE 2.1-1 MTF DAILY CHARGE AMOUNTS**

| PERIOD | DAILY CHARGE |
|---|---|
| October 1, 2017 - September 30, 2018 (for ADFMs not enrolled in TRICARE Prime) | $18.60 |
| October 1, 2018 - December 31, 2019 (for ADFMs not enrolled in TRICARE Prime) | $19.05 |
| January 1, 2020 - December 31, 2020 (for ADFMs not enrolled in TRICARE Prime) | $19.55 |
| January 1, 2021- December 21, 2021 (for ADFMs not enrolled in TRICARE Prime) | $20.15 |
| 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 Diagnosis Related Group (DRG)-based payment system and the mental health per diem payment system and services provided by institutions other than hospitals (e.g., Residential Treatment Centers (RTCs)), the contractor shall apply a cost-share of 25% of the allowable charges.

**1.3.3.3 Cost-Shares: Maternity**

**1.3.3.3.1** Determination. The contractor shall determine maternity care cost-shares as follows:

**1.3.3.3.1.1** Apply the inpatient cost-share formula 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:** Apply the inpatient cost-share formula 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 Market/MTF inpatient childbirth unit. The contractor shall charge ADFMs a per diem (or a $25.00 minimum charge) for an admission and shall not charge separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

**1.3.3.3.1.2** Apply the ambulatory surgery cost-share formula 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** Apply the outpatient cost-share formula to maternity care which terminates in a planned childbirth at home.

**1.3.3.3.1.4** The contractor shall cost-share otherwise covered medical services and supplies directly related to "complications of pregnancy", as defined in the Regulation, 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, are cost-shared on the same basis as the termination of pregnancy.

**1.3.3.3.3** The contractor shall cost-share claims for **pregnancy testing** on an outpatient basis when the delivery is on an inpatient basis.

**1.3.3.3.4** When the beneficiary delivers in a **professional office birthing suite** located in the office of a physician or certified nurse-midwife (which is not an otherwise TRICARE-approved BC) the contractor shall adjudicate the claim as an at-home birth.

**1.3.3.3.5** The contractor shall cost-share claims for **prescription drugs** provided on an outpatient basis during the maternity episode but not directly related to the maternity care on an outpatient basis.

**1.3.3.3.6** Newborn cost-share. Effective for all inpatient admissions occurring on or after October 1, 1987, the contractor shall ensure separate claims are submitted for the mother and newborn. The contractor shall cost-share for inpatient claims services rendered to a beneficiary newborn 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, the contractor shall not charge a 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 TRICARE Prime, the contractor shall charge a cost-share 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, the contractor shall not charge a cost-share during the period the newborn is deemed enrolled in TRICARE Prime.
- For all other beneficiaries, the contractor shall apply a cost-share to all days in the inpatient stay, unless the newborn is deemed enrolled in TRICARE 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, the contractor shall not charge a cost-share during the period the newborn is deemed enrolled in TRICARE Prime.
- For family members of other than active duty members, the contractor shall charge a cost-share of 25% of the total allowed charges unless the newborn is deemed enrolled in TRICARE Prime.

**1.3.3.3.6.2.2** Different newborn date of birth and date of admission:

- For ADFMs, the contractor shall not charge a cost-share during the period the newborn is deemed enrolled in TRICARE Prime.
- For family members of other than active duty members, the contractor shall charge a cost-share of 25% of the total allowed charges unless the newborn is deemed enrolled in TRICARE Prime.

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

- The treatment is otherwise allowable as a benefit; and
- Treatment delay 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 may cause, or increase the likelihood of, a stillbirth or newborn injury or illness; or
- The usual course of treatment is 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**

The contractor shall apply these special cost-sharing procedures only to claims paid under the DRG-based payment system for dates of service prior to January 1, 2018, and to all TRICARE For Life (TFL) claims before and after January 1, 2018.

**1.3.3.4.2 TRICARE Standard**

**1.3.3.4.2.1** Cost-shares for ADFMs. The contractor shall charge ADFMs or their sponsors 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 an MTF, whichever is greater.

**1.3.3.4.2.2** Cost-shares for beneficiaries other than ADFMs.

**1.3.3.4.2.2.1** The contractor shall charge a cost-share the lesser of:

**1.3.3.4.2.2.1.1** An amount based upon a single, specific per diem amount which shall 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 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 Defense Health Agency (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 contractor shall calculate the per diem amount 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 is the average cost per day for these beneficiaries.

- Multiply this amount by 0.25. In this way total cost-sharing amounts 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 contractor shall charge the per diem amount 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 contractor shall count the last day of eligibility to determine 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 contractor shall charge a cost-share based upon a one-day stay. (The number of hospital days contain one day in this situation.)

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

**1.3.3.4.2.2.2** The contractor shall not charge a cost-share exceeding the DRG-based amount.

**1.3.3.4.2.2.3** Where the dates of service span different FYs (or CY for dates of service after December 31, 2017), the contractor shall apply a per diem cost-share amount for each year 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 contractor shall apply cost-sharing provisions for the same as those for TRICARE Standard.

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

**1.3.3.4.4 TRICARE Prime**

The contractor shall not apply a cost-share for ADFMs. For beneficiaries other than ADFMs, the contractor shall charge a cost-share of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider; or, an $11 per diem rate, 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. The contractor shall apply these special cost-sharing procedures only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system, the contractor shall follow the procedures in paragraph 1.3.3.2 or 1.3.3.4.

**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 TRICARE 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 and ending on December 31, 2017, the contractor shall apply inpatient cost-sharing for mental health services as described in paragraph 1.3.3.2.1. The contractor shall apply cost-shares to admissions to any hospital for mental health services, any RTC, and any inpatient/residential SUD detoxification and rehabilitation program. For TRICARE Prime ADFMs, the contractor shall apply a cost-share of $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 contractor shall apply a cost-share of 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 contractor shall apply a cost-share of the lower of paragraphs 1.3.3.5.4.2.1 or 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 is 25% of the per diem adjusted so that total beneficiary cost-share equals 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount is only applicable with TRICARE is first payer. DHA updates this fixed daily amount annually and posts it on the DHA website at http://www.health.mil/rates. DHA will also furnish this fixed daily amount to the contractor. The following fixed daily amounts are effective for services rendered on or after October 1 of each FY.

- 2019 - $248 per day.
- 2020 - $255 per day.
- 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** Claims which span a period in which two separate per diems exist. The contractor shall compute the cost-share on the actual per diem in effect for each day of care for claims subject to the inpatient mental health per diem payment system which spans a period in which two separate per diems exist.

**1.3.3.5.6** Cost-share whenever leave days are involved. The contractor shall not charge for leave days when such days are included in a hospital stay.

**1.3.3.5.7** The contractor shall apply inpatient cost-shares to claims for services that are provided during an inpatient admission which are not included in the per diem rate if the contractor cannot determine where the service was rendered and the patient status 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 includes 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: PHPs And Intensive Outpatient Program (IOPs)**

**1.3.3.6.1** For care rendered prior to October 3, 2016, 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 shall identify on the claim form that the psychotherapy is related to a partial hospitalization stay so the proper inpatient cost-sharing is applied. The cost-share for ADFMs enrolled in TRICARE 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 taken for partial hospitalization regardless of sponsor status. The cost-share for ADFMs is taken from the PHP claim.

**1.3.3.6.2** For care rendered on or after October 3, 2016, the contractor shall apply outpatient cost-shares for PHP and IOP services. The contractor shall also apply outpatient cost-shares to associated psychotherapy billed separately by the individual professional provider. The contractor shall ensure these providers identify on the claim form that the psychotherapy is related to PHP or IOP care so the contractor can apply the proper outpatient cost-share. Cost-shares for standard beneficiaries are in paragraph 1.3; cost-sharing requirements for TRICARE Prime beneficiaries are in paragraph 1.2.

**1.3.3.7 Cost-Shares: Ambulatory Surgery**

**1.3.3.7.1** For non-TRICARE Prime ADFMs, the contractor shall, for all services reimbursed as ambulatory surgery, charge a $25 cost-share on the facility claim. The contractor shall not deduct a cost-share 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 cost-share shall be 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 upon a percentage rather than a set amount, the contractor shall take the cost-share from all ambulatory surgery claims. For professional services, the contractor shall charge cost-share of 25% of the allowed amount. For the facility claim, the contractor shall charge a cost-share that 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 ensures 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 may be less in some cases. This ensures that the beneficiaries get the benefit of the group payment rates when such rate are more advantageous, but they are never disadvantaged by them. If there is no group payment rate for a procedure, the cost-share is simply 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, the contractor shall charge an eligible former spouse the first $150.00 of the reasonable costs/charges for otherwise covered outpatient services and supplies provided in any one FY (CY for dates of service after December 31, 2017). 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 retain a legal familial relationship with the member or former member and are included in the member's or former member's family

deductible. The contractor shall not require the former spouse to 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 FY (CY for dates of service after December 31, 2017).

**1.3.3.8.2** Cost-Share. The contractor shall charge an eligible former spouse cost-share 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 the network provider agrees to a negotiated (discounted) rate, the contractor shall base the cost-share upon 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) is 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 is 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 is 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 is 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 is 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 is 25% of the allowable billed charges after it has been adjusted by the discount.

**Note:** For all inpatient care for ADFMs, the cost-share continues to be either the daily charge or $25 per stay, whichever is higher. There is no change to the requirement that the ADFM's cost-share is 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 upon 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 TRICARE 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** The contractor shall not require copayments or authorizations for the following preventive services 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 contractor shall waive the cost-share 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 the TPM, Chapter 7, Section 2.1, paragraph 1.1.5.13.

**1.3.3.10.3** The contractor shall not require a beneficiary 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** The contractor shall apply the appropriate cost-sharing and deductibles for all other preventive services described in the TPM, Chapter 7, Section 2.1, paragraphs 1.2 and Section 2.5.

**1.4 TRICARE Extra**

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

**1.4.2** If a non-enrolled TRICARE beneficiary receives care from a network provider out of the region of residence, and if the beneficiary has not met the FY (CY for dates of service after December 31, 2017) catastrophic cap, the beneficiary owes the TRICARE 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 is contracted.

**1.4.3 Preventive Services**

**1.4.3.1** The contractor shall not require copayments or authorizations for the following preventive services 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 are billed on a claim, then the contractor shall waive the cost-share 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** The contractor shall not require a beneficiary 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** The contractor shall apply the appropriate cost-share and deductibles 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 contractor shall apply the following 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** For ADFMs, the cost-share equals 15% of the contractor negotiated fee.

**1.5.2.2.2** For retirees, their family members, and survivors, the cost-share equals 20% of the contractor negotiated fee.

#### 1.5.2.3 TRICARE Standard

**1.5.2.3.1** For ADFMs, the cost-share equals 20% of the allowable charge.

**1.5.2.3.2** For retirees, their family members, and survivors, the cost-share equals 25% of the allowable charge.

#### 1.5.3 Inpatient: Non-Network Providers

The contractor shall apply the following beneficiary copayment/cost-sharing requirements for medically necessary ambulance services when paid on an inpatient basis:

**1.5.3.1** For ADFMs, the contractor shall not charge a cost-share for ambulance services (transfers) rendered in conjunction with an inpatient stay.

**1.5.3.2** For other beneficiaries, the cost-share equals 25% of the allowable amount.

### 1.6 Exceptions

#### 1.6.1 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:

**1.6.1.1** Any readmission to an acute care hospital which is not more than 60 days from the date of the last inpatient discharge is treated as one inpatient confinement with the last admission for cost-share amount determination.

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

**1.6.2 Inpatient Cost-Share: Maternity Care**

See paragraph 1.3.3.3. The contractor shall consider all admissions related to a single maternity episode as one confinement regardless of the number of days between admissions. For ADFMs, the contractor shall apply the cost-share to the first institutional claim received.

**1.6.3 Special Cost-Share Provisions**

**1.6.3.1** For services provided prior to International Classification of Diseases, 10th Revision Clinical Modification (ICD-10-CM) implementation. Effective October 1, 1987, the contractor shall not charge an inpatient cost-share amount, from DRG-exempt institutional provider claims in the following categories, that exceeds that which would have been imposed if the service were subject to the DRG-based payment system. The contractor shall not apply this to ADFM claims. For all other beneficiaries, the contractor shall charge a cost-share the lesser of:

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

**1.6.3.1.1 Child Bone Marrow Transplantation (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).

**1.6.3.1.2 Child Human Immunodeficiency Virus (HIV) Seropositivity**

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

**1.6.3.1.3 Child Cystic Fibrosis**

All services related to discharges involving a beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis code 277.0 (cystic fibrosis).

**1.6.3.2** 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 contractor shall not charge an inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories, that exceed that which would have been imposed if the service were subject to the DRG-based payment system. The contractor shall not apply this to ADFM claims. For all other beneficiaries, the contractor shall charge a cost-share the lesser of:

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

#### 1.6.3.2.1 Child BMT

All services related to discharges involving BMT for a beneficiary less than 18 years old as classified in ICD-10-CM.

#### 1.6.3.2.2 HIV Seropositivity

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

#### 1.6.3.2.3 Child Cystic Fibrosis

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

#### 1.6.3.2.4 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 are placed in Survivor status and are responsible for retiree cost-shares. See the Transitional Survivor Status policy in the TPM, Chapter 10, Section 7.1.

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

### 1.7 Catastrophic Loss Protection

See Section 3.

### 1.8 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 -