

CHAPTER 12
SECTION 2.1

TRICARE - COSTS AND UNIFORM HMO BENEFIT

Issue Date: May 15, 1996

Authority: [32 CFR 199.4](#), [32 CFR 199.5](#), [32 CFR 199.17](#), and [32 CFR 199.18](#)

I. POLICY

A. TRICARE Standard program deductible and cost share amounts are defined in [32 CFR 199.4](#). They are identical to those applied under Basic CHAMPUS.

B. TRICARE Extra program deductible and cost share amounts are defined in [32 CFR 199.17](#).

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

D. Fees under the Program for Persons With Disabilities are defined in [32 CFR 199.5](#).

E. No copayments or authorizations are required for TRICARE Prime clinical preventive services which are described in Policy [Chapter 12, Section 8.1](#).

F. 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):

1. Diagnostic radiology and ultrasound services included in the CPT code range from 70000 through 76999;

2. Diagnostic nuclear medicine services included in the CPT code range from 78000 through 78999;

3. Pathology and laboratory services included in the CPT code range from 80000 through 89399; and

4. Cardiovascular studies included in the CPT code range from 93000 through 93350.

NOTE: Contractors are not required to search their files for claims for ancillary services which were not processed according to these guidelines. The contractor shall, however, if requested by

an appropriate individual, adjust specific claims under these guidelines if the date of service is on or after March 26, 1998.

G. Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Chapter 12, Section 2.1, Table 1](#) for additional information on the benefits and costs under TRICARE.

II. POLICY CONSIDERATIONS

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

B. 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.

C. **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 Health Care Provider Record shows the provider to be contracted.**

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