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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 95
6010.55-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.55-M, issued August 2002.

CHANGE TITLE: WAIVER OF COST-SHARES FOR CERTAIN CLINICAL
PREVENTIVE SERVICES

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): In accordance with National Defense Authorization
Act (NDAA) for 2009, Section 711, these changes waive cost-shares/copayments for
certain clinical preventive services provided to TRICARE Standard and Extra
beneficiaries who are not Medicare eligible.

EFFECTIVE DATE: October 14, 2008.

IMPLEMENTATION DATE: September 1, 2009.

This change is made in conjunction with Aug 2002 TPM, Change No. 99.

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Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 21 PAGE(S)
DISTRIBUTION: 6010.55-M

CHANGE 95
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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 2

Section 1, pages 1 - 4 and 15 - 17
Addendum A, pages 1 through 12

Section 1, pages 1 - 4 and 15 - 19
Addendum A, pages 1 through 12

COST-SHARES AND DEDUCTIBLES

ISSUE DATE: December 16, 1983

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

I. POLICY

A. General

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

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

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

4. Fees under the Extended Care Health Option (ECHO) are defined in [32 CFR 199.5](#).

5. See the attached [Chapter 2, Addendum A](#) for additional information on the benefits and costs under TRICARE.

6. Waiver of Cost-Sharing and Deductible.

a. Operation Desert Shield/Desert Storm.

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

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

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

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

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

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

3 The waiver of cost-sharing will be based on the dates of care/service.

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

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

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

b. Operation Joint Endeavor.

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

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

c. Operation Noble Eagle/Operation Enduring Freedom.

(1) The TRICARE Standard and Extra deductible is waived for family members of members of the reserves or National Guard who have been ordered to active

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duty in support of operations that result from the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001.

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

(3) The exception to the deductible and cost-share requirements under Operation Noble Eagle/Operation Enduring Freedom for TRICARE Standard and Extra is effective for services rendered from September 14, 2001, through October 31, 2009.

d. For Certain Reservists. The Director, TRICARE Management Activity (**TMA**), may waive the individual or family deductible for dependents of a reserve component member who is called or ordered to active duty for a period of more than 30 days but less than one year in support of a contingency operation. For this purpose, a reserve component member is either a member of the reserves or National Guard member who is called or ordered to full-time federal National Guard duty. A contingency operation is defined in 10 U.S.C. 101(a)(13). Also, for this purpose a dependent is a lawful husband or wife of the member or an eligible child.

B. TRICARE Prime.

1. Copayments and enrollment fees under TRICARE Prime are subject to review and annual updating. See [Chapter 2, Addendum A](#) for additional information on the benefits and costs. In accordance with Section 752 of the National Defense Authorization Act (**NDAA**), **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 FY 2001 Authorization Act.

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.

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.

4. No copayments or authorizations are required for TRICARE Prime clinical preventive services which are described in the **TRICARE Policy Manual (TPM)**, [Chapter 7, Section 2.2](#).

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5. 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):

a. Diagnostic radiology and ultrasound services included in the CPT¹ procedure code range from 70000 through 76999, or any other code for associated contrast media;

b. Diagnostic nuclear medicine services included in the CPT¹ procedure code range from 78000 through 78999;

c. Pathology and laboratory services included in the CPT¹ procedure code range from 80000 through 89399; and

d. Cardiovascular studies included in the CPT¹ procedure code range from 93000 through 93350.

e. Venipuncture included in the CPT¹ procedure code range from 36400 - 36416.

f. Collection of blood specimens in the CPT¹ procedure code range from 36591 and 36592.

g. Fetal monitoring for CPT¹ procedure codes 59020, 59025, and 59050.

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.

NOTE: Multiple discounting will not be applied to the following procedure codes for venipuncture, fetal monitoring and collection of blood specimens; 36400-36416, 36591, 36592, 59020, 59025, and 59050.

6. Point of Service (POS) option. See [Chapter 2, Section 3](#).

C. Basic Program: TRICARE Standard.

1. Deductible Amount: Outpatient Care.

a. 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) 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 CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

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(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:

(a) The single, specific per diem supplied by TMA after the application of the agreed upon discount rate; OR,

(b) Twenty-five percent (25%) of the billed charge.

(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.

(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:

(a) The fixed daily amount supplied by TMA after the application of the agreed upon discount rate; OR,

(b) Twenty-five percent (25%) of the billed charge.

(5) For Residential Treatment Centers (RTC), the cost-share for other than ADFMs shall be 25% of the TRICARE rate after it has been adjusted by the discount.

(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 I.C.3.d.](#)) For Prime ADFMs, the cost-share is \$0 for care provided on or after April 1, 2001.

j. Preventive Services.

(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](#):

(a) Colorectal cancer screening.

- (b) Breast cancer screening.
- (c) Cervical cancer screening.
- (d) Prostate cancer screening.
- (e) Immunizations.
- (f) Well-child visits for children under six years of age.

(g) 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 paragraph I.C.3.j.(1)(a) through (e). If one or more of the procedure codes described in the TPM, Chapter 7, Section 2.1 for those preventive services listed in paragraph I.C.3.j.(1)(a) through (e) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

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

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

(4) Appropriate cost-sharing and deductibles will apply for all other preventive services under TRICARE Standard. See Chapter 7, Sections 2.1 and 2.5.

(5) The contractor shall process claims for reimbursement of copayments paid for those services exempted from copayments rendered from October 14, 2008 through the implementation date of this change as prescribed in the Underpayments provisions in the TOM. Contractors will add a message to the Explanation of Benefits (EOB) to advise the provider that this is a retroactive adjustment to the copayment to alert the provider regarding a refund to the beneficiary of the copayment amount.

D. TRICARE Extra.

1. For Extra deductibles and cost-shares, see Chapter 2, Addendum A.

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.

3. Preventive Services.

g. 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) Colorectal cancer screening.
- (2) Breast cancer screening.
- (3) Cervical cancer screening.
- (4) Prostate cancer screening.
- (5) Immunizations.
- (6) Well-child visits for children under six years of age.

(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 paragraph I.D.3.a.(1) through (5). If one or more of the procedure codes described in the TPM, Chapter 7, Section 2.1 for those preventive services listed in paragraph I.D.3.a.(1) through (5) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

b. 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.

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

d. Appropriate cost-sharing and deductibles will apply for all other preventive services under TRICARE Standard. See Chapter 7, Sections 2.1 and 2.5.

e. The contractor shall process claims for reimbursement of copayments paid for those services exempted from copayments rendered from October 14, 2008 through the implementation date of this change as prescribed in the Underpayments provisions in the TOM. Contractors shall add a message to the EOB to advise the provider that this is a retroactive adjustment to the copayment to alert the provider regarding a refund to the beneficiary of the copayment amount.

E. Cost-Shares: Ambulance Services.

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

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

a. TRICARE Prime:

(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 [Chapter 2, Addendum A](#) for further information.

(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 [Chapter 2, Addendum A](#) for further information.

(3) For retirees and their family members, \$20.

b. TRICARE Extra:

(1) A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

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

c. TRICARE Standard:

(1) A cost-share of 20% of the allowable charge for ADFMs.

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

2. Inpatient: Non-Network Providers:

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

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

F. Exceptions.

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

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

b. Certain heart and lung hospitals are excepted from cost-share requirements. See [Chapter 1, Section 28](#), entitled "Legal Obligation To Pay".

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2. Inpatient Cost-Share: Maternity care. See [paragraph I.C.3.c](#). 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.

3. Special Cost-Share Provisions. 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 (1) that calculated according to [paragraph I.C.3.b.\(2\)](#), or (2) that calculated according to [paragraph I.C.3.d.\(2\)](#).

a. Child bone marrow transplant. All services related to discharges involving bone marrow transplant for a beneficiary less than 18 years old with ICD-9-CM principal or secondary diagnosis code V42.8 and ICD-9-CM procedure codes 41.0 through 41.04, 41.06, and 41.91.

b. Child 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.

c. Child Cystic Fibrosis. All services related to discharges involving beneficiary less than 18 years old with ICD-9-CM principle or secondary diagnosis code 277.0 (cystic fibrosis).

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 [Chapter 10, Section 7.1](#).

G. Catastrophic Loss Protection.

See [Chapter 2, Section 2](#).

- END -

BENEFITS AND BENEFICIARY PAYMENTS UNDER THE TRICARE PROGRAM

NOTE 1: Beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) and enrollment fees may be updated for inflation annually (cumulative effect applied and rounded to the nearest whole dollar) by the national CPI-U medical index (the medical component of the Urban Consumer Price Index). Beneficiary cost shares (i.e., beneficiary payments expressed as a percentage of the provider's fee) will not be similarly updated.

I. TRICARE PRIME PROGRAM ANNUAL ENROLLMENT FEES

Does not apply to the TRICARE Extra Program (Also see "Point of Service (POS) Option", [paragraph IV](#)):

TRICARE PRIME PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIREES, THEIR FAMILY MEMBERS, ELIGIBLE FORMER SPOUSES & SURVIVORS
E1 - E4	E5 & ABOVE	
None	None	<p>\$230 per Retiree or Family Member \$460 Maximum per Family</p> <p>EXCEPTION: Effective March 26, 1998, the enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare.</p>

II. TRICARE EXTRA PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime Program. (Also see "Point of Service (POS) Option", [paragraph IV](#).)

TRICARE EXTRA PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFMs)		RETIREES, THEIR FAMILY MEMBERS & SURVIVORS
E1 - E4	E5 & ABOVE	
\$50 per Individual \$100 Maximum per Family	\$150 per Individual \$300 Maximum per Family	\$150 per Individual \$300 Maximum per Family

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III. TRICARE STANDARD PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime or Extra Programs:

TRICARE STANDARD PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFM's)		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS
E1 - E4	E5 & ABOVE	
\$50 per Individual \$100 Maximum per Family	\$150 per Individual \$300 Maximum per Family	\$150 per Individual \$300 Maximum per Family

NOTE 2: These charts are not intended to be a comprehensive listing of all services covered under TRICARE. All care is subject to review for medical necessity and appropriateness:

NOTE 3: An eligible former spouse is responsible for payment of copayment/cost-sharing amounts identical to those required for beneficiaries other than family members of active duty members.

IV. OUTPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ADFM's		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
INDIVIDUAL PROVIDER SERVICES Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit.	ADFM's: Cost-share--15% of the fee negotiated by the contractor. Retirees, their Family Members & Survivors: Cost-share--20% of the fee negotiated by the contractor.	ADFM's: Cost-share--20% of the allowable charge. Retirees, their Family Members & Survivors: Cost-share--25% of the allowable charge.
OUTPATIENT HOSPITAL DEPARTMENTS Clinics visits; therapy visits; medical supplies; consultations; treatment room; etc. NOTE: Use other parts of this table for cost-sharing of ASC services, ER services, DME, etc.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit. No separate copayment/cost-share for separately billed professional charges.		

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ADFMS		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
LABORATORY AND X-RAY SERVICES (See Note 4.)	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit. (See Note 4)	ADFMS: Cost-share--15% of the fee negotiated by the contractor. Retirees, their Family Members & Survivors: Cost-share--20% of the fee negotiated by the contractor.	ADFMS: Cost-share--20% of the allowable charge. Retirees, their Family Members & Survivors: Cost-share--25% of the allowable charge.
ANCILLARY SERVICES Refer to Chapter 2, Section 1 for specific CPT code ranges	\$0 copayment per visit.	\$0 copayment per visit.	No copayment (See Note 3.)		
ROUTINE PAP SMEARS Frequency to depend on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology. (See Note 4.)	No copayment.	No copayment.	No copayment.		
AMBULANCE SERVICES When medically necessary as defined in the TRICARE Policy Manual (TPM) and the service is a covered benefit.	\$0 copayment per visit.	\$0 copayment per visit.	\$20 copayment per occurrence.		
EMERGENCY SERVICES Emergency and urgently needed care obtained on an outpatient basis, both network and non-network, and in and out of the Region.	\$0 copayment per visit.	\$0 copayment per visit.	\$30 copayment per emergency room visit.		
NOTE 4: If these services are performed by the office visit provider on a date different from the office visit or performed by a different provider such as an independent laboratory or radiology facility (even if performed on the same day as the related office visit) the beneficiary will owe a separate copayment for the services. Also, no copayment will be collected for these services when they are billed and provided as clinical preventive services to TRICARE Prime enrollees. Effective for dates of service on or after October 14, 2008, cost-shares are waived for certain preventive services as described in Chapter 2, Section 1, paragraph I.C.3.j. and paragraph I.D.3.					
NOTE 5: For dates of service on or after March 26, 1998, under TRICARE Prime, services defined as "ancillary services" in Chapter 2, Section 1 require no copayment.					

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ADFM's		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
DME, PROSTHETIC DEVICES, HEARING AIDS FOR ADFM's, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED BENEFITS (If dispensed for use outside of the office or after the home visit.)	\$0 copayment per visit.	\$0 copayment per visit.	Cost-share - 20% of the fee negotiated by the contractor.	ADFM's: Cost-share--15% of the fee negotiated by the contractor. Retirees, their Family Members & Survivors: Cost-share--20% of the fee negotiated by the contractor.	ADFM's: Cost-share--20% of the allowable charge. Retirees, their Family Members & Survivors: Cost-share--25% of the allowable charge.
HOME HEALTH CARE Part-time or intermittent skilled nursing and home health aide services, physical, speech, & occupational therapy, medical social services, routine and non-routine medical services. NOTE: DME, osteoporosis drugs, pneumococcal pneumonia, influenza virus and hepatitis B vaccines, oral cancer drugs, antiemetic drugs, orthotics, prosthetics, enteral and parenteral nutritional therapy and drugs/biologicals administered by other than oral methods are services that can be paid in addition to the prospective payment amount subject to applicable copayment/ cost-sharing and deductible amounts.	\$0 copayment.	\$0 copayment.	\$0 copayment.	\$0 cost-share.	\$0 cost-share.

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IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ADFMs		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
HOSPICE CARE NOTE: A separate cost-share <u>may be</u> (optional) collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.	\$0 copayment.	\$0 copayment.	\$0 copayment.	\$0 cost-share.	\$0 cost-share.
FAMILY HEALTH SERVICES Family planning and well baby care (up to 24 months of age). The exclusions listed in the TPM will apply.	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit. (See Note 4.)	ADFMs: Cost-share--15% of the fee negotiated by the contractor. Retirees, their Family Members & Survivors: Cost-share--20% of the fee negotiated by the contractor.	ADFMs: Cost-share--20% of the allowable charge. Retirees, their Family Members & Survivors: Cost-share--25% of the allowable charge.
OUTPATIENT MENTAL HEALTH TO INCLUDE HOME One hour of therapy, no more than two times each week (when medically necessary).	\$0 copayment per visit.	\$0 copayment per visit.	\$25 copayment for individual visits. \$17 copayment for group visits.	Retirees, their Family Members & Survivors: Cost-share--20% of the fee negotiated by the contractor.	Retirees, their Family Members & Survivors: Cost-share--25% of the allowable charge.
PRESCRIPTION DRUGS See Addendum B.					
NOTE 6: If medically necessity is established for a non-formulary drug, patients may qualify for the \$9 copayment for up to a 30-day supply in the TRRx or a 90-day supply in the TMOP program.					
AMBULATORY SURGERY (same day) ALL SURGICAL PROCEDURES REGARDLESS OF WHERE THEY ARE PERFORMED With the exclusion of those surgical procedures referenced in Chapter 2, Section 1, paragraph I.B.5.e. and g.	\$0 copayment per visit.	\$0 copayment per visit.	\$25 copayment No separate copayment/cost-share for separately billed professional charges.	ADFMs: Cost-share--\$25. for Ambulatory Surg. Retirees, their Family Members & Survivors: Cost-share --20% of the institutional fee negotiated by the contractor.	ADFMs: \$25. Retirees, their Family Members & Survivors: Lesser of 25% of group rate or 25% of billed charge.

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BENEFITS AND BENEFICIARY PAYMENTS UNDER THE TRICARE PROGRAM

IV. OUTPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 8.)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
	ADFMS		RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
	E1 - E4	E5 & ABOVE			
TYPE OF SERVICE (SEE NOTE 11.)					
BIRTHING CENTER Prenatal care, outpatient delivery, and postnatal care provided by TRICARE authorized birthing center.	\$0 copayment.	\$0 copayment.	\$25 copayment.	ADFMS: \$25. Retirees, their Family Members & Survivors: Cost-share--20% of the fee negotiated by the contractor.	ADFMS: \$25. Retirees, their Family Members & Survivors: Lesser of 25% of birthing center rate or 25% of billed charge.
IMMUNIZATIONS (See Note 7.) Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations.	\$0 copayment per visit.	\$0 copayment per visit.	Not covered under Prime.	ADFMS: Cost-share--15% of the fee negotiated by the contractor. Retirees, their Family Members & Survivors: Not covered under TRICARE Extra.	ADFMS: Cost-share--20% of the allowable charge. Retirees, their Family Members & Survivors: Not covered under TRICARE Standard.
EYE EXAMINATIONS (See Note 7.) One routine examination per year for family members of active duty sponsors.	\$0 copayment per visit.	\$0 copayment per visit.	Not covered under Prime. (See Note 7.)		
NOTE 7: Additional immunizations and eye examinations are covered under the TRICARE Prime Program's "clinical preventive services". See the TPM, Chapter 7, Section 2.2.					
CLINICAL PREVENTIVE SERVICES Includes those services listed in the TPM, Sections 2.1, 2.2, and 2.5.	\$0 copayment	\$0 copayment	\$0 copayment	ADFMS: Cost-share--15% of the fee negotiated by contractor. Retirees, their Family Members & Survivors: Cost-share--20% of the fee negotiated by the contractor.	ADFMS: Cost-share--20% of the allowable charge. Retirees, their Family Members & Survivors: Cost-share--25% of the allowable charge.
NOTE 8: No copayment may be collected for these services when they are billed and provided as specified in the TPM, Chapter 7, Section 2.2.					
NOTE 9: Cost-shares are waived for certain preventive services under Standard and Extra as described in Chapter 2, Section 1, paragraph I.C.3.j. and paragraph I.D.3. See the TPM, Chapter 7, Sections 2.1, 2.2, and 2.5.					
NOTE 10: No enhanced outpatient benefits under the TRICARE Extra Program.					

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V. INPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ACTIVE DUTY FAMILY MEMBERS (ADFM's)	RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
NOTE 11: No enhanced inpatient benefits under the TRICARE Prime or Extra programs.				
HOSPITALIZATION Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services, meals including special diets, drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, x-ray and other radiology services, necessary medical supplies and appliances, blood and blood products.	\$0 copayment per visit.	\$11 per diem charge (\$25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	ADFM's: Per diem charge (\$25 minimum charge per admission). No separate cost-share for separately billed professional charges. Retirees, their Family Members & Survivors: \$250 per diem copayment or 25% cost-share of total charges (based on the fee schedule negotiated by the contractor), whichever is less, for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	ADFM's: Per diem charge (\$25 minimum charge per admission). No separate cost-share for separately billed professional charges. Retirees, their Family Members & Survivors: DRG per diem copayment or 25% cost-share of billed charges for institutional services, whichever is less, plus 25% cost-share of allowable for separately billed professional charges.
MATERNITY Hospital and professional services (prenatal, delivery, postnatal).				

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BENEFITS AND BENEFICIARY PAYMENTS UNDER THE TRICARE PROGRAM

V. INPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ACTIVE DUTY FAMILY MEMBERS (ADFMs)	RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
NEWBORN/ADOPTEE CARE Hospital and professional services.	\$0 copayment. No separate copayment/cost-share for separately billed professional charges.	<p>Same newborn date of birth and date of admission: \$11 per day (\$25 minimum charge) applies to the 4th and subsequent days of the newborn's inpatient stay.</p> <p>Different newborn date of birth and date of admission: \$11 per day (\$25 minimum charge) applies to all days of the newborn's inpatient stay.</p>	<p>ADFMs: \$0 as newborn is deemed enrolled in Prime for up to 60 days for cost-sharing purposes. No separate cost-share for separately billed professional charges.</p> <p>Retirees, their Family Members & Survivors: Same newborn date of birth and date of admission: 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 \$250 OR 25% of TRICARE contractor negotiated charges for institutional services, plus 20% cost-share of separately billed contractor negotiated professional charges.</p>	<p>ADFMs: \$0 as newborn is deemed enrolled in Prime for up to 60 days for cost-sharing purposes. No separate cost-share for separately billed professional charges.</p> <p>Retirees, their Family Members & Survivors: DRG Hospital: Same newborn date of birth and date of admission: 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 DRG per diem copayment OR 25% of billed charges for institutional services, plus 25% cost-share of allowable separately billed professional charges.</p>
NOTE: The TRICARE Regional Director of each TRICARE Regional Office (TRO) and Deputy Director of each TRICARE Area Office (TAO) shall be granted the authority to extend the deemed period up to 120-days, on a case-by-case or regional basis.				

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V. INPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ACTIVE DUTY FAMILY MEMBERS (ADFM's)	RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
NEWBORN/ADOPTEE CARE (Continued)			<p>Different newborn date of birth and date of admission: Unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of hospital days for the newborn multiplied by \$250 or 25% of TRICARE contractor negotiated charges for institutional services, plus 20% cost-share of separately billed contractor negotiated professional charges.</p>	<p>Different newborn date of birth and date of admission: Unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of hospital days for the newborn multiplied by DRG per diem copayment OR 25% of billed charges for institutional services, plus 25% cost-share of allowable separately billed professional charges.</p> <p>DRG Exempt Hospital: Unless the newborn is deemed enrolled in Prime, the cost-share will be 25% of allowed charges for institutional services, plus 25% cost-share of allowable separately billed professional charges.</p>
<p>NOTE: The TRICARE Regional Director of each TRO and Deputy Director of each TAO shall be granted the authority to extend the deemed period up to 120-days, on a case-by-case or regional basis.</p>				

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V. INPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ACTIVE DUTY FAMILY MEMBERS (ADFMs)	RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
SKILLED NURSING FACILITY (SNF) CARE Same benefit as Medicare except that there is no limitation to the number of days of coverage. Benefit includes semiprivate room, regular nursing services, meals including special diets, physical, occupational and speech therapy, drugs furnished by the facility, necessary medical supplies, and appliances.	\$0 copayment per visit.	\$11 per diem charge (\$25 minimum charge per admission). No separate copayment/cost-share for separately billed professional charges.	ADFMs: Per diem charge (\$25 minimum charge per admission). Retirees, their Family Members & Survivors: \$250 per diem copayment or 20% cost-share of total charges (based on the fee schedule negotiated by the contractor), whichever is less, for institutional services, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).	ADFMs: Per diem charge (\$25 minimum charge per admission). Retirees, their Family Members & Survivors: 25% cost-share of allowed charges for institutional services, plus 25% cost-share of allowable for separately billed professional charges.

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V. INPATIENT SERVICES (Continued)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ACTIVE DUTY FAMILY MEMBERS (ADFMs)	RETIRES, THEIR FAMILY MEMBERS & SURVIVORS		
<p>FOR MENTAL ILLNESS With authorization, up to 30 days per fiscal year for adults (age 19+), up to 45 days per fiscal year for children under age 19; up to 150 days residential treatment for children and adolescents.</p>	\$0 copayment per visit.	\$40 per diem charge.	<p>ADFMs: \$20 per diem charge (\$25 minimum charge per admission).</p>	<p>ADFMs: \$20 per diem charge (\$25 minimum charge per admission).</p>
<p>SUBSTANCE USE TREATMENT (Inpatient, partial) With authorization, seven days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.</p>		No separate copayment/cost-share for separately billed professional charges.	<p>Retirees, their Family Members & Survivors: Cost-share--20% of total charges (based on the fee schedule negotiated by the contractor) for institutional services, plus 20% cost-share of separately billed professional charges (based on the fee schedule negotiated by the contractor).</p>	<p>Retirees, their Family Members & Survivors: Inpatient High Volume Hospital: Cost-share--25% hospital specific per diem. Inpatient Low Volume Hospital: <u>Lower</u> of fixed daily amount or 25% hospital billed charges.</p>
<p>PARTIAL HOSPITALIZATION-MENTAL HEALTH With authorization, up to 60 days per fiscal year (minimum of three hours/day of therapeutic services).</p>				<p>RTC: Cost-share--25% of the TRICARE allowed amount. Partial Hospitalization: Cost-share--25% of the TRICARE allowed amount. Plus, 25% cost-share of allowable charges for separately billed professional charges.</p>

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VI. POINT OF SERVICE (POS)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 11.)	ACTIVE DUTY FAMILY MEMBERS (ADFMS)	RETIREES, THEIR FAMILY MEMBERS & SURVIVORS		
A Prime enrollee may receive services under the POS option by self-referring for non-emergency care. Refer to Chapter 2, Section 3 , for policy on the POS option.	Outpatient Deductible: \$300.00 individual \$600.00 family. Inpatient and Outpatient Cost-Share: 50% of the allowed charges. (See Note 12.)	Outpatient Deductible: \$300.00 individual \$600.00 family. Inpatient and Outpatient Cost-Share: 50% of the allowed charges. (See Note 12.)	POS option does NOT apply to TRICARE Extra beneficiaries.	POS option does NOT apply to TRICARE Standard beneficiaries.
NOTE 12: TRICARE reimbursement will be limited to 50% of the billed/allowed charges.				

Refer to [Chapter 2, Section 2](#) for information on catastrophic loss protection.

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