



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 18
6010.58-M
OCTOBER 23, 2009**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

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

CONREQ: 14903

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: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 17

**Reta Michak
Acting Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 19 PAGE(S)
DISTRIBUTION: 6010.58-M**

**CHANGE 18
6010.58-M
OCTOBER 23, 2009**

REMOVE PAGE(S)

CHAPTER 2

Section 1, pages 15 through 17

Addendum A, pages 1 through 12

APPENDIX A

pages 15 and 16

INSERT PAGE(S)

Section 1, pages 15 through 18

Addendum A, pages 1 through 13

pages 15 and 16

1.3.3.10 Preventive Services

1.3.3.10.1 Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TRICARE Policy Manual (TPM), [Chapter 7, Sections 2.1 and 2.5](#):

1.3.3.10.1.1 Colorectal cancer screening.

1.3.3.10.1.2 Breast cancer screening.

1.3.3.10.1.3 Cervical cancer screening.

1.3.3.10.1.4 Prostate cancer screening.

1.3.3.10.1.5 Immunizations.

1.3.3.10.1.6 Well-child visits for children under six years of age.

1.3.3.10.1.7 Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5](#). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraphs 1.3.3.10.1.1 through 1.3.3.10.1.5](#) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

1.3.3.10.2 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.

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

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

1.3.3.10.5 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 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.

1.4 TRICARE Extra

1.4.1 For Extra deductibles and cost-shares, see [Addendum A](#).

1.4.2 If non-enrolled TRICARE beneficiary receives care from a network provider out of the region of residence, and if the beneficiary has not met the fiscal year catastrophic cap, the beneficiary shall pay the Extra cost-share to the provider. The contractor for the beneficiary's

residence shall process the claim under TRICARE Extra claims processing procedures if the TRICARE Encounter Provider Record (TEPRV) shows the provider to be contracted.

1.4.3 Preventive Services

1.4.3.1 Based upon the NDAA for FY 2009 (Public Law 110-417, Section 711), effective for dates of service on or after October 14, 2008, no copayments or authorizations are required for the following preventive services as described in the TPM, [Chapter 7, Sections 2.1 and 2.5](#):

1.4.3.1.1 Colorectal cancer screening.

1.4.3.1.2 Breast cancer screening.

1.4.3.1.3 Cervical cancer screening.

1.4.3.1.4 Prostate cancer screening.

1.4.3.1.5 Immunizations.

1.4.3.1.6 Well-child visits for children under six years of age.

1.4.3.1.7 Visits for all other beneficiaries over age six when the purpose of the visit is for one or more of the covered benefits listed in [paragraphs 1.4.3.1.1 through 1.4.3.1.5](#). If one or more of the procedure codes described in the TPM, [Chapter 7, Section 2.1](#) for those preventive services listed in [paragraphs 1.4.3.1.1 through 1.4.3.1.5](#) is billed on a claim, then the cost-share is waived for the visit. However, services other than the covered benefits listed above that are provided during the same visit are subject to appropriate cost-sharing and deductibles.

1.4.3.2 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.

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

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

1.4.3.5 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 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.

1.5 Cost-Shares: Ambulance Services

1.5.1 For the basis of payment of ambulance services, see [Chapter 1, Section 14](#).

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Section 1

Cost-Shares And Deductibles

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

1.5.2.1 TRICARE Prime

1.5.2.1.1 For care provided prior to April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$10. For care provided on or after April 1, 2001, for ADFMs in pay grades E-1 through E-4, \$0. See [Addendum A](#) for further information.

1.5.2.1.2 For care provided prior to April 1, 2001, for ADFMs in pay grades E-5 and above, \$15. For care provided on or after April 1, 2001, for ADFMs in pay grades E-5 and above, \$0. See [Addendum A](#) for further information.

1.5.2.1.3 For retirees and their family members, \$20.

1.5.2.2 TRICARE Extra

1.5.2.2.1 A cost-share of 15% of the fee negotiated by the contractor for ADFMs.

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

1.5.2.3 TRICARE Standard

1.5.2.3.1 A cost-share of 20% of the allowable charge for ADFMs.

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

1.5.2.4 Inpatient: Non-Network Providers

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

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

1.5.2.5 Exceptions

1.5.2.5.1 Inpatient Cost-share Applicable To Each Separate Admission

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

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

1.5.2.5.1.2 Certain heart and lung hospitals are excepted from cost-share requirements. See [Chapter 1, Section 27](#), entitled "Legal Obligation To Pay".

1.5.2.5.2 Inpatient Cost-Share: Maternity Care

See [paragraph 1.3.3.3](#). All admissions related to a single maternity episode shall be considered one confinement regardless of the number of days between admissions. For ADFMs, the cost-share will be applied to the first institutional claim received.

1.5.2.5.3 Special Cost-Share Provisions

Effective October 1, 1987, the inpatient cost-share amount from DRG-exempt institutional provider claims in the following categories cannot exceed that which would have been imposed if the service were subject to the DRG-based payment system. This will not affect ADFMs. For all other beneficiaries, the cost-share shall be the lesser of:

- That calculated according to [paragraph 1.3.3.2.2](#); or
- That calculated according to [paragraph 1.3.3.4.2](#).

1.5.2.5.3.1 Child Bone Marrow Transplant (BMT)

All services related to discharges involving **BMT** for a beneficiary less than 18 years old with International Classification of Diseases, 9th Revision, Clinical Modification (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.

1.5.2.5.3.2 Child Human Immunodeficiency Virus (HIV) Seropositivity

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

1.5.2.5.3.3 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).

1.5.2.5.4 Cost-Sharing for Family Members of a Member who Dies While on Active Duty

Those in Transitional Survivor status, are not distinguished from other ADFMs for cost-sharing purposes. After the Transitional Survivor status ends, eligible TRICARE beneficiaries may be placed in Survivor status and will be responsible for retiree cost-shares. See the Transitional Survivor Status policy in the TPM, [Chapter 10, Section 7.1](#).

1.6 Catastrophic Loss Protection

See [Section 2](#).

- END -

Benefits And Beneficiary Payments Under The TRICARE Program

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 Urban Consumer Price Index (CPI-U) medical index (the medical component of the CPI-U). Beneficiary cost-shares (i.e., beneficiary payments expressed as a percentage of the provider's fee) will not be similarly updated.

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:

1.0 TRICARE PRIME PROGRAM ANNUAL ENROLLMENT FEES

Does not apply to the TRICARE Extra Program (also see [paragraph 5.0](#), "Point of Service (POS) Option"):

TRICARE PRIME PROGRAM		
ACTIVE DUTY FAMILY MEMBERS (ADFM)s		RETIREES, THEIR FAMILY MEMBERS, ELIGIBLE FORMER SPOUSES, & SURVIVORS
E1 - E4	E5 & ABOVE	
None	None	\$230 per Retiree or Family Member \$460 Maximum per Family 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.

2.0 TRICARE STANDARD AND EXTRA PROGRAM ANNUAL FISCAL YEAR DEDUCTIBLE

Applies to all outpatient services, does not apply to the TRICARE Prime Program (also see [paragraph 5.0](#), "POS Option"):

TRICARE STANDARD AND EXTRA PROGRAM		
ADFM)s		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

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

3.0 OUTPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 5)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMS		RETIREES, 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.	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 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.		
LABORATORY AND X-RAY SERVICES (see Note 2)	\$0 copayment per visit.	\$0 copayment per visit.	\$12 copayment per visit (see Note 2).		
ANCILLARY SERVICES Refer to Section 1 for specific CPT code ranges.	\$0 copayment per visit.	\$0 copayment per visit.	No copayment (see Note 1).		
ROUTINE PAP SMEARS Frequency to depend on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology (see Note 2).	No copayment.	No copayment.	No copayment.		

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 5)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
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.	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.
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.1		
DME, HEARING AIDS FOR ADFMs, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED BENEFITS (If dispensed for use outside of the office or after the home visit.)	\$0 copayment per visit.	\$0 copayment per visit.	Cost-share - 20% of the fee negotiated by the contractor.		

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 5)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
<p>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.</p>	\$0 copayment.	\$0 copayment.	\$0 copayment.	\$0 cost-share.	\$0 cost-share.
<p>HOSPICE CARE Note: A separate cost-share may be (optional) collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.</p>					

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 5)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
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 2).	ADFMs: Cost-share--15% of the fee negotiated by contractor.	ADFMs: Cost-share--20% 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.
AMBULATORY SURGERY (same day) Authorized hospital-based or freestanding Ambulatory Surgical Center (ASC) that is TRICARE certified.	\$0 copayment per visit.	\$0 copayment per visit.	\$25 copayment.	ADFMs: Cost-share--\$25. for ASC.	ADFMs: \$25.
ALL SURGICAL PROCEDURES REGARDLESS OF WHERE THEY ARE PERFORMED With the exclusion of those surgical procedures referenced Section 1, paragraphs 1.2.4.5 and 1.2.4.7.				Retirees, their Family Members, & Survivors: Cost-share--20% of the fee negotiated by the contractor.	Retirees, their Family Members, & Survivors: Lesser of 25% of group rate or 25% of billed charge.
BIRTHING CENTER Prenatal care, outpatient delivery, and postnatal care provided by TRICARE authorized birthing center.					

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

3.0 OUTPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE (SEE POS OPTION)					
TRICARE BENEFITS	TRICARE PRIME PROGRAM (SEE NOTE 5)			TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMS		RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
	E1 - E4	E5 & ABOVE			
IMMUNIZATIONS (See Note 4) 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.	ADFMs: Cost-share--20% of the allowable charge.
EYE EXAMINATIONS (See Note 4) 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 4)	Retirees, their Family Members, & Survivors: Not covered under TRICARE Extra.	Retirees, their Family Members, & Survivors: Not covered under TRICARE Standard.
CLINICAL PREVENTIVE SERVICES Includes those services listed in the TPM, Chapter 7, Sections 2.1, 2.2, and 2.5.	\$0 copayment.	\$0 copayment.	\$0 copayment.	ADFMs: Cost-share--15% of the fee negotiated by contractor.	ADFMs: Cost-share--20% of the allowable charge.
				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.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

4.0 INPATIENT SERVICES

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFM's	RETIREEES, THEIR FAMILY MEMBERS, & SURVIVORS		
<p>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.</p>	\$0 copayment per visit.	<p>\$11 per diem charge (\$25 minimum charge per admission).</p> <p>No separate copayment/cost-share for separately billed professional charges.</p>	<p>ADFM's: Per diem charge (\$25 minimum charge per admission). No separate cost-share for separately billed professional charges.</p> <p>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).</p>	<p>ADFM's: Per diem charge (\$25 minimum charge per admission). No separate cost-share for separately billed professional charges.</p> <p>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.</p>
<p>MATERNITY Hospital and professional services (prenatal, delivery, postnatal).</p>				

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMs	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
NEWBORN/ADOPTEE CARE (see Note 8) 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 fourth 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 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>

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMs	RETIREEES, THEIR FAMILY MEMBERS, & SURVIVORS		
NEWBORN/ADOPTEE CARE (see Note 8) (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>

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFM's	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
<p>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.</p>	\$0 copayment per visit.	<p>\$11 per diem charge (\$25 minimum charge per admission).</p> <p>No separate copayment/cost-share for separately billed professional charges.</p>	<p>ADFM's: Per diem charge (\$25 minimum charge per admission).</p> <p>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).</p>	<p>ADFM's: Per diem charge (\$25 minimum charge per admission).</p> <p>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.</p>

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

4.0 INPATIENT SERVICES (CONTINUED)

BENEFICIARY COPAYMENT/COST-SHARE				
TRICARE STANDARD BENEFITS	TRICARE PRIME PROGRAM		TRICARE EXTRA PROGRAM	TRICARE STANDARD PROGRAM
TYPE OF SERVICE (SEE NOTE 7)	ADFMs	RETIREES, 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>	<p>\$0 copayment per visit.</p>	<p>\$40 per diem charge.</p> <p>No separate copayment/cost-share for separately billed professional charges.</p>	<p>ADFMs: \$20 per diem charge (\$25 minimum charge per admission).</p> <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>ADFMs: \$20 per diem charge (\$25 minimum charge per admission).</p> <p>Retirees, their Family Members, & Survivors: Inpatient High Volume Hospital: Cost-share--25% hospital specific per diem.</p> <p>Inpatient Low Volume Hospital: Lower of fixed daily amount or 25% hospital billed charges.</p> <p>RTC: Cost-share--25% of the TRICARE allowed amount.</p> <p>Partial Hospitalization: Cost-share--25% of the TRICARE allowed amount. Plus, 25% cost-share of allowable charges for separately billed professional charges.</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>				
<p>PARTIAL HOSPITALIZATION-MENTAL HEALTH With authorization, up to 60 days per fiscal year (minimum of three hours/day of therapeutic services).</p>				

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

5.0 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 7)	ADFM's	RETIREES, THEIR FAMILY MEMBERS, & SURVIVORS		
A Prime enrollee may receive services under the Point of Service option by self-referring for non-emergency care. Refer to Section 3, for policy on the POS option.	<p>Outpatient Deductible: \$300.00 individual \$600.00 family.</p> <p>Inpatient and Outpatient Cost-Share: 50% of the allowed charges (see Note 9).</p>	<p>Outpatient Deductible: \$300.00 individual \$600.00 family.</p> <p>Inpatient and Outpatient Cost-Share: 50% of the allowed charges (see Note 9).</p>	POS option does NOT apply to TRICARE Extra beneficiaries.	POS option does NOT apply to TRICARE Standard beneficiaries.

Refer to Section 2 for information on catastrophic loss protection.

Note 1: 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.

Note 2: 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 Section 1, paragraphs 1.3.3.10 and 1.4.3.**

Note 3: For dates of service on or after March 26, 1998, under TRICARE Prime, services defined as "ancillary services" in Section 1 require no copayment.

Note 4: Additional immunizations and eye examinations are covered under the TRICARE Prime Program's "clinical preventive services". See the TPM, Chapter 7, Section 2.2.

Note 5: 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 6: **Cost-shares are waived for certain preventive services under TRICARE Standard and Extra as described in Section 1, paragraphs 1.3.3.10 and 1.4.3. See Chapter 7, Sections 2.1, 2.2, and 2.5.**

Note 7: No enhanced outpatient benefits under the TRICARE Extra Program.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 2, Addendum A

Benefits And Beneficiary Payments Under The TRICARE Program

Note 8: The TRICARE Regional Director (RD) and 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.

Note 9: TRICARE reimbursement will be limited to 50% of the billed/allowed charges.

- END -

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging