TRICARE® Covered Services

Take an active role in verifying your TRICARE coverage

TRICARE covers most care that is medically necessary and considered proven. There are special rules and limitations for certain types of care, and some types of care are not covered at all. TRICARE policies are very specific about which services are covered and which are not. It is in your best interest to take an active role in verifying your coverage.

To verify coverage, visit www.tricare.mil/coveredservices or call your regional contractor.

Note: Overseas, all host nation care must meet TRICARE’s policies for coverage. You are financially responsible for 100 percent of the cost for care that TRICARE does not cover. Beneficiary category and location determine which overseas program options are available to you. Each program option has specific guidelines about how to access care. Check with your TRICARE Overseas Program (TOP) Regional Call Center before visiting host nation providers.

OUTPATIENT SERVICES

Ambulance Services

The following ambulance services are covered:

• Emergency transfers between a beneficiary’s home, accident scene, or other location and a hospital
• Transfers between hospitals
• Ambulance transfers from a hospital-based emergency room to a hospital more capable of providing the required care
• Transfers between a hospital or skilled nursing facility and another hospital-based or freestanding outpatient therapeutic or diagnostic department/facility

The following are excluded:

• Use of an ambulance service instead of taxi service when the patient’s condition would have permitted use of regular private transportation
• Transport or transfer of a patient primarily for the purpose of having the patient nearer his or her home, family, friends, or primary physician

• Medicabs or ambicabs that function primarily as public passenger conveyances transporting patients to and from their medical appointments

Note: Air or boat ambulance is only covered when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the beneficiary to the nearest hospital with appropriate facilities, and the patient’s medical condition warrants speedy admission or is such that transfer by other means is not advisable.

Note that overseas, aeromedical evacuations, or air evacuations, for emergency care are only approved when medically necessary. TOP Standard, TRICARE For Life, TRICARE Young Adult Standard, TRICARE Reserve Select, and TRICARE Retired Reserve beneficiaries are required to pay for air evacuation up front and file a claim for reimbursement (less any cost-shares).

TRICARE will only reimburse air evacuation when it is medically necessary and to the closest, safest location that can provide the required care. For more information about air evacuation overseas, contact your TOP Regional Call Center.

* Some health care services are covered by TRICARE only within the United States and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands), but are not covered overseas (e.g., skilled nursing facilities, home health care services, and hospice care).

Breast Pumps, Breast Pump Supplies, and Breast-feeding Counseling

Beginning December 19, 2014, breast pumps, breast pump supplies, and breast-feeding counseling are covered for all pregnant TRICARE beneficiaries and TRICARE beneficiaries who plan to breast-feed an adopted infant.

You are covered to receive one pump per birth or adoption. For your pump to be covered by TRICARE, you must get a prescription from a TRICARE-authorized provider. You may get your pump and supplies from any TRICARE-authorized

This fact sheet is not all-inclusive. For additional information, please visit www.tricare.mil.

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provider or retail store or pharmacy. No cost-shares or copayments will apply to the purchase of these breast-feeding services and supplies.

Heavy-duty hospital-grade breast pumps are also covered in certain situations.

For more details, contact your regional contractor.

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies**

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are generally covered if prescribed by a physician and if directly related to a medical condition. Covered DMEPOS generally include:

- DMEPOS that are medically necessary and appropriate and prescribed by a physician for a beneficiary’s specific use.
- Duplicate DMEPOS items that are necessary to provide a fail-safe, in-home life-support system. In this case, “duplicate” means an item that meets the definition of DMEPOS and serves the same purpose, but may not be an exact duplicate of the original DMEPOS item. For example, a portable oxygen concentrator may be covered as a backup for a stationary oxygen generator.

**Laboratory and X-ray Services**

Laboratory and X-ray services are generally covered if prescribed by a physician. Laboratory-developed tests (LDTs) must be FDA-approved and medically necessary.

**Note:** Non-FDA-approved LDTs may be covered under the Non-FDA Approved LDTs Demonstration Project. For more information, visit [www.tricare.mil/ldt](http://www.tricare.mil/ldt).

**Respite Care for Active Duty Service Members**

Respite care is covered for ADSMs who are homebound as a result of a serious injury or illness incurred while serving on active duty. Respite care is available if the ADSM’s plan of care includes frequent interventions by the primary caregiver.*

The following respite care limits apply:

- Five days per calendar week
- Eight hours per calendar day

Respite care must be provided by a TRICARE-authorized home health care agency and requires prior authorization from the regional contractor and the ADSM’s approving authority (e.g., the Defense Health Agency—Great Lakes or referring military hospital or clinic). The ADSM is not required to enroll in the TRICARE Extended Care Health Option (ECHO) program to receive the respite care benefit.

* More than two interventions are required during the eight-hour period per day that the primary caregiver would normally be sleeping.

**INPATIENT SERVICES**

**Hospitalization (semiprivate room or special care units when medically necessary)**

Hospitalization covers general nursing; hospital, physician, and surgical services; meals (including special diets); medications; operating and recovery room care; anesthesia; laboratory tests; X-rays and other radiology services; medical supplies and appliances; and blood and blood products.

**Note:** Surgical procedures designated “inpatient only” may only be covered when performed in an inpatient setting.

**Skilled Nursing Facility Care (semiprivate room)**

Skilled nursing facility care covers skilled nursing services; meals (including special diets); physical and occupational therapy and speech pathology; TRICARE Pharmacy Program-approved or covered drugs furnished by the facility; and necessary medical supplies and appliances. TRICARE covers skilled nursing days only if they are medically necessary.

**Note:** TRICARE does not cover purely custodial care. Skilled nursing facilities are only covered in the United States and U.S. territories.

* Overseas, significant limitations apply.*
CLINICAL PREVENTIVE SERVICES

Comprehensive Health Promotion and Disease Prevention Examinations

Adult: An annual comprehensive clinical preventive examination is covered for beneficiaries of all TRICARE program options if it includes an immunization, breast cancer screening, cervical cancer screening, colon cancer screening, or prostate cancer screening.

TRICARE Prime beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without receiving an immunization, breast cancer screening, cervical cancer screening, colon cancer screening, or prostate cancer screening (one examination per age group): 18–39 and 40–64.

Pediatric: Preventive services for children from birth until reaching age six are covered by all TRICARE program options under the well-child care benefit (for more information on well-child care, see the Targeted Health Promotion and Disease Prevention Services section of this fact sheet). For children age 6 and older, an annual comprehensive clinical preventive examination is covered if it includes an immunization. School enrollment physicals for children ages 5–11 are also covered.

TRICARE Prime beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without receiving an immunization (one examination per age group): 6–11, 12–17.

Note: Annual sports physicals are not covered.

Targeted Health Promotion and Disease Prevention Services

The following screening examinations may be covered for all eligible beneficiaries when provided in conjunction with a comprehensive clinical preventive examination or during other patient encounters. The intent is to maximize preventive care.

Cancer Screenings

• Breast cancer screenings:
  • Clinical breast examination: For women under age 40, a clinical breast examination is covered during a preventive health visit. For women age 40 and older, an annual clinical breast examination is covered.
  • Mammograms: Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15 percent or greater lifetime risk of breast cancer (according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:
    • History of breast cancer, ductal carcinoma in situ, lobular carcinoma in situ, atypical ductal hyperplasia, or atypical lobular hyperplasia
    • Extremely dense breasts when viewed by mammogram
    • Known BRCA1 or BRCA2 gene mutation*
    • First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves*
    • Radiation therapy to the chest between ages 10 and 30
    • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes
  • Breast screening magnetic resonance imaging: Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20 percent or greater lifetime risk of breast cancer (according to risk-assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model), or who have any of the following risk factors:
    • Known BRCA1 or BRCA2 gene mutation*
    • First-degree relative (parent, child, sibling) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves*
    • Radiation to the chest between ages 10 and 30
    • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndromes, or a first-degree relative with a history of one of these syndromes
  * Listing of the BRCA1 or BRCA2 gene mutations as additional risk factors does not imply TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

• Cervical cancer screenings:
  • Human papillomavirus (HPV) DNA testing: Covered as a cervical cancer screening only when performed in conjunction with a Pap test, and only for women age 30 and older.
  • Pap tests: Covered annually for women starting at age 18 (younger if sexually active) or less often at patient and provider discretion (though not less than every three years).

• Colonoscopy:
  • Average risk: Once every 10 years beginning at age 50.
  • Increased risk: Once every five years for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp before reaching age 60, or colorectal cancer diagnosed in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second-degree relatives.
• High risk: Once every one to two years for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPPC. Optical colonoscopy should be performed beginning at age 20–25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn’s disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.

• Fecal occult blood testing: Covered annually starting at age 50.

• Proctosigmoidoscopy or sigmoidoscopy:
  - Average risk: Once every three to five years beginning at age 50
  - Increased risk: Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer
  - High risk: Annual flexible sigmoidoscopy, beginning at age 10–12, for individuals with known or suspected familial adenomatous polyposis

• Prostate cancer: A digital rectal examination and prostate-specific antigen screening is covered annually for certain high-risk men ages 40–49 and all men over age 50.

• Skin cancer: Examinations are covered at any age for beneficiaries who are at high risk due to family history, increased sun exposure, or clinical evidence of precursor lesions.

Cardiovascular Diseases

• Blood pressure screening: Screening is covered annually for children ages 3 until reaching age 6 and a minimum of every two years after reaching age 6 (children and adults).

• Cholesterol screening: Age-specific, periodic lipid panel as recommended by the National Heart, Lung, and Blood Institute.

Eye Examinations

• Well-child care coverage (infants and children until reaching age 6):
  - Infants (until reaching age 3): One eye and vision screening is covered at birth and at 6 months.
  - Children (from age 3 until reaching age 6): One routine eye examination is covered every two years. ADFM children are covered for one routine eye examination annually.

• Adults and children (over age 6): ADFMs receive one eye examination each year.

• Diabetic patients (any age): Eye examinations are not limited. One eye examination per year is recommended.

• Retired service members, their families, and others:
  - TRICARE Prime: Routine eye examination is covered once every two years.
  - TRICARE Standard: Eye examinations are not covered after reaching age 6.

Note: ADSMs enrolled in TRICARE Prime must receive all vision care at military hospitals or clinics unless specifically referred by their primary care managers (PCMs) to civilian network providers in their enrolled TRICARE region, or to non-network providers if a network provider is not available. ADSMs enrolled in TOP Prime Remote may obtain periodic eye examinations from network providers without prior authorization as needed to maintain fitness-for-duty status.

Hearing

Preventive hearing examinations are only allowed under the well-child care benefit. A newborn audiology screening should be performed on newborns before hospital discharge or within the first month after birth. Evaluative hearing tests may be performed at other ages during routine exams.

Immunizations

Age-appropriate vaccines, including annual flu vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). Coverage is effective the date the recommendations are published in the CDC’s Morbidity and Mortality Weekly Report. For more information, visit www.cdc.gov.

The HPV vaccine is a limited benefit and may be covered when the beneficiary has not been previously vaccinated or completed the vaccine series.

• Females: The HPV vaccine Gardasil (HPV4) or Cervarix (HPV2) is covered for females ages 11–26. The series of injections must be completed before reaching age 27 for coverage under TRICARE.

• Males: Gardasil is covered for all males ages 11–21 and is covered for males ages 22–26 who meet certain criteria.

A single dose of the shingles vaccine Zostavax is covered for beneficiaries age 60 and older.

Note: Vaccines for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered. Vaccines for personal overseas travel are not covered.

Infectious Disease Screening

TRICARE covers screening for infectious diseases, including: hepatitis B, rubella antibodies, and HIV, and screening and/or preventive treatment for tetanus, rabies, hepatitis A and B, meningococcal meningitis, and tuberculosis.
Patient and Parent Education Counseling
Counseling services expected of good clinical practice are included with the appropriate office visit and are covered at no additional charge. Examples include dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; dental health promotion; accident and injury prevention; stress; bereavement; and suicide risk assessment.

School Physicals
School physicals are covered for children ages 5–11 if required in connection with school enrollment.

Note: Annual sports physicals are not covered.

Well-Child Care (birth until reaching age 6)
Well-child care covers routine newborn care; comprehensive health promotion and disease prevention examinations; vision and hearing screenings; height, weight, and head circumference measurement; routine vaccines; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with American Academy of Pediatrics (AAP) and CDC guidelines. Your child can receive preventive-care well-child visits as frequently as the AAP recommends, but no more than nine visits in two years. Visits for diagnosis or treatment of an illness or injury are covered separately under outpatient care.

OUTPATIENT MENTAL HEALTH CARE SERVICES

Outpatient Psychotherapy
Referrals and prior authorizations may be required for certain outpatient services. ADSMs should always seek nonemergency mental health care at military hospitals and clinics when available. If services are not available, ADSMs must obtain referrals from their military hospital or clinic or service point of contact (SPOC) before receiving civilian care. All other TRICARE beneficiaries (non-ADSMs) do not need referrals or prior authorizations for the first eight outpatient mental health care visits per fiscal year (FY) (October 1–September 30) for a covered benefit, such as psychotherapy, to a network provider. Prior authorization from your regional contractor is required beginning with the ninth outpatient mental health care visit per FY. Care access and rules vary by beneficiary type, location, and TRICARE program option.

Physician referral and supervision may be required when seeing mental health counselors and are always required when seeing pastoral counselors.

Note: Overseas, additional limitations on mental health care services may apply.

The following outpatient psychotherapy limits apply:

- **Psychotherapy:** Two sessions per week in any combination of the following types:
  - Individual (adult or child): 60 minutes per session; may extend to 120 minutes for crisis intervention
  - Family or conjoint: 90 minutes per session; may extend to 180 minutes for crisis intervention
  - Group: 90 minutes per session

- **Collateral visits:** Up to 60 minutes per visit are covered. Collateral visits are counted as individual psychotherapy sessions. Beneficiaries have the option of combining collateral visits with other individual or group psychotherapy visits.

Psychoanalysis
Psychoanalysis is long-term mental health therapy that explores unconscious thoughts to gain insight into behaviors and symptoms. Treatment must be given by approved providers who are specifically trained in psychoanalysis. Psychoanalysis always requires prior authorization.

Psychological Testing and Assessment
Testing and assessment are covered when medically or psychologically necessary and provided in conjunction with otherwise-covered psychotherapy or as a required part of the assessment and reassessment process for applied behavior analysis under the Comprehensive Autism Care Demonstration. For more information about testing and assessment related to autism care services, visit www.tricare.mil/autism.

Psychological tests are considered to be diagnostic services and are not counted toward the limit of two psychotherapy visits per week.

Limitations:

- Testing and assessment are generally limited to six hours per FY. Any testing beyond six hours requires a review for medical necessity. Psychological testing must be medically necessary and not for educational purposes.

Exclusions:

- Psychological testing is not covered for the following circumstances:
  - Academic placement
  - Job placement
  - Child custody disputes
  - General screening in the absence of specific symptoms
  - Teacher or parental referrals
  - Testing to determine whether a beneficiary has a learning disability
  - Diagnosed specific learning disorders or learning disabilities

Medication Management
If you take prescription medications for a mental health disorder you must be under the care of a provider who is authorized to prescribe those medications. Your provider will manage the dosage and duration of your prescription to ensure you are receiving the best care possible. Medication-management appointments are medical appointments and do not count toward the first eight outpatient mental health care visits per FY.
INPATIENT MENTAL HEALTH CARE SERVICES

Prior authorization is required for all nonemergency inpatient mental health care services. Psychiatric emergencies do not require prior authorization for inpatient admission, but authorization is required for continued stay. Admissions resulting from psychiatric emergencies should be reported to your regional contractor within 72 hours of admission. Authorization is required for continued stay and is coordinated between the inpatient unit and the regional contractor. ADSMs who receive care at military hospitals and clinics do not require prior authorization. Emergency and inpatient hospital services are considered medically necessary only when the patient’s condition requires hospital personnel and facilities. Generally, these services may be medically necessary in certain detoxification circumstances or for stabilization of a medical condition.

Note: Overseas, additional limitations on mental health care services may apply.

Acute Inpatient Psychiatric Care

Acute inpatient psychiatric care may be covered on an emergency or nonemergency basis. Prior authorization from your regional contractor is required for nonemergency inpatient admissions. In emergency situations, authorization is required for continued stay.

Limitations:
• Patients age 19 and older: 30 days per FY or in any single admission
• Patients age 18 and younger: 45 days per FY or in any single admission

Inpatient admissions for substance use disorder detoxification and rehabilitation count toward the 30- or 45-day limit for acute inpatient psychiatric care. Limitations may be waived if determined to be medically or psychologically necessary.

Psychiatric Partial Hospitalization Program

Psychiatric partial hospitalization programs (PHPs) are capable of providing an interdisciplinary program of therapeutic services at least three hours a day, five days a week, in any combination of day, evening, night, and weekend treatment programs. The following rules apply:
• Prior authorization from your regional contractor is required. PHP admissions are not considered emergencies.
• Facilities must be TRICARE-authorized.
• PHPs must agree to participate in TRICARE.

Limitations:
PHP care is limited to 60 treatment days (whether full- or partial-day treatment) per FY. These 60 days are not offset by or counted toward the 30- or 45-day inpatient limit for acute inpatient psychiatric care.

Limitations may be waived if determined to be medically or psychologically necessary.

Psychiatric Residential Treatment Center Care

TRICARE covers psychiatric residential treatment center (RTC) extended care for children and adolescents with psychological disorders that require continued treatment in a therapeutic environment. The following rules apply:
• Facilities must be TRICARE-authorized.
• Unless therapeutically contraindicated, the family and/or guardian should actively participate in the continuing care of the patient through either direct involvement at the facility or geographically distant family therapy.
• Prior authorization from your regional contractor is always required.
• RTC care is considered elective and is not considered an emergency.
• Admission primarily for substance use rehabilitation is not authorized for psychiatric RTC care.
• In an emergency, psychiatric inpatient hospitalization must be sought first.
• Care must be recommended and directed by a psychiatrist or clinical psychologist.

Limitations:
• Care is limited to 150 days per FY or in any single admission.
• RTC care is only covered for patients until reaching age 21.
• RTC care does not count toward the 30- or 45-day inpatient limit.

Limitations may be waived if determined to be medically or psychologically necessary.

SUBSTANCE USE DISORDER SERVICES

Substance use disorders include alcohol or drug abuse or dependence. For TRICARE to reimburse the cost of care, you must see a TRICARE-authorized institutional provider—an authorized hospital or an organized treatment program in an authorized freestanding or hospital-based substance use disorder rehabilitation facility. TRICARE covers substance use disorder services up to three benefit periods per beneficiary, per lifetime.

Inpatient Detoxification

TRICARE covers emergency and inpatient hospital services when medically necessary for the treatment of the acute phases of substance use withdrawal (detoxification) when the patient’s condition requires the personnel and facilities of a hospital or substance use disorder rehabilitation facility (SUDRF).

Limitations:
• Diagnosis-related group (DRG) exempt facility: seven days per episode count toward the FY 30- or 45-day inpatient psychiatric care limit. However, DRG exempt facility detoxification does not count toward the three lifetime episodes of care limit.
• Inpatient detoxification in a freestanding SUDRF counts toward the 30- or 45-day inpatient psychiatric care limit.
Rehabilitation
Rehabilitation of a substance use disorder may occur in an inpatient (residential) or partial hospitalization setting. TRICARE covers 21 days of rehabilitation per benefit period in a TRICARE-authorized facility, whether inpatient or partial hospitalization or a combination of both.

Limitations:
- 21-day rehabilitation limit per episode
- Three episodes per lifetime
- Counts toward the 30- or 45-day limit for acute inpatient psychiatric care

Limitations may be waived if determined to be medically or psychologically necessary.

* A benefit period begins with the first day of covered treatment and ends 365 days later.

Substance Use Disorder Rehabilitation Facility Outpatient Care
Outpatient substance use care must be provided by an approved SUDRF.

Limitations:
- Individual or group therapy: 60 visits per benefit period*
- Family therapy: 15 visits per benefit period*
- Partial hospitalization care: 21 treatment days per FY

Limitations may be waived if determined to be medically or psychologically necessary.

* A benefit period begins with the first day of covered treatment and ends 365 days later.

Botulinum Toxin (Botox) Injections
Botox injections for cosmetic procedures, among other examples, such as certain types of headaches or muscle spasms, are not covered. Cost-sharing may apply for injections to treat certain other defined conditions.

Cardiac and Pulmonary Rehabilitation
Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.

Cosmetic, Plastic, or Reconstructive Surgery
Surgery is only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after cancer surgery, reconstruct the breast after cancer surgery, or when medically necessary.

Cranial Orthotic Device or Molding Helmet
Cranial orthotic devices are covered for adjunctive use for infants from ages 3–18 months whose synostosis has been surgically corrected, but who still have moderate to severe cranial deformities. Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery.

Dental Care and Dental X-rays
Both are covered only for adjunctive dental care (i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition). Prior authorization is required for adjunctive dental care.

Diagnostic Genetic Testing
Testing is covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient. The test must be FDA-approved. Routine genetic testing is not covered.

Education and Training
Education and training are only covered under ECHO, the Comprehensive Autism Care Demonstration, and diabetic outpatient self-management training services. Diabetic outpatient self-management training services must be performed by programs approved by the American Diabetes Association. The provider’s “Certificate of Recognition” from the American Diabetes Association must accompany the claim for reimbursement.
Eyeglasses or Contact Lenses
ADSMs may receive eyeglasses at military hospitals or clinics at no cost. For all other beneficiaries, the following are covered:

- Contact lenses and/or eyeglasses for treatment of infantile glaucoma
- Corneal or scleral lenses for treatment of keratoconus
- Scleral lenses to retain moisture when normal tearing is not present or is inadequate
- Corneal or scleral lenses to reduce corneal irregularities other than astigmatism
- Intraocular lenses, contact lenses, or eyeglasses for loss of human lens function resulting from intraocular surgery, ocular injury, or congenital absence

Note: Adjustments, cleaning, and repairs for eyeglasses are not covered.

Facility Charges for Non-Adjunctive Dental Services
Generally, dental care is not covered as a TRICARE medical benefit, but instead is covered under the dental benefit. This includes situations that are dental emergencies. Hospital and anesthesia charges related to routine dental care for children under age 5, or those with disabilities, may be covered in addition to dental care related to some medical conditions.

Note: Prior authorization is required.

Food, Food Substitutes and Supplements, or Vitamins
Medically necessary nutritional formulas are covered when used as the primary source of nutrition for enteral, parenteral, or oral nutritional therapy. Intraperitoneal nutrition therapy is covered for malnutrition as a result of end-stage renal disease. Ketogenic diets may be cost-shared if part of a medically necessary admission for epilepsy. Vitamins may be cost-shared only when used as a specific treatment of a medical condition. Additionally, prenatal vitamins that require a prescription may be cost-shared, but are covered for prenatal care only.

Hearing Aids
Hearing aids are covered only for ADFMs who meet specific hearing loss requirements.

- Hearing aids are excluded under any circumstances for retirees, retiree family members, TRICARE Reserve Select (TRS) members, and TRICARE Retired Reserve (TRR) members.
- TRICARE Young Adult coverage for hearing aids depends on the young adult’s sponsor status. If the sponsor is an ADSM, hearing aids are covered the same as for an ADFM. If the sponsor is a TRS member, retiree, or TRR member, hearing aids are excluded under any circumstances.

Laser/LASIK/Refractive Corneal Surgery
Surgery is covered only to relieve astigmatism following a corneal transplant.

Private Hospital Rooms
Private rooms are not covered unless ordered for medical reasons or because a semiprivate room is not available. Hospitals that are subject to the TRICARE DRG payment system may provide the patient with a private room, but will receive only the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.

Reproductive Services
Generally, assisted reproductive services and noncoital reproductive procedures, including artificial insemination, in vitro fertilization, and gamete intrafallopian transfer, are not covered under TRICARE. However, there are some types of infertility assessment, testing, and care that TRICARE may cover only when used in conjunction with natural conception.

Assisted reproductive services may also be available to service members who have sustained serious or severe illness or injury while on active duty that led to the loss of their natural reproductive ability, including (but not limited to) those with neurological, physiological, and/or anatomical injuries.

For more information, contact your PCM or SPOC or visit www.tricare.mil/coveredservices.

Shoes, Shoe Inserts, Shoe Modifications, and Arch Supports
Shoe and shoe inserts are covered only in very limited circumstances. Orthopedic shoes may be covered if they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered.

Tobacco-Cessation Medications
TRICARE covers prescription and over-the-counter medications to help you quit tobacco, except when these medications are purchased at a retail pharmacy. Covered tobacco-cessation medications are available in the United States for TRICARE beneficiaries age 18 and older who are not eligible for Medicare. Overseas, the medications are available to ADSMs and their dependents enrolled in a TRICARE Prime option at military pharmacies and through TRICARE Pharmacy Home Delivery (where available, including in the U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

For more information, visit www.tricare.mil/quittobacco.
EXCLUSIONS

The following specific services are excluded under any circumstances. This list is not all-inclusive. Check your regional contractor’s Web site for additional information.

Note: Medical services that are needed as a result of receiving an excluded medical service are not covered.

- Acupuncture (may be offered at some military hospitals or clinics and approved for certain ADSMs, but is not covered for care received by civilian providers)
- Alterations to living spaces
- Autopsy services or post-mortem examinations
- Birth control/contraceptives (non-prescription)
- Camps (e.g., for weight loss)
- Charges that providers may apply to missed or rescheduled appointments
- Chiropractors and naturopaths
- Counseling services that are not medically necessary for the treatment of a diagnosed medical condition (e.g., educational, vocational, and socioeconomic counseling; stress management; lifestyle modification)
- Custodial care
- Diagnostic admissions
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chair lifts
- Exercise equipment, spas, whirlpools, swimming pools, health club memberships, or other such charges or items
- Experimental or unproven procedures (unless authorized under specific exceptions in TRICARE regulations)
- Foot care (routine), except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs, such as severe diabetes
- General exercise programs, even if recommended by a physician and regardless of whether rendered by an authorized provider
- Inpatient stays:
  - For rest or rest cures
  - To control or detain a runaway child, whether or not admission is to an authorized institution
  - To perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis
  - In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- Learning-disability services
- Medications:
  - Drugs prescribed for cosmetic purposes
  - Fluoride preparations
  - Food supplements
  - Homeopathic and herbal preparations
  - Multivitamins
  - Over-the-counter products (except insulin and diabetic supplies)
  - Weight reduction products
  - Megavitamins and orthomolecular psychiatric therapy
  - Mind-expansion and elective psychotherapy
  - Non-surgical treatment of obesity or morbid obesity
  - Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone
- Postpartum inpatient stay for a mother to stay with a newborn infant (usually primarily for the purpose of breast-feeding the infant) when the infant (but not the mother) requires the extended stay, or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay
- Psychiatric treatment for sexual dysfunction
- Services and supplies:
  - Provided under a scientific or medical study, grant, or research program
  - Furnished or prescribed by an immediate family member
  - For which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE-eligible
  - Furnished without charge (i.e., cannot file claims for services provided free of charge)
  - For the treatment of obesity, such as diets, weight-loss counseling, weight-loss medications, wiring of the jaw, or similar procedures
  - Inpatient stays directed or agreed to by a court or other governmental agency (unless medically necessary)
  - Required as a result of occupational disease or injury for which any benefits are payable under a workers’ compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted
  - That are (or are eligible to be) fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (for which TRICARE is the last payer for any remaining charges)
• Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth
• Sterilization reversal surgery
• Surgery performed primarily for psychological reasons (e.g., psychogenic surgery)
• Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE

• Transportation, except by ambulance
• X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer screening and other tests allowed under the clinical preventive services benefit

FOR INFORMATION AND ASSISTANCE

<table>
<thead>
<tr>
<th>Region</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRICARE North Region</strong></td>
<td>Health Net Federal Services, LLC 1-877-TRICARE (1-877-874-2273) <a href="http://www.hnfs.com">www.hnfs.com</a></td>
</tr>
<tr>
<td><strong>TRICARE South Region</strong></td>
<td>Humana Military, a division of Humana Government Business 1-800-444-5445 HumanaMilitary.com</td>
</tr>
<tr>
<td><strong>TRICARE West Region</strong></td>
<td>UnitedHealthcare Military &amp; Veterans 1-877-988-WEST (1-877-988-9378) <a href="http://www.uhc">www.uhc</a> milit arywest.com</td>
</tr>
<tr>
<td><strong>TRICARE Overseas Program (TOP) Regional Call Center—Eurasia-Africa¹</strong></td>
<td>+44-20-8762-8384 (overseas) 1-877-678-1207 (stateside) <a href="mailto:tricarelon@internationalsos.com">tricarelon@internationalsos.com</a></td>
</tr>
<tr>
<td><strong>TOP Regional Call Center—Latin America and Canada¹</strong></td>
<td>+1-215-942-8393 (overseas) 1-877-451-8659 (stateside) <a href="mailto:tricarephi@internationalsos.com">tricarephi@internationalsos.com</a></td>
</tr>
<tr>
<td><strong>TOP Regional Call Centers—Pacific¹</strong></td>
<td>Singapore: +65-6339-2676 (overseas) 1-877-678-1208 (stateside) <a href="mailto:sin.tricare@internationalsos.com">sin.tricare@internationalsos.com</a> Singapore: +61-2-9273-2710 (overseas) 1-877-678-1209 (stateside) <a href="mailto:sydtricare@internationalsos.com">sydtricare@internationalsos.com</a></td>
</tr>
<tr>
<td><strong>TRICARE Pharmacy Program</strong></td>
<td>1-877-363-1303 1-877-540-6261 (TDD/TTY) <a href="http://www.express-scripts.com/TRICARE">www.express-scripts.com/TRICARE</a> <a href="http://www.tricare.mil/pharmacy">www.tricare.mil/pharmacy</a> Express Scripts Member Choice Center (convert retail prescriptions to home delivery) 1-877-363-1433</td>
</tr>
<tr>
<td><strong>TRICARE Web Site</strong></td>
<td><a href="http://www.tricare.mil">www.tricare.mil</a></td>
</tr>
</tbody>
</table>

¹ For toll-free contact information, visit www.tricare-overseas.com.

An Important Note About TRICARE Program Information

At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. Military hospital and clinic guidelines and policies may be different than those outlined in this publication. For the most recent information, contact your TRICARE regional contractor or local military hospital or clinic. The TRICARE program meets the minimum essential coverage requirement under the Affordable Care Act.

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