



TRICARE® Covered Benefits and Services



HUMANA MILITARY
HEALTHCARE SERVICES
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TRICARE covers most medically necessary inpatient and outpatient care. This chart provides an overview of the special rules and limits for TRICARE-covered benefits and services. This overview is not all-inclusive. For additional details, see Sections 5 and 7 of the *TRICARE Provider Handbook*, visit www.humana-military.com, or call 1-800-444-5445.

Covered Outpatient and Inpatient Services

Service	Coverage Details	Prior Authorization Requirements ¹
Adjunctive Dental Care	<ul style="list-style-type: none"> Covered when medically necessary 	<ul style="list-style-type: none"> Required Emergency adjunctive care does not require prior authorization
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	<ul style="list-style-type: none"> Medical equipment or supplies needed by patient in order to arrest or reduce functional loss Must be ordered by a physician 	<ul style="list-style-type: none"> A prescription requesting DMEPOS and signed by the beneficiary's physician is required for rental or purchase of DMEPOS. Prescriptions must specify the beneficiary's diagnosis, the particular type of equipment needed, the reason it is needed, and the duration for which it will be needed. A certificate of medical necessity may be accepted in place of a prescription.
Emergency Care	<ul style="list-style-type: none"> Covered for qualified medical, maternity, and psychiatric conditions Ambulance services covered for emergency situations 	<ul style="list-style-type: none"> In all emergency situations, the TRICARE Prime beneficiary must notify his or her primary care manager (PCM) or Humana Military of any emergency inpatient admission within 24 hours or the next business day so that ongoing care can be coordinated. Requests for authorizations may be entered at www.humana-military.com or faxed to Humana Military at 1-877-548-1547.
Home Health Care (provided by participating home health care agencies)	<ul style="list-style-type: none"> Covers a limited number of hours per week of either part-time or intermittent services Patient must be confined to the home and under the care of a physician Plan of care is managed by the home health agency 	<ul style="list-style-type: none"> All home health services require prior authorization from Humana Military and must be renewed every 60 days.
Hospice Care	<p>Provided in three benefit periods:</p> <ul style="list-style-type: none"> First two benefit periods: 90 days long and begin on the day that the beneficiary signs the hospice election statement and both the attending physician and the hospice medical director sign the physician's certificate of terminal illness Final benefit period: Unlimited number of 60-day periods, each of which requires recertification of the terminal illness 	<ul style="list-style-type: none"> Required for all hospice care If patient does not meet criteria for admission for hospice services, the provider cannot bill TRICARE
Hospitalization (semiprivate room/special care units when medically necessary)	<ul style="list-style-type: none"> Covered services include: General nursing; hospital; physician and surgical services; meals (including special diets); drugs/medications; operating/recovery room care; anesthesia; laboratory tests; X-rays/other radiology services; medical supplies and appliances; and blood and blood products Surgical procedures considered "inpatient only" may only be covered when performed in an inpatient setting Semiprivate rooms and special care units may be covered if medically necessary 	<ul style="list-style-type: none"> Notify Humana Military by Web, fax, or Interactive Voice Response of inpatient admission within 24 hours or the next business day
Maternity Care	<ul style="list-style-type: none"> Medical services related to prenatal care, labor and delivery, and postpartum care Eligible beneficiaries can receive maternity care from the first obstetric visit through up to six weeks after the birth of the child 	<ul style="list-style-type: none"> Required for obstetric (inpatient and outpatient) care for TRICARE Prime, TRICARE Prime Remote (TPR), and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) beneficiaries (Obtain authorization at mother's first pregnancy-related appointment with the PCM or provider.) Maternity inpatient stays require additional prior authorization
Skilled Nursing Facility (SNF) Care	<ul style="list-style-type: none"> Covered when provided at a SNF rather than in a nursing home or in the patient's home TRICARE only covers care at Medicare-certified, TRICARE-participating SNFs in semiprivate rooms. TRICARE pays secondary to Medicare and other health insurance. TRICARE covers an unlimited number of days as medically necessary based on the Minimum Data Set assessments performed on scheduled intervals. 	<ul style="list-style-type: none"> Required
Urgent Care	<ul style="list-style-type: none"> Services covered when required for illness or injury that would not result in further disability or death if not immediately treated, but does require professional attention within 24 hours 	<ul style="list-style-type: none"> Urgent care for TRICARE Prime, TPR, and TPRADFM beneficiaries should be provided by their assigned PCMs unless beneficiaries have a referral from their PCM, or call Humana Military for assistance before receiving urgent care.

1. The prior authorization requirements listed here are not for beneficiaries using TRICARE For Life, unless the service is not covered by Medicare.

The information contained in these charts is not all-inclusive.



TRICARE Covered Benefits and Services

Covered Clinical Preventive Services

Service	Procedures and Frequency Limitations
Cancer Screenings	<ul style="list-style-type: none"> • Colonoscopy: Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50. • Increased Risk: Once every five years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or with two or more first-degree relatives at any age. Perform optical colonoscopy beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Perform an optical colonoscopy 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 HNPCC. Optical colonoscopy should be performed beginning at age 20 to 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 to 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: Perform either guaiac-based or immunochemical-based testing of three consecutive samples annually starting at age 50. • Mammograms: Perform a mammography annually beginning at age 40. For high-risk patients, perform a baseline mammogram at age 35 and annually thereafter. • Magnetic resonance imaging (MRI): Perform annually for asymptomatic beneficiaries (<i>age 30 or older under TRICARE Prime or age 35 or older under TRICARE Standard</i>) considered to be at high risk for developing breast cancer by American Cancer Society® guidelines, including women with: <ul style="list-style-type: none"> • BRCA1 or BRCA2 gene mutation • First-degree relative (<i>parent, child, or sibling</i>) with a BRCA1 or BRCA2 gene mutation • Lifetime risk of approximately 20–25 percent or greater as defined by BRCAPRO or other models that are largely dependent on family history • History of chest radiation between ages 10–30 • History of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndromes, or a first-degree relative with one of these syndromes • Proctosigmoidoscopy or sigmoidoscopy: Once every three to five years beginning at age 50. <ul style="list-style-type: none"> • Increased Risk: Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives. • High Risk: Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected familial adenomatous polyposis. • Prostate cancer: Perform a digital rectal exam and prostate-specific antigen screening annually for all men over 50; all men 45 or older with a family history of prostate cancer in at least one family member; African-American men age 45 or older regardless of family history; and all men 40 and older with a family history of prostate cancer in two or more family members. • Routine Pap smears: Perform a Pap smear annually, or less often, at patient and provider discretion (<i>though not less than every three years</i>), for women starting at age 18 (<i>younger if sexually active</i>). • Skin cancer: Exams are covered at any age for a beneficiary who is at high risk due to family history or increased sun exposure.
Cardiovascular	<ul style="list-style-type: none"> • Blood pressure screenings: Children ages 3–6, annually; children over age 6 and adults, minimum of every two years • Cholesterol test: A lipid panel cholesterol test is covered at least once every five years beginning at age 18
Hearing	Preventive hearing examinations are only covered under the well-child care benefit. All neonates should undergo audiology screening before leaving the hospital. If they are not tested at birth, infants should undergo audiology screening before one month of age. Hearing evaluations may be performed for all children during routine exams.
Human Papillomavirus (HPV)	Covered for all females ages 11–26 years who have not completed the vaccine series, regardless of sexual activity or clinical evidence of previous HPV infection. The vaccine is not covered after age 26.
Immunizations	<ul style="list-style-type: none"> • Age-appropriate vaccines, including influenza vaccines, as recommended by the Centers for Disease Control and Prevention. • Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations are also covered.
Infectious Disease Screening	Covered screenings for infectious diseases include rubella antibodies, and human immunodeficiency virus (HIV); screening and/or prophylaxis for tetanus, rabies, Rh immune globulin, hepatitis A, hepatitis B, meningococcal meningitis, and tuberculosis. Routine HPV screening is not covered.
Shingles Vaccine	The TRICARE medical (<i>not pharmacy</i>) benefit covers a single dose of the shingles vaccine Zostavax®, administered in a provider's office, for beneficiaries age 60 and older.
Well-Child Care (<i>birth to 6 years</i>)	Routine newborn care; comprehensive health promotion and disease prevention exams; vision and hearing screenings; height, weight, and head circumference measurement; routine immunizations; and developmental and behavioral appraisal.
Vision Coverage	Routine and comprehensive eye exams for a vision screening not related to another medical or surgical condition may be covered. Vision coverage varies based on beneficiary category, program option, and age.