Elite D, Value D & Core D GHS WI.IA
In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in the *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		✓
Ambulance – response but not transport		✓ Limitations and coverage guidelines established by Original Medicare
Any treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of that license.	✓	
Biofeedback, including psychiatric therapy with biofeedback, except when it is considered medically necessary and covered under Original Medicare.	✓	
Chelation therapy	✓	
Clinical trials are subject to all terms, conditions, restrictions, exclusions, and other coverage under our Plan.		✓ See Chapter 3 Section 5 for coverage of Medicare-approved clinical trials.
Colorectal cancer screening – CT colonography	✓	
Contraceptive management, including all services, items, supplies or drugs. Examples: Implantable contraceptive device and delivery system, cervical cap, condom, diaphragm, foam, gel, hormone patch, IUD, pills, spermicide, vaginal ring, elective sterilization procedures.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Dental care, non-routine		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Drugs (pill form and those used for self-injection) that meet the definition of a Part D drug; this includes drugs that may be provided or administered by staff, or self-administered in a hospital outpatient setting such as emergency room, observation unit, and surgery center or pain clinic if not required for the medical condition being treated. Please refer to Chapter 5 to determine your coverage in these situations.		✓ Limitations and coverage guidelines established by Original Medicare

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance).		✓ Covered when medically necessary
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
*Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		✓
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Immunizations when covered under Part D following Original Medicare guidelines, including but not limited to Zostavax and Tetanus-Diphtheria-Pertussis vaccines.	✓ Zostavax, Shingrix	✓ Tetanus-Diphtheria-Pertussis vaccines (when received for injury)
Naturopath services (uses natural or alternative treatments).	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Outpatient prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.	✓	
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone, a television, or a battery-operated fan.	✓	
Private duty nurse	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids. Radial keratotomy, LASIK surgery, vision therapy, other low vision aids, eyeglasses or contact lenses, intraocular lenses for vision correction (astigmatism or presbyopia).	✓ Repairs to eyewear	✓ See Vision care, in the Medical Benefits Chart in Section 2, above, for supplemental benefit information.
Replacement drugs due to being lost, stolen, damaged or destroyed.		✓
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care	✓ Chiropractic services for preventative/maintenance	✓ Manual manipulation of the spine to correct a subluxation, Lab and x-ray, examinations and therapies.
Routine foot care • The cutting or removal of corns and calluses. • The trimming, cutting, clipping, or debriding of nails. Other hygienic and preventative maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other services performed in the absence of localized illness, injury, or symptoms involving the foot.		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). See Podiatry services, in the Medical Benefits Chart in Section 2, above, for supplemental benefit information.
Routine or elective services, when provided by an out of network provider without prior approval by a Quartz Medicare Advantage Medical Director. Example: Lab work or medical care that is foreseen and not considered urgently needed services or a medical emergency.	✓	
Services considered not reasonable and necessary, according to the standards of Original Medicare		✓ Unless these services are listed by our plan as covered services

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.	✓	
Services provided under another plan for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. Examples include coverage by Workers' Compensation, medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation. If coverage under this legislation is optional for you because you could have elected it, or could have had it elected for you, benefits will not be paid for any injury or sickness that would have been covered under the other plan had it been elected.	✓	
Supportive devices for the feet Supportive devices for the feet (such as custom molded orthotics and removable foot inserts.)		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Surgical treatment for morbid obesity		✓ Limitations and coverage guidelines established by Original Medicare
Telemedicine or online services that are not included in the CMS covered Telehealth benefit.		✓
Third-party examinations and related services performed or requested for: licensing, insurance, sports physicals, or examinations ordered by a court are excluded unless otherwise stated as a Covered Service. Coverage will be provided if the third-party physical exam is substituted for a covered wellness exam if performed by a Plan Provider. Example: Screening for TB performed and/or requested by primary care provider (PCP)		✓ Coverage will be provided if the third-party physical exam is substituted for a covered wellness exam if performed by a Plan Provider.
Transportation which is routine or non-emergent by other transport providers or services. Examples: Taxi, bus or van	✓	
Weight loss treatment, including but not limited to medications, self-help groups, exercise and weight loss programs and dietary supplements.	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

*Immediate family is defined as spouse, mother, father, grandparents, children, grandchildren, brothers, sisters, mother-in-law, father-in-law, brothers-in-law, sisters-in-law, daughters-in-law, and sons-in-law. Adopted and step relationships are also included in immediate family.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.