Elite & EliteD UW

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *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
Ambulance – response but without transport		√ Limitations and coverage guidelines established by Original Medicare
Acupuncture	√	
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.	√	
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	√	
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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		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.	√	
Routine dental care such as fillings, dentures, treatment and removal (extraction) or replacement of teeth.	√	
Non-routine dental care	√	√ 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 Part D drug; this includes drugs that may be 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.		√ Limitations and coverage guidelines established by Original Medicare
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.	√	
Hearing aids or evaluations including the fitting, checking, repairs or modification of hearing aids or supplies (batteries).		√

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
See Hearing Aids, in the Medical Benefits Chart in Section 2, above, for supplemental benefit information.		
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	√ Tetanus-Diphtheria-Pertussis vaccines (when received for injury)
Naturopath services (uses natural or alternative treatments).	√	
Orthopedic and/or therapeutic 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 or a television.	√	
Private duty nurses	√	
Private room in a hospital.		√ Covered only when medically necessary.
Radial keratotomy, LASIK surgery, vision therapy and other low vision aids, eyeglasses or contact lenses, intraocular lenses for vision correction (astigmatism or presbyopia)	√ Repairs to eyewear	√ Coverage of one pair of eyeglasses or contact lenses following cataract operation; and, $300 toward purchase of eyeglasses or contact lenses annually.
Replacement drugs due to being lost, stolen, damaged or destroyed.		√
Reversal of sterilization procedures and or non-prescription contraceptive	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
supplies.		
Routine care not associated with the clinical trial is subject to all terms, conditions, restrictions, exclusions, and other coverage under our Plan.	√	
Routine chiropractic care	√ Chiropractic services for maintenance	√ Manual manipulation of the spine to correct subluxation, Lab and x-ray and examination
Routine foot care • The cutting or removal of corns and calluses • The trimming, cutting, clipping, or debriding of nails • Other hygienic and preventive 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 service performed in the absence of localized illness, injury, or symptoms involving the foot.		√ Medicare provides limited coverage for foot care and debridement with the presence of a qualifying systemic condition; secondary infection or pain; or, evidence of neuropathy but no vascular impairment.
Routine or elective services, when provided by non-plan providers without prior approval by Senior Preferred 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 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	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.		
Supplies, equipment, or drugs that do not require a prescription; or, supplies or equipment when purchased without a prescription. Example: Joint sleeve or brace, exercise equipment, over the counter medicines or dietary supplements	√	
Supportive devices for the feet (custom-molded orthotics or removable foot inserts)		√ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Surgical treatment for morbid obesity		√ Limitations and coverage guidelines established by Original Medicare.
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.	√	
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	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.