

Providence Medicare Plans

Addendum - Member Handbook/Evidence of Coverage

Section 10 Medical care and services that are **NOT** covered (list of exclusions and limitations for + RX plans)

Please add this document to your Member Handbook/Evidence of Coverage. This addendum specifically describes and clarifies additional items and services that are not covered by Providence Medicare Plans:

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 10.
2. Services that you get from non-plan providers (*unless* you are enrolled on a Providence Medicare Choice plan and use your Point of Service (POS) benefit), *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-plan providers that is arranged or approved by a plan provider. Refer to Section 2 for information about using plan providers and the exceptions that apply.
3. Services that you get without a referral from your PCP, when a referral from your PCP is required for getting that service (unless you use your Point of Service (POS) benefit).
4. Services that you get without prior authorization, when prior authorization is required for getting that service. (Section 7 gives a definition of prior authorization and Section 10 tells which services require prior authorization.)
5. Services that are not reasonable and necessary according to the standards of original Medicare unless these services are otherwise listed by Providence Medicare Plans as a covered service. Providence Medicare Plans provide all covered services according to Medicare guidelines.
6. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (Refer to Section 2 for more information about getting care for a medical emergency).
7. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or unless for certain services covered under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Providence Medicare Plans and Original Medicare to not be generally accepted by the medical community. Refer to Section 2 for information about participation in clinical trials while you are a member of Providence Medicare Plans.
8. Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.

9. Private room in a hospital, *unless* medically necessary.
10. Private duty nurses.
11. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
12. Nursing care on a full-time basis in your home.
13. Custodial care is not covered by Providence Medicare Plans *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
14. Homemaker services.
15. Charges imposed by immediate relatives or members of your household.
16. Meals delivered to your home.
17. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
18. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
19. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
20. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 10) and is limited according to Medicare guidelines.
21. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
22. Orthopedic shoes *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 10, in the Benefits Chart under "Outpatient Medical Services").
23. Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 10, in the Benefits Chart under "Outpatient Medical Services").
24. Hearing aids and routine hearing examinations.
25. Routine eyeglasses (*except* after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
26. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia unless listed on the formulary.
27. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)

28. Acupuncture.
29. Naturopath services.
30. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered. Dental is generally not covered under the plan or is limited according to Original Medicare guidelines except surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a medical doctor or doctor of dentistry. Covered dental services are limited to surgery related to the facial area below the eyes including the reduction of any fractures of the jaw or facial bones. Items and services in connection with the care, treatment, filling, removal or replacement of teeth such as routine exams, cleanings, X-rays, tooth extractions, crowns and bridgework and their supporting structures are not covered. The supporting structures of the teeth include gingivae, dentogingival junction, periodontal membrane, and cementum of the teeth and alveolar process.
31. Lens extras for cataract hardware are not covered unless medically necessary. Examples of lens extras include tints, anti-reflective coating, U-V lenses, or oversize lenses.
32. If a cataract extraction is performed on one eye and then is performed on the other eye and no eyeglasses or contact lenses are purchased between the two surgical procedures, Providence Medicare Plans will cover only one pair of eyeglasses or contact lenses after the second surgery.
33. Subnormal vision aids, aniseikonic lenses or plain (non-prescription lenses) glasses, replacement for lost or broken lenses, sunglasses, or two pair of glasses and other low vision aids and services.
34. Procedures, services, supplies and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Providence Health Plan or Original Medicare.
35. Missed appointments or completion of claim forms.
36. Reports, evaluations, or routine physical exams primarily for insurance, licensing, employment or other third party and non-preventive purposes.
37. Treatment for corns and calluses, removal of nail (except complete removal), and other routine foot care unless medically necessary.
38. Treatment or counseling in the absence of illness, including marriage counseling.
39. Treatment prior to coverage – Services or supplies received by a member before the member was covered under this agreement are not covered.
40. Autopsies and services related to autopsies are not covered.
41. Additional days in the hospital for pure convenience or desire of the patient are not covered.
42. Appliances, equipment, or supplies primarily for comfort or a convenience - These non-covered items include equipment used for environmental control, such as air conditioners, humidifiers, air filters, whirlpools, heat lamps, or tanning lights.
43. Enrollment in a health, athletic, or similar club.
44. Injections, which can be self-administered, such as insulin.
45. Long-term rehabilitation, including physical, occupational and speech therapy.

46. Massage therapy services.
47. Orthognathic surgery - Services and supplies to shorten or lengthen the upper or lower jaw are not covered, except when medically necessary as determined by Providence Health Plan.
48. Outpatient drugs and medicines you buy and administer yourself with or without a doctor's prescription.
49. Out-of-area services if the need could have reasonably been foreseen prior to leaving the service area except for renal dialysis services.
50. Psychological enrichment of self-help programs for mentally healthy individuals.
51. Guest meals in a hospital or skilled nursing facility.
52. Services performed by immediate relatives or members of your household.
53. Care for conditions that state or local law requires to be treated in a public facility.
54. Surrogate parenting and all cost associated with surrogate parenting.
55. Services or supplies that are not medically necessary for the treatment of an illness or injury as determined by Providence Health Plan in accordance with generally accepted medical standards are not covered. The only exceptions to this provision are the preventive care benefits described in the benefits section, and medically necessary infertility benefits.
56. Elective sterilizations and services relating to intrauterine devices.
57. Religious non-medical health care institutions/practitioner's services.
58. Conception by artificial means, such as in vitro fertilization, zygote intra-fallopian transfers and gamete intra-fallopian transfers (GIFT).
59. Ambulance claims where transport is refused.

60. Providence Medicare Plans or Medicare does not cover the following list of Medical supplies. This list is not all-inclusive and is subject to change. There may be other medical supplies or Durable Medical Equipment (DME) items not included in this listing that are not covered:

Air cleaners	Incontinent pads
Air conditioners	Injectors (hypodermic jet pressure powered devices for injection of insulin)
Bathtub lifts	Irrigating kits
Bathtub seats	Leotards
Bed baths (home type)	Massage devices
Bed lifters (bed elevator)	Oscillating Beds
Bedboards	Overbed tables
Beds-lounge (power or manual)	Paraffin bath units (standard)
Beds-oscillating	Parallel bars
Blood glucose analyzer reflectance colorimeter	Portable room heaters
Braille teaching texts	Portable whirlpool pumps
Carafes	Preset portable oxygen systems
Dehumidifiers (room or central heating system type)	Pressure leotards
Diathermy machines (standard or pulses wave types)	Pulse tachometer
Disposable sheets and bags	Raised toilet seats
Elastic stockings	Sauna baths
Electric air cleaners	Spare tanks of oxygen
Electrical stimulation for wounds	Speech teaching machines
Electrostatic machines	Stairway elevators
Elevators	Standing tables
Emesis basins	Support hose
Esophageal dilators	Surgical leggings
Exercise equipment	Syringes
Fabric supports	Telephone alert system
Face masks (surgical)	Telephone arms
Grab bars	Toilet seats
Heat and massage foam cushion pad	Treadmill exercisers
Heating and cooling plants	Whirlpool pumps
Humidifiers (room or central heating system types)	White canes