LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

Excluded Services

In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

- Services obtained from a Non-Participating/Out-of-Network Provider, except for treatment of an Emergency Medical Condition.
- Any amounts in excess of maximum benefit limitations of Covered Expenses stated in this Policy.
- Services not specifically listed as Covered Services in this Policy.
- Services or supplies that are not Medically Necessary.
- Services or supplies that Cigna considers to be for Experimental Procedures or Investigative Procedures or Unproven Procedures.
- Services received before the Effective Date of coverage.
- Services received after coverage under this Policy ends.
- Services for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot, unless it occurred during a community protest; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Insured Person being engaged in an illegal occupation.
- Any services provided by a local, state or federal government agency, except (a) when payment under this Policy is expressly required by federal or state law.
- Any services required by state or federal law to be supplied by a public school system or school district.
- Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid or medical assistance benefits under the Colorado Medical Assistance Act, Title 25.5, Articles 4, 5, and 6, C.R.S.). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- If the Insured Person is eligible for Medicare part A, B, C or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- Court-ordered treatment or hospitalization, unless such treatment is medically necessary and listed as covered in this Policy.
- Professional services or supplies received or purchased from Yourself or a facility or health care professional that provides remuneration to You, directly or indirectly, or to an organization from which You receive, directly or indirectly, remuneration.
- Services of a Hospital emergency room for any condition that is not an Emergency Medical Condition as defined in this Policy.

- Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care.
- Private duty nursing except when provided as part of the Home Health Care Services or Hospice Services benefit in this Policy or as specifically stated in the section of this Policy titled "Benefits/Coverage (What is Covered)".
- Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy.
- Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Health Disorder.
- Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
- Any services or supplies provided by or at a place for the aged, a nursing home, or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
- Assistance in activities of daily living, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or Homemaker Services, and services primarily for rest, domiciliary or convalescent care.
- Services performed by unlicensed practitioners or services which do not require licensure to perform, for example mediation, breathing exercises, guided visualization.
- Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Services which are self-directed to a free-standing or Hospital based diagnostic facility.
- Services ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider:
    - Has not been actively involved in Your medical care prior to ordering the service, or
    - Is not actively involved in Your medical care after the service is received.

  This exclusion does not apply to mammography.
- Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- Orthodontic Services, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction , except for treatment for medically necessary orthodontia for a person born with a cleft lip or cleft palate..
- Dental Implants: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants, excludes medically necessary treatment of cleft lip, cleft palate.
- Any services covered under both this medical plan and an accompanying exchange-certified pediatric dental plan and reimbursed under the dental plan will not be reimbursed under this plan.

- Hearing aids, except as specifically stated in this Policy, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), limited to the least expensive professionally adequate device. A hearing aid is any device that amplifies sound.
- Routine hearing tests except as specifically provided in this Policy under "Benefits/Coverage (What is Covered)".
- Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Gene Therapy including, but not limited to, the cost of the Gene Therapy product, and any medical, surgical, professional and facility services directly related to the administration of the Gene Therapy product.
- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Cosmetic surgery, therapy or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury, medically necessary surgery or congenital defect of a Newborn child, or to treat congenital hemangioma (port wine stains) on the face and neck of an insured person 18 years and younger, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Nonmedical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays, except as specifically stated in this Policy. This exclusion does not apply to health education services for chronic diseases and self-care on topics such as stress management and nutrition.
- Services and procedures for redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty and blepharoplasty, regardless of clinical indications.
- Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire
- The following services related to the evaluation or treatment of fertility and/or Infertility, sterilization reversals; donor semen and donor eggs; ovum transplants; In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Policy.
- Cryopreservation of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition
- Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices (except for treatment as a result of diabetes).

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices.
- Myoelectric prostheses peripheral nerve stimulators.
- Electronic prosthetic limbs or appliances unless Medically Necessary, when a less-costly alternative is not sufficient.
- Prefabricated foot Orthoses.
- Cranial banding/cranial orthoses/other similar devices, except when used postoperatively for synostotic plagiocephaly.
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
- Orthoses primarily used for cosmetic rather than functional reasons.
- Non-foot Orthoses, except only the following non-foot orthoses are covered when Medically Necessary:

  a. Rigid and semi-rigid custom fabricated Orthoses;

  b. Semi-rigid pre-fabricated and flexible Orthoses; and

  c. Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
- Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction, except as otherwise stated in this Policy under "Bariatric Surgery".
- Routine physical exams or tests that do not directly treat an actual Illness, Injury or condition. This includes reports, evaluations, or hospitalization not required for health reasons; physical exams required for or by an employer or for school, or sports physicals, or for insurance or government authority, and court ordered, forensic, or custodial evaluations, except as otherwise specifically stated in this Policy.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Treatment that will not result in a favorable modification or prevent deterioration.
- Educational services except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- Nutritional counseling or food supplements, except as stated in this Policy.
- Exercise equipment, comfort items and other medical supplies and equipment not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded medical equipment includes, but is not limited to: air purifiers, air conditioners, humidifiers treadmills; spas; elevators; supplies for comfort, hygiene or beautification; wigs, disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy.
- Physical, and/or Occupational Therapy/Medicine except when provided during an inpatient Hospital confinement or as specifically stated in the benefit schedule and under ' Rehabilitative Therapy (Physical Therapy, Occupational Therapy and Speech Therapy) Services' in the section of this Policy titled " Benefits/Coverage (What is Covered)".
- All Foreign Country Provider charges are excluded under this Policy except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Benefits/Coverage (What is Covered)".

- Routine foot care including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, except as otherwise stated in this Policy.
- Charges for which We are unable to determine Our liability because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a standby Physician.
- Charges for animal to human organ transplants.
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

Prescription Drug Benefit Exclusions

The following are not covered under this Policy. No payment will be made for the following expenses:

- Drugs not approved by the Food and Drug Administration;
- Any drugs that are not on the Prescription Drug List and not otherwise approved for coverage through the non-Prescription Drug List exception process.
- Drugs, devices and/or supplies available over the counter that do not require a prescription by federal or state law, except as otherwise stated in this Policy, or specifically designated as No Cost Preventive Care and required under the Patient Protection and Affordable Care Act (PPACA);
- Drugs that do not require a Federal legend (a Federal designation for drugs requiring supervision of a Physician), other than insulin;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs are covered under the medical benefits of this Policy and require Prior Authorization. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Infused Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions are covered under the medical benefits of this Policy;
- Any drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido/ and or sexual desire;
- Any drugs used for weight loss, weight management, metabolic syndrome, and antiobesity agents;
- Any drugs that are Experimental or Investigational or Unproven as described in this Policy; except as specifically stated in the sections of this Policy titled “Clinical Trials” and any benefit language concerning “Off Label Drugs”;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The American Hospital Formulary Service Drug Information or AHFS) or in medical literature. Medical literature means scientific studies published in a peer-reviewed English-language bio-medical journals ;

- Implantable contraceptive products inserted by the Physician are covered under the Policy's medical benefits
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies except for those pertaining to Diabetic Supplies and Equipment;
- Prescription vitamins other than prenatal vitamins, dietary supplements, herbal supplements and fluoride other than supplements specifically designated as preventive under the Patient Protection and Affordable Care Act (PPACA);
- Drugs used for cosmetic purposes that have no medically acceptable use, such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products;
- Medications used for travel prophylaxis, except anti-malarial drugs
- Drugs obtained outside the United States;
- Any fill or refill of Prescription Drugs and Related Supplies to replace those lost, stolen, spilled, spoiled or damaged before the next refill date;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to the Insured Person while a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Any Drugs, medications, or other substances dispensed or administered in any outpatient setting. This includes, but is not limited to, items dispensed by a Physician.
- Drug convenience kits;
- Prescriptions more than one year from the original date of issue;
- Any costs related to the mailing, sending or delivery of Prescription Drugs;
- Any intentional misuse of this benefit, including prescriptions purchased for consumption by someone other than the Insured Person.

Prescription Drug Benefit Limitations

Each Prescription Order or refill, unless limited by the drug manufacturer's packaging, shall be limited as follows:

- Up to a 30-day supply, at a Retail Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the Policy benefit schedule);or
- Up to a 90 day supply, at a 90 Day Retail Pharmacy for drug tiers 1 through 4 and up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging. To locate a 90-Day Retail Pharmacy You can call the Customer Service number on Your ID card or go to www.cigna.com/ifp-providers (for detailed information about drug tiers please refer to the Policy benefit schedule).
- Up to a 90-day supply at Express Scripts Pharmacy, Cigna's home delivery Pharmacy for drugs tiers 1 through 4 and Up to a 30-day supply of tier 5 drugs, unless limited by the drug manufacturer's packaging (for detailed information about drug tiers please refer to the Policy benefit schedule).
- Tobacco cessation medications that are included on Cigna's Prescription Drug List are limited to two 90 day supplies per Year.
- Managed drug limits (MDL) may apply to dose and/or number of days' supply of certain drugs; managed drug limits are based on recommendations of the federal Food and Drug Administration (FDA) and the drug manufacturer.
- To a dosage and/or dispensing limit as determined by the P&T Committee.

Supplemental Drug Discount Program

You are responsible for paying 100% of the cost for any Prescription Drugs or Related Supplies excluded by this plan. However, the Supplemental Drug Discount Program allows participating pharmacies to charge You and Your Family Member(s) the discounted cost of non-covered Prescription Drugs and Supplies. This means you will pay 100% of the discounted cost, rather than the full cost, of Prescription Drugs and Supplies the plan does not cover. Please Note: the out-of-pocket costs that You and Your Family Member(s) pay for any Prescription Drugs or Related Supplies the plan does not cover will not be applied to the Insured Person's Deductible or Out-of-Pocket Maximum.

Pediatric Vision Benefit Exclusions

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Any Injury or Illness when paid or payable by Workers' Compensation or similar law, or which is work related.
- Charges in excess of the usual and customary charge for the Service or Material.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or Investigational or Unproven non-conventional treatment or device.
- Magnification or low vision aids not otherwise listed in "What Is Covered" within the Pediatric Vision Benefits section, above.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Spectacle lens treatments, "add ons", or lens coatings not otherwise listed in "What Is Covered." within the Pediatric Vision Benefits section above.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- For or in connection with Experimental or Investigational or Unproven procedures or treatment methods not approved by the American Medical Association or the appropriate vision specialty society.
- Claims submitted and received in-excess of twelve-(12) months from the original Date of Service.
- Services provided out of network without Cigna's prior approval are not covered