

## **Exclusions and Limitations: What Is Not Covered by This Policy**

### **Excluded Services**

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

1. **Services obtained from a Non-Participating/Out-of-Network Provider**, except for treatment of an Emergency Medical Condition.
2. Any **amounts in excess of maximum benefit limitations of Covered Expenses** stated in this Policy.
3. Services **not specifically listed as Covered Services** in this Policy.
4. Services or supplies that are **not Medically Necessary**.
5. Services or supplies that are considered to be for **Experimental Procedures or Investigational Procedures or Unproven Procedures**.
6. Services **received before the Effective Date of coverage**.
7. Services **received after coverage under this Policy ends**.
8. Services **for which you have no legal obligation to pay** or for which no charge would be made if you did not have a health plan or insurance coverage.
9. Any condition for which benefits are paid, 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.
10. Conditions caused by: (a) an **act of war (declared or undeclared)**; (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**; (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**; (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the Illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
11. Any **services provided by a local, state or federal government agency**, except when payment under this Policy is expressly required by federal or state law.
12. Any services required by state or federal law to be supplied by a public school system or school district.
13. Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and military treatment facilities will be considered for payment according to current legislation.
14. **If the Insured Person is enrolled in Medicare** Part A, B, C or D, Cigna Healthcare will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna Healthcare would have paid if it were the sole insurance carrier.
15. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this Policy.

16. Professional **services or supplies received or purchased directly or on your behalf** from any of the following:
  - Yourself or your employer;
  - A person who lives in the Insured Person's home, or that person's employer;
  - A person who is related to the Insured Person by blood, marriage or adoption, or that person's employer; 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.
17. Services of a Hospital emergency room **for any condition that is not an Emergency Medical Condition** as defined in this Policy.
18. **Custodial Care, including but not limited to rest cures; infant, child or adult day care, including geriatric day care.**
19. **Private duty nursing** except when provided as part of the home health care services or Hospice Care Services benefit in this Policy.
20. Inpatient room and board **charges in connection with a Hospital stay primarily for environmental change or Physical Therapy.**
21. 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 a Mental Health Disorder.
22. **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; acupuncture point injection therapy; 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.
23. 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.
24. **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.
25. **Services performed by unlicensed practitioners** or services which do not require licensure to perform, for example-meditation, breathing exercises, guided visualization.
26. 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.
27. **Services which are self-directed** to a free-standing or Hospital-based diagnostic facility.

28. 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.

29. **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.
30. **Orthodontic services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction, except as specifically provided in this Policy.
31. **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.
32. 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.
33. **Hearing aids** including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this Policy, limited to the least expensive professionally adequate device. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.
34. **Routine hearing tests** except as specifically provided in this Policy under “Comprehensive Benefits, What the Plan Pays For.”
35. **Genetic screening** or pre-implantation 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.
36. **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.
37. **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 Care.
38. An **eye surgery solely for the purpose of correcting refractive defects** of the eye, such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).
39. Outpatient **speech therapy**, except as specifically stated in this Policy.
40. **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 or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
41. **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 except as specifically stated in this Policy.

42. **Non-medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays, except as otherwise stated in this Policy.
43. Any services 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 do not consist exclusively of Covered Services.
44. **Services and procedures** for redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty; blepharoplasty and; orthognathic surgeries.
45. Procedures, surgery or treatments to **change characteristics of the body** to those of the opposite sex unless such services are deemed Medically Necessary or otherwise meet applicable coverage requirements.
46. Any treatment, Prescription Drug, service or supply **to treat sexual dysfunction**, enhance sexual performance or increase sexual desire.
47. All services related to **the treatment of fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Policy.
48. **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
49. 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.
50. Blood administration **for the purpose of general improvement in physical condition**.
51. **Orthopedic shoes** (except when joined to Braces), shoe inserts, foot Orthotic Devices.
52. **External and internal power enhancements** or power controls for Prosthetic limbs and terminal devices.
53. **Myoelectric Prostheses** peripheral nerve stimulators.
54. **Electronic Prosthetic limbs or appliances** unless Medically Necessary, when a less-costly alternative is not sufficient.
55. **Prefabricated foot Orthoses**.
56. **Cranial banding/cranial Orthoses/other similar devices**, except when used postoperatively for synostotic plagiocephaly.
57. **Orthosis shoes**, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers.
58. Orthoses primarily used for cosmetic rather than functional reasons.

59. **Non-foot Orthoses**, except **only** the following non-foot Orthoses are covered when Medically Necessary:
- Rigid and semi-rigid custom fabricated Orthoses;
  - Semi-rigid pre-fabricated and flexible Orthoses; and
  - Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
60. 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.
61. **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.
62. 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.
63. **Educational services** except for Diabetic Self-Management Training Programs, treatment for Autism, or as specifically provided or arranged by Cigna Healthcare.
64. **Nutritional counseling or food supplements**, except as stated in this Policy.
65. **Exercise equipment, comfort items and other medical supplies and equipment** not specifically listed as Covered Services in the “Comprehensive Benefits: What the Policy Pays For” 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.
66. **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 Services (Physical Therapy, Occupational Therapy and Speech Therapy)” in the section of this Policy titled “Comprehensive Benefits: What the Policy Pays For.”
67. **Foreign Country Provider** charges except as specifically stated under “Foreign Country Providers” in the section of this Policy titled “Comprehensive Benefits: What the Policy Pays For.” In the event an Insured Person dies outside of the United States, charges for medical evacuation and repatriation of his or her remains to the United States are not covered.
68. **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, a systemic condition, Injury or symptoms involving the feet except as otherwise stated in this Policy.

69. **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 90 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.
70. Charges for the **services of a standby Physician**.
71. Charges for **animal to human organ transplants**.
72. **Claims received by Cigna Healthcare after 15 months from the date service was rendered**, except in the event of a legal incapacity.
73. Services obtained from a **Dedicated Virtual Care Physician** that are not Dedicated Virtual Urgent Care or Dedicated Virtual Primary Care services.