

General Exclusions

This section indicates services, supplies, conditions, situations and charges that are excluded from coverage and are not considered Covered Services under this Benefit Booklet. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. The exclusions below are in addition to the exclusions found elsewhere in this Benefit Booklet, including but not limited to those exclusions found in the **COVERED SERVICES** section of this Benefit Booklet. This information is provided as an aid to identify certain common items, which may be misconstrued as Covered Services.

We do not provide benefits for services, supplies, conditions, situations or charges:

1. That We, in administering the Plan, determine are not Medically Necessary. Emergency medical care is not subject to this exclusion as long as such care meets the definition of emergency medical care, see the **Emergency Care and Urgent Care** section of this Benefit Booklet;
2. For care received from a Out-of-Network Provider, except for Emergency Care, Urgent Care or as preauthorized by Us as a Covered Service;
3. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet;
4. That are Experimental/Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Us, in administering the Plan;
5. To the extent they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Benefit Booklet will be coordinated with such governmental units to the extent required under existing state and/or federal laws;
6. For which benefits are payable under Medicare Part A, Medicare Part B and/or Medicare Part D, or would have been payable if you had applied for Medicare Part A, Medicare Part B and/or Medicare Part D, unless otherwise specified in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled **Medicare** in **ADMINISTRATIVE INFORMATION**;
7. In excess of the Maximum Allowable Amount for Medical Supplies, durable medical equipment and appliances unless otherwise specified in this Benefit Booklet;
8. Incurred before your Effective Date;
9. Incurred after the termination date of this coverage unless otherwise specified in this Benefit Booklet;
10. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for Surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts),;
11. For services performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition that is resolved or stable;
For dental prosthesis and any treatment for teeth, gums, tooth or upper or lower jaw augmentation or reduction (orthognathic Surgery) and related service, unless otherwise specified in this Benefit Booklet;
12. Weight loss programs, whether or not they are pursued under medical or Physicians supervision, unless otherwise specified in this Benefit Booklet;
13. Treatment of obesity, including but not limited to for surgical treatment of morbid obesity (bariatric surgery/lap banding);
14. For care received in an emergency room which is not Emergency Care;
15. For research studies or screening examinations, unless otherwise specified in this Benefit Booklet;
16. For stand-by charges of a Physician;
17. Immunizations for travel.

18. Routine exams and immunizations required as a condition of employment, for licensing, sport programs, insurance, church, or camp.
19. For Private Duty Nursing Services, except when provided through the Home Care Services or Hospice Care Services sections of this Benefit Booklet;
20. Related to male or female sexual or erectile dysfunction or inadequacies, regardless of origin or cause. This exclusion includes prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency;
21. Nutritional and/or dietary supplements, unless otherwise specified in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist;
22. For complications arising from non-Covered Services and supplies;
23. Related to your leaving a Hospital or other facility against the medical advice of the Physician;
24. For services or supplies for the treatment of Intractable Pain and/or Chronic Pain;
25. Services that exceed the visit or Benefit Period Maximum payments as listed in the Benefit Booklet or *Health Benefit Plan Description Form*;
26. Breast reduction surgery (reduction mammoplasty) or services related to breast reduction surgery, unless the breast reduction surgery is performed as a result of breast cancer;
27. For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party, except as specified under the **ADMINISTRATIVE INFORMATION** section;
28. For any illness or injury that occurs as a result of any act of war, declared or undeclared, while serving in the military, or services and supplies furnished by a military facility for disabilities connected to military service;
29. For a condition resulting from a riot, civil disobedience, nuclear explosion or nuclear accident;
30. For court-ordered testing or care unless Medically Necessary and preauthorized by Us, in administering this Plan;
31. For which you have no legal obligation to pay in the absence of this or like coverage;
32. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
33. Prescribed, ordered or referred by, or received from, a member of your immediate family (parent, child, Spouse, sister, brother or self);
34. For completion of claim forms or charges for medical records or reports, unless otherwise required by law;
35. For missed or canceled appointments;
36. For mileage costs or other travel expenses, except as preauthorized by Us, in administering this Plan;
37. For Custodial Care, or domiciliary or convalescent care, whether or not recommended or performed by a professional;
38. For foot care to improve comfort or appearance including, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails;
39. For sex transformation Surgery and related services, or the reversal thereof;
40. For marital counseling or personal growth;
41. For eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise specified in this Benefit Booklet;
42. For hearing aids services, unless otherwise specified in this Benefit Booklet;

43. For services or supplies primarily for educational, vocational, or training purposes, unless otherwise specified in this Benefit Booklet;
44. Services to reverse voluntarily induced sterility;
45. Services of any type for the treatment of infertility;
46. For Experimental infertility procedures and non-Medically Necessary infertility procedures including, but not limited to artificial insemination, In-Vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT);
47. For or related to services (including but not limited to speech therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, learning disabilities, behavioral problems, hyperkinetic syndromes or mental retardation (except for Prescription Drugs for treatment of these conditions);
48. For personal hygiene services, self help devices that are not medical in nature, or services and supplies for comfort and convenience;
49. For care related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;
50. Related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST), biofeedback, chelating agents (except for treatment of heavy metal poisoning) and iridology;
51. Health club Memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas;
52. For self-help training and other forms of non-medical self care, unless otherwise specified in this Benefit Booklet;
53. For hair loss treatment, even if the hair loss is caused by a medical condition, except for alopecia areata or as otherwise specified in this Benefit Booklet;
54. For peripheral bone density scans;
55. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services;
56. For medical, surgical services and appliances related to temporomandibular joint (TMJ) therapy regardless of Medical Necessity;
57. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy;
58. Provided or billed by a residential treatment center, school, halfway house, custodial care facility for the developmentally disabled, drug and alcohol residential program , or outward bound program, even if psychotherapy is included;
59. For rolfing therapy, myotherapy or prolotherapy;
60. For ambulance transportation if you could have been transported by private automobile or by commercial or public transportation without endangering your health or safety;
61. For orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes);
62. For air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, wristlets, breast pumps, augmentative communication devices, surgical supports, and corsets or other articles of clothing, unless otherwise specified in this Benefit Booklet;
63. For items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly.
64. Language training for educational, psychological or speech delays;
65. Diversional, recreational or vocational therapies such as hobbies, arts and crafts;

66. Sclerotherapy for the treatment of varicose veins in the lower extremities, including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by any method;
67. Cardiac rehabilitation home programs, on-going conditioning and maintenance
68. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another women for an infertile couple

Human Organ and Tissue Transplant Services:

1. Human Organ and Tissue Transplant services that are performed at any Hospital that is not designated or approved by Us for the organ or tissue being transplanted;
2. If you are not a suitable candidate as determined by the Hospital designated and approved by Us to provide Human Organ and Tissue Transplant services;
3. For donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or for their respective family Members or friends;
4. For any transplant, treatment, procedure, facility, equipment, drug, device, service or supply that requires federal or other governmental agency approval and such approval is not granted at the time services are provided, including any service or supply associated with or provided in follow-up;
5. For transplants of organs other than those listed in the **HUMAN ORGAN AND TISSUE TRANSPLANT** section of this Benefit Booklet including non-human organs;
6. Procurement of a donor organ which has been sold rather than donated;
7. Related to artificial and/or mechanical hearts or for subsequent services and supplies for a heart condition as long as any of the artificial or mechanical heart remains in place. This exclusion includes services for implantation, removal and complications.
8. For non-covered transportation and lodging.

Retail Pharmacy/Mail Order Prescription Drugs:

1. Non-formulary prescription drugs;
2. Prescription drugs and supplies received from an Out-of-Network pharmacy or a pharmacy who is not a UA Network pharmacy;
3. Prescription drugs and supplies received as an inpatient in a hospital or other covered inpatient facility, except where covered as part of the inpatient stay;
4. Non-legend prescription drugs;
5. Drugs prescribed for weight control or appetite suppression;
6. Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
7. Drugs not approved by the FDA;
8. Any new FDA approved drug product or technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. We may at Our sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology
9. Any medications used to treat infertility;
10. Delivery charges for prescriptions;
11. Charges for the administration of any drug unless dispensed in the Physician's office or through Home Health Care;

12. Drugs which are provided as samples to the Provider;
13. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
14. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUG** section;
15. Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use);
16. Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and prescription drugs that have an over-the-counter bioequivalent, even if written as a prescription;
17. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin;
18. Prescription drugs which are dispensed in quantities or refill frequency which exceed the applicable limits, established by Us, at Our sole discretion;
19. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed;
20. Prescription Drugs dispensed for the purpose of international travel;
21. Prescription Drugs which have been obtained through a Home Health Agency;
22. Replacement of lost or stolen Prescription Drugs;
23. Maintenance drugs from an UA Network retail pharmacy after a total of a 90 day supply has been purchased at an UA Network retail pharmacy – all maintenance drugs must be purchased from the University of Colorado Hospital Mail Order Prescription Service to be covered.
24. Prescription Drugs dispensed from a non-UA Network retail or mail order pharmacy.

Clinical Trials

1. Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
2. Any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
3. Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
4. An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
5. Costs for the management of research relating to the clinical trial or study;
6. Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Certificate; or
7. Any service or procedure related to the diagnosis, treatment or prevention of complications related to a clinical trial.