



Plan Disclosure



Administered by:



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- Premium Advantage Series
- No Deductible Plans
- HSA Qualified Plans
- Allied™ Cost Saver
- Allied™ Cost Saver *PLUS* Major Medical

Wellness Horizons® Health Plans– Common Provisions for All Plans

The following information describes the Wellness Horizons® health plans policy benefits, limitations, exclusions and requirements. Exact provisions for the plan are contained in the master policy. Each insured employee will receive a Certificate of Insurance which contains a detailed explanation of the plan provisions. Some provisions, benefits, exclusions and limitations listed in this guide may vary depending on the state in which the employer is located.

Final rates and eligibility for all groups are determined at the time of underwriting. DO NOT cancel current coverage until your new group coverage has been approved in writing by Allied.

Please contact Allied Sales Support at 1-888-767-7133 for up-to-date information on your state and to discuss special underwriting situations.

Participation, Contribution Requirements and Eligibility

A minimum of two (2) insured employees is required at all times, and a minimum employee participation of 75% of the eligible employees must be enrolled. Any employee who waives coverage because they have a qualifying existing coverage is not counted in the above participation totals (unless the qualifying coverage is another plan with that same employer). However, at least 50% of the full-time employees, except in CA, GA and OK, must participate in the plan for the group to be considered eligible. The employer must contribute a minimum of 25% of each employee's premium costs. There is no minimum participation requirement for dependents.

Eligibility: An eligible employee is a person directly employed and actively at work (including approved medical leave) on a full-time basis in the regular business of the employer, and compensated by the employer with regular periodic wages for service. Full-time is 30 hours per week (24 hours in OK and 25 hours in OH).

Eligible dependents are an employee's legal spouse who is not legally separated or divorced from the employee and is not a member of the armed forces, and an employee's unmarried children, including stepchildren, legally adopted or foster children, under the age of 25 (regardless of whether a full-time student) who are primarily dependent (at least 50%) on the employee for support and maintenance.

Waivers

Waivers must be completed for ALL eligible employees and/or dependents not enrolling for coverage. If the waiver is because of qualifying existing coverage, the waiver will not count against the calculation of the group's participation. An employee's failure

to complete a waiver could jeopardize his or her future rights to coverage.

Effective Dates and Rates

A group may request any effective date provided that a complete application, signed on or before the requested effective date, is received in our office no later than five working days following that date. Receipt of 100% of employee enrollment forms or waivers is mandatory before coverage can be approved. In all circumstances, coverage is not in effect until approval is granted in writing by Allied National.

A group that has coverage effective on a date other than the first of the month will have its second month's premium prorated, so that future billing months begin on the first of the month.

Multi Location Groups

Groups with multiple locations need to be rated by Allied at the home office with the total employee count and PPO selection for each location.

Dependent Rating

Wellness Horizons health plans use an "all" children rate. When a group has a high average number of children per employee, rates may be increased to compensate for the number of children.

Pre-Existing Conditions

A pre-existing condition is a bodily injury or sickness, whether a physical or mental condition, regardless of the cause for the condition, for which medical advice, diagnosis, care or treatment was recommended or received by an insured person within the six (6) month period ending on the enrollment date. Medical advice, diagnosis, care or treatment will be taken into account only if it is recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law. A pregnancy existing on or before the enrollment date is not considered a pre-existing condition. No benefits are payable for a pre-existing condition until a continuous period of: (a) twelve (12) months (CA – 6 months, IN – 9 months, KS – 90 days) from the enrollment date, with respect to other than late applicants, and (b) eighteen (18) months (CA – 12 months, IN – 15 months) with respect to late applicants, has elapsed.

A pre-existing conditions benefit allowance of \$1,000 will be provided to an insured person who does not qualify for credit toward satisfying his/her pre-existing condition exclusion period as described above.

Takeover Benefits

Takeover benefits allow a group to switch coverage while maintaining valuable credit toward such things as deductibles and pre-existing condition exclusion periods.

Takeover benefits provide:

- Credit for prior "Creditable Coverage" applied toward the pre-existing condition limitation if there has not been a break in coverage exceeding 62 days (or length of time mandated by state). The "portability" provisions apply to all initial insured members and subsequent timely additions to a group. Creditable Coverage also applies to individual plans, so even new employees can qualify.
- Credit will be granted for deductible amounts satisfied under a prior Creditable Coverage during the 90 days prior to the effective date or current calendar year, whichever is greater.

LabOne® Benefits

Wellness Horizons health plans extend the insured member's benefit by automatically enrolling them in the Lab Card® Program, which provides outpatient lab testing at no charge when done at a LabOne facility or at a doctor's office that sends the tests to a LabOne or Quest facility. It is a voluntary program, meaning that insured members can choose not to have their testing done using their LabOne Card; however, the insured members will be responsible for their coinsurance or copay for laboratory charges.

Wellness Benefit

All major medical plans include routine preventive care coverage for mammograms, pap smears, PSA testing and child immunizations under the Office Visit Benefit. In addition, these plans feature an Annual Wellness Benefit which provides an annual wellness exam. The wellness exam is subject to the office visit copay, pays up to \$250 in benefits and covers routine exams and testing (hearing, vision, heart, etc.), x-rays and laboratory tests used for the early detection of diseases. On plans without an office visit benefit, routine preventive care coverage and the Annual Wellness Benefit are subject to a \$40 Copay.



Premium Advantage, No Deductible and HSA Plan Provisions

Prescription Drug Coverage

Each insured employee will receive a prescription drug ID card that can be used at participating pharmacies across the nation, including most of the major national chains. Insured members may also purchase maintenance drugs through the mail. For more information, please visit Allied at www.alliednational.com. The following prescription drug restrictions apply:

- Copay, deductible and coinsurance amounts do not count toward satisfaction of deductible and out-of-pocket costs under the major medical plan, except under the deductible integrated benefit option.
- Benefits are based upon the contracted price or the maximum allowable cost as determined by the prescription drug card service. The maximum allowable charge is the ceiling price set by the prescription drug card service on the generic equivalents of a brand name drug.
- If a brand name drug is prescribed with no substitutions allowed, the insured member pays the applicable brand name copay and coinsurance. If a brand name drug is requested by the insured when the prescription allows generic substitutions, the insured member is also responsible for the additional cost difference between the brand name drug and the generic alternative.

Pre-Notification

Wellness Horizons health plans assist the insured person and his or her family with medical education material, high-risk monitoring programs, and coordination of treatment plans and costs with doctors and hospitals. These services help ease a patient through the medical process and control expenses to the benefit of all insured members.

Wellness Horizons health plans request that insured members give pre-admission notification in the following instances:

- Within 30 days from the date of diagnosis of a pregnancy.
- Outpatient surgery exceeding \$1,000 (not required with Cost Saver).
- Inpatient admission and treatment.
- Human organ or tissue transplants.

Rating and Renewal Disclosure

Premiums are subject to change every 12 months. The same rate table for each rating period will be used for all new and renewing employers. Each employer's premium may vary from the rate table due to health status, claims experience and duration of coverage as allowed by state law.

Employer participation in the plan is on a monthly renewable basis. In addition to the reasons for termination of coverage detailed in the policy, the Insurance Company may a) discontinue the plan in its entirety in any state provided they discontinue coverage for all similarly situated employees in that state, provide at least 90 days advance notice of discontinuance and offer the option to purchase any other group health insurance coverage offered in that state; or b) discontinue offering all health insurance coverage in the small group market in a state by providing at least 180 days advance notice of non-renewal.

See the Certificate of Insurance for complete plan details.

In addition to the plan provisions listed in the previous section, Wellness Horizons® major medical plans (Premium Advantage, No Deductible and HSA plans) have the following plan provisions:

Life Extra Optional Coverage and Life Only Coverage

Life Extra optional coverage and Life Only coverage (for those not electing medical coverage) are available for Wellness Horizons Major Medical and Cost Saver *PLUS* Major Medical. In addition to the term life coverage, these provide accidental death and dismemberment coverage for the insured member that pays three ways:

- Full benefits for accidental death
- The full amount of the life benefit for multiple loss of hands, feet, limbs or eyesight
- One-half the amount if one loss occurs

Life benefit amounts are available in \$1,000 units from \$10,000 to \$50,000. These benefits reduce by 35% at age 65, and the resulting amounts are reduced by an additional 35% every five years thereafter to a minimum benefit of \$1,000.

You can select life coverage benefits for employees based on one of the following:

- INCOME** – Benefits can equal one-half, one, two or three times the employee's annual earnings rounded to the nearest \$1,000.
- JOB CLASS** – Benefit levels can be arranged by job titles. If benefits are set up according to class, each class must have at least two employees and the benefit for each class may be no more than 2 1/2 times the benefit of the next lower class.
- INCOME CLASS** – Benefits can reflect a company's pay scale with a prearranged benefit amount set for each pay level.
- FLAT AMOUNT** – All eligible employees can be covered for the same benefit amount.

If the employer elects Life Extra coverage, all employees must take the coverage.

Life coverage provided by Guarantee Trust Life Insurance Company, Glenview, IL.

Participation Rules for Life Coverage

1. All employees insured under the health portion of the coverage must be covered with Life Extra if elected by the employer;
2. All employees not taking health coverage may apply for Life Only by completing an evidence of insurability application; and
3. Employees with health waivers may apply for Life Only coverage. 100% participation of waived employees is required.

Medical Underwriting

Wellness Horizons major medical plans are medically underwritten. Final rates are based on a review of all applicable medical information. Coverage is contingent upon meeting all eligibility requirements and acceptance of final rates. **Do not cancel current coverage until coverage has been approved in writing by Allied.**

Allied Cost Saver and Cost Saver *PLUS* Major Medical Only Provisions

Eligible Expenses

An eligible expense is the maximum allowable charge for the following services. Benefits for some covered expenses may vary according to state law and benefit plan selected. All benefits shown apply to any applicable calendar year maximum benefit.

Doctor's Office Visits: The Office Visit Benefit applies to the following services when performed in the doctor's office – exams, consultations, immunizations, mammograms and pap smears, plus most diagnostic and surgical services costing less than \$200. After the office visit copay, these services are paid at 100% in-network or 80% out-of-network. Any listed service that costs more than \$200, or other services not listed (even if performed in the doctor's office and on the same bill as the office visit) are considered other outpatient services and are subject to deductible, copay and coinsurance.

Out-of-Network Charges from Non-PPO Providers: Paid at 80% if injury or sickness occurs outside the PPO service area while traveling for a period of 90 days or less, while permanently residing outside the service area, while attending school full-time outside the service area (dependent child only), or when receiving services at a PPO hospital from a non-PPO provider. These charges apply to the out-of-network deductible and out-of-pocket maximum.

Routine Exams and Immunizations for Children: Subject to schedule of visits outlined in the policy, and state laws.

Lifetime Maximum Benefit for Hospice Care: One benefit period not to exceed six months

Daily Maximum Facility Benefit for extended care and inpatient hospital confinement for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency care) after \$250 copay: \$20, \$25, \$50, or \$100 per day according to plan chosen.

Calendar Year Maximum Treatment Days for inpatient hospital confinement for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency care): 31 days

Lifetime Maximum for Alcohol and Chemical Dependency Care: \$10,000

Lifetime Maximum for Physical Diagnosis or Treatment of Infertility Conditions: \$500

Lifetime Maximum Aggregate Benefit:

Cost Saver \$500,000

Cost Saver *PLUS* Major Medical \$5,000,000

Pregnancy Care Benefit for Employee or Spouse Only: If elected, payable same as any other sickness. (Optional for groups of 5 or more; 4 or more in OH; included for all size groups in CA.) No well baby benefit included.

Complications of Pregnancy: Payable same as any other sickness

Calendar Year Maximum Visits:

- Home Health Care: 20 visits
- Acupuncture treatment: 10 visits
- Outpatient care for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency): 10 visits
- Orthopedic manipulation, occupational therapy, physical therapy and massage therapy: 10 visits
- Speech therapy: 10 visits

Covered Expenses also include maximum allowable charges for the following medically necessary expenses: Hospital and surgical services by a physician; inpatient R.N. services; services by an anesthetist or physical therapist; X-ray or radiation therapy; X-ray exams and tests; ambulatory surgical center charges; blood, blood plasma, oxygen, anesthesia and their administration; initial artificial limbs or eyes to replace natural limbs or eyes lost while insured under this plan; casts, splints, surgical dressings, trusses, braces, crutches and the rental of durable mechanical medical equipment not to exceed purchase price; initial eyeglasses or contact lens(es) required as a result of cataract surgery; breast reconstruction surgery and prostheses required as a result of mastectomy(ies) performed while insured under this policy.

Life Extra Optional Coverage and Life Only Coverage

Allied Cost Saver

Life Extra optional coverage is available with the Cost Saver plan. If elected by the employer, a level \$10,000 is available for each employee. If elected by the employer, Life Extra coverage must be taken for all covered employees.

Life Only coverage is not available with the Cost Saver plan.

Life coverage is provided by Guarantee Trust Life Insurance Company, Glenview, IL.

Cost Saver *PLUS* Major Medical

Life Extra Optional Coverage and Life Only coverage (for those not electing medical coverage) are available with the Cost Saver *PLUS* Major Medical plan. See "Life Extra Optional Coverage and Life Only Coverage" under the "Premium Advantage, No Deductible and HSA Plan Provisions" section of this

Plan Disclosure for details.

Medical Underwriting

The Allied Cost Saver limited benefit plan is not medically underwritten. Employees fill out a simple enrollment form without medical questions. There are no premium rate-ups at underwriting time due to medical history.

Cost Saver *PLUS* Major Medical is medically underwritten. Unless a guaranteed issue case, group acceptance and rates are based upon the medical risk presented by a group. Acceptance and rates are based upon the health of the entire group and the case is either issued or declined on a group basis (no declination of individuals). Even for guaranteed issue cases, medical underwriting is required and allowed to determine the proper health load for the group.

Group Size

Cost Saver is available for groups of 2 or more. Contact Allied Sales Support at 1-888-767-7133 for groups of 100+.

Cost Saver *PLUS* Major Medical is only for groups of 2–50.

Cost Saver *PLUS* Major Medical Eligible Expenses

The following benefit provisions override similar limitations in the Cost Saver policy as described to the left when an individual becomes eligible for major medical benefits.

- Lifetime Maximum – \$5,000,000
- Calendar Year Maximum – \$1,000,000 except where indicated otherwise.
- Organ transplants – limited to \$1,000,000 maximum lifetime benefit when participating in an approved health care coordination care plan. If not participating in an approved plan, benefits are limited to 50% coinsurance to a maximum benefit of \$100,000. Human organ or tissue donor expenses are limited to \$10,000.
- Implantable Devices – 150% of cost

See the Certificate of Insurance for complete plan details.

Premium Advantage, No Deductible and HSA Plan Eligible Expenses

An eligible expense is the maximum allowable charge for the following services. Benefits for some covered expenses may vary according to state law and benefit plan selected.

Doctor's Office Visits: The Office Visit Benefit applies to the following services when performed in the doctor's office (office visits, urgent care and emergency room subject to deductible on HSA plans): exams, consultations, immunizations, mammograms and pap smears, plus most diagnostic and surgical services costing less than \$200. After the in-network office visit copay, these services are paid at 100% in-network. Out-of-network office visits are subject to two times the copay and applicable out-of-network coinsurance. Any listed service that costs more than \$200, or other services not listed, even if performed in the doctor's office and on the same bill as the office visit, are subject to deductible, copay and coinsurance.

Urgent Care Services: Are subject to the doctor's office visit copay plus \$20 (urgent care copay). Benefits payable same as for doctor's office visits after the urgent care copay. This applies to Premium Advantage plans only.

Emergency Room Services: \$100 copay, then subject to coinsurance. This applies to Premium Advantage plans only.

Out-of-Network Charges from Non-PPO Providers: Paid at lesser of 80% or in-network coinsurance if injury or sickness occurs outside the PPO service area while traveling for 90 days or less, while permanently residing outside the service area, while attending school full time outside the service area (dependent child only), or when receiving services at a PPO hospital from a non-PPO provider. These charges apply to out-of-network deductible and out-of-pocket maximum.

Routine Exams and Immunizations for Children: Subject to schedule of visits outlined in policy.

Hospital Daily Rate (Including Nursing Charges)

- Ward and semi-private: Full amount up to semi-private room
- Observation Room: Semi-private room prorated
- Intermediate Care Unit and Step-Down Unit: Two times semi-private room
- Private Room: Semi-private room
- Intensive Care Unit: Three times semi-private room
- Skilled Nursing Unit: Full amount up to 50% semi-private room
- Extended Care Facility: Daily rate not to exceed a daily benefit of \$125 for 60 days during any calendar year

Calendar Year Maximum Treatment Days for inpatient hospital confinement for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency care): 31 days

Lifetime Maximum Aggregate Benefit (except as otherwise indicated in the Schedule of Benefits): \$5,000,000

Calendar Year Maximum Aggregate Benefit (except as otherwise indicated in the Schedule of Benefits): \$1,000,000

Lifetime Maximum Benefit per Human Organ or Tissue Transplant if insured person is being treated in accordance with an approved care plan under health care coordination: \$1,000,000. If insured person is not under health care coordination: 50% of charges to maximum benefit of \$100,000. Human organ or tissue transplant from a donor: \$10,000

Lifetime Maximum Benefit for Alcoholism and Chemical Dependency: \$10,000

Lifetime Maximum Benefit for Allergy Testing and Allergen Immunotherapy: \$500

Lifetime Maximum Benefit for Durable Mechanical Medical Equipment: \$5,000

Lifetime Maximum Benefit for Orthotics and Orthopedic Devices: \$5,000

Lifetime Maximum Benefit for Physical Diagnosis or Treatment of Infertility Conditions: \$500

Lifetime Maximum Benefit for Hospice Care: One benefit period not to exceed six months

Implantable Devices: 150% of cost

Kidney Dialysis: \$500 per treatment

Pregnancy Care Benefit for Employee or Spouse Only: Payable same as any other sickness (if benefit elected)

Complications of Pregnancy: Payable same as any other sickness

Well Baby Care: Two days payable same as any other sickness

Calendar Year Maximum Visits:

- Orthopedic Manipulation, Occupational Therapy and Massage Therapy: 20 visits
- Home health care: 40 visits
- Acupuncture treatment: 20 visits
- Outpatient care for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency care): 26 visits
- Inpatient care for nervous, emotional or mental disorders or disease care (including alcoholism and chemical dependency care): 31 days
- Speech therapy: 20 visits

Out-of-Network Limitations:

Office Visit and Urgent Care Copay: Two times in-network copay then out-of-network coinsurance applied.

Deductible: Additional deductible: Two times in-network deductible. No family limit for out-of-network deductibles.

Out-of-Pocket Maximum*: Additional, equal to two times in-network out-of-pocket maximum. Family limit is two times individual limit.

**With the No Deductible plan all out-of-network copays are two times in-network copays. Family limit for out-of-pocket maximum for in-network and out-of-network services is two times the individual limit.*

Covered expenses also include maximum allowable charges for the following medically necessary expenses: Hospital and surgical services by a physician; inpatient R.N. services; services by an anesthesiologist or physical therapist; X-ray or radiation therapy; X-ray exams and test; ambulatory surgical center charges; blood, blood plasma, oxygen, anesthesia and their administration; initial artificial limbs or eyes to replace natural limbs or eyes lost while insured under this plan; casts, splints, surgical dressings, trusses, braces, crutches and the rental of durable mechanical medical equipment not to exceed purchase price; initial eyeglasses or contact lens(es) required as a result of cataract surgery; breast reconstruction surgery and prostheses required as a result of mastectomy(ies) performed while insured under this policy.

See the Certificate of Insurance for complete plan details.

Limitations and Exclusions for All Wellness Horizons Health Plans

Unless specific exceptions to the following limitations and exclusions are made, no benefits shall be payable under this Part for any expenses caused by, incurred for, or resulting from:

- a. Bodily Injury or Sickness which arises out of or in the course of any employment for wage or profit (except for Insured Persons insured for the Optional Occupational Major Medical Expense Insurance Benefit for Corporate Officers, Owners and Partners), nor for a Bodily Injury or Sickness for which the Employee has or had a right to compensation under any Workers' Compensation insurance or similar insurance, or under any Workers' Compensation law, occupational disease law or similar law;
- b. Services or supplies for which no charge is made, or for which the Insured Person is not required to pay, or for which a third party (or his/her insurance coverage) is responsible;
- c. Pregnancy (unless the Insured Employee's eligible Participating Employer has elected the Optional Pregnancy Benefit), except that Complications of Pregnancy shall be considered a Sickness under the Policy;
- d. War or any act of war;
- e. Participation in a riot; engaging in an illegal occupation; injury sustained while legally intoxicated and operating a motor vehicle; injury sustained while under the influence of any controlled substance (unless prescribed by and taken under the direction of a Doctor); or the commission of, or attempting to commit, an assault, battery or felony;
- f. Cosmetic surgery nor any treatment for ensuing complications; cosmetic surgery includes but is not limited to: (1) surgery to the upper and lower eyelid; (2) augmentation mammoplasty; (3) full or partial facial lifts; (4) dermal or chemo abrasion; (5) scar revision; (6) otoplasty; (7) lift, stretch or reduction of abdomen, buttocks, thighs or upper arm; (8) silicone injections to any part of the body; (9) circumcision and (10) rhinoplasty; unless such surgery is required for a condition resulting from congenital defects or birth abnormalities or from Bodily Injury, and (except for a newborn child) such Bodily Injury occurred while the Insured Person was insured under this Part;
- g. Reduction mammoplasty that is not Medically Necessary;
- h. Elective surgery which is not Medically Necessary, except for Eligible Expenses incurred by an Insured Person for vasectomies, tubal ligations or hysterectomies when recommended and prescribed by a Doctor;
- i. Prevention or correction of teeth irregularities, including removal of soft tissue impacted teeth and malocclusion of jaws by wire appliances, braces or other mechanical aids, or any other care, repair, removal, replacement or treatment of or to the teeth or any surrounding tissues, except:
 - 1) treatment made necessary by Bodily Injury to Sound and Natural teeth incurred while the Insured Person was insured under this Part; or
 - 2) for the excision of partial bony or full bony impacted teeth or of a tumor or cyst, or an incision and drainage of an abscess or cyst;
- j. Treatment or surgery as the result of temporomandibular joint dysfunction;
- k. Treatment or surgery as the result of prognathism, retrognathism, micrognathism, or any treatment or surgery to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible;
- l. Penile implant, reconstruction of vasectomy, or reconstruction of tubal ligation;
- m. Keratotomy or other surgical procedures to

- correct refractive errors, or examinations for and the cost of eyeglasses, contact lenses or hearing aids;
- n. Exogenous or morbid obesity, including but not limited to:
 - 1) weight reduction programs of any type;
 - 2) all surgical procedures for the purpose of or as the result of weight reduction of an Insured; and
 - 3) all surgical procedures for reconstruction, repair or reversal of gastric or jejunoileal bypass as a result thereof;
 - o. Repair or replacement of artificial limbs or eyes, except if:
 - 1) for the Insured Person's primary prosthetic used for daily living activities (not an additional or back-up prosthetic, or secondary prosthetic for a specialized purpose or function such as sports, bathing or similar limited activity);
 - 2) made Medically Necessary as a result of physical bodily change, or natural breakdown of the prosthetic, incurred while the Insured Person was insured under this Part;
 - 3) the lack of repair or replacement is significantly impacting one or more daily living activities of the Insured Person;
 - 4) it is recommended and prescribed by a Doctor; and
 - 5) benefits have not previously been paid on behalf of the Insured Person for repair or replacement of artificial limbs or eyes, while the Insured Person was insured under this Part.
 - p. Inpatient and Outpatient prescription drugs which are not directly related to a specific diagnosis, not Medically Necessary or legally obtainable without a written prescription by a Doctor; nor any Outpatient drugs (prescription or non-prescription) unless under the optional Outpatient Prescription Drug Benefit;
 - q. Expenses incurred for periodic physical examinations other than for child supervision services which are not directly related to treatment of a Bodily Injury or Sickness, except as provided for in the Schedule of Benefits;
 - r. Expenses arising from the treatment of a Bodily Injury or Sickness for which the Insured Person is not under the regular care of a Doctor or which are not authorized or prescribed by a Doctor;
 - s. Services furnished by a Hospital or institution which:
 - 1) does not meet the definition specified in the Policy;
 - 2) is owned or operated by the United States Government or any agency thereof or is owned or operated by any State, Province or any other political subdivision unless there is a legal obligation for the Insured Person to pay in the absence of insurance;
 - t. Expenses for treatment, paring or removal of corns, calluses or toenails (other than partial or complete removal of nail roots) except when prescribed by a Doctor who is treating the Insured Person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis; or treatment of the feet by posting or strapping, or range of motion studies, or orthotics;
 - u. Expenses incurred as the result of attempted suicide or intentionally self-inflicted Bodily Injury or Sickness while sane or insane;
 - v. Expenses incurred on a date on which the Insured Person is not insured under this Part;
 - w. Treatment of infertility by artificial insemina-

- tion, in vitro fertilization of an ovum and/or development of an embryo in a laboratory, or use of fertility drugs; except that benefits shall be payable for medical or surgical services which are Medically Necessary for the physical diagnosis or treatment of infertility of an Insured Person, as set forth in paragraph 2 (Eligible Expense) of the Certificate;
- x. Services received or supplies purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, provided the procedure or treatment is approved for use in the United States and the claim is submitted in English or with English translation;
 - y. Any medical procedure or drug considered Experimental Treatment;
 - z. Services or supplies which are not Medically Necessary or which are for maintenance due to bodily injury or sickness, including but not limited to such items as: surgical stockings, special bras following breast reconstruction, or supplies for Durable Mechanical Medical Equipment and prosthetics (including but not limited to prosthetic socks and gel liners); or replacement parts or repairs to Durable Mechanical Medical Equipment and prosthetics (including replacement or repairs due to recall by the manufacturer or required by law or regulation), except as provided for in the Schedule of Benefits;
 - aa. Custodial or Convalescence Care;
 - bb. An organ or tissue transplant or replacement, except those organ or tissue transplants or replacements specified under the Schedule of Benefits; or for or related to transplantation of animal or artificial organs or tissues; or for somatic cell nuclear transfer (SCNT) technologies or stem cell implantation procedures;
 - cc. Any service or supply in connection with the implant of an artificial organ, including the implant of the artificial organ;
 - dd. Any organ which is sold rather than donated to the Insured Person;
 - ee. Any service or supply in connection with autologous bone marrow transplantation for treatment of any disease other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, neuroblastomas and breast cancer when combined with high dose chemotherapy;
 - ff. Any service or supply in connection with autotransfusion/transplantation of autologous stem cells for the treatment of leukopenia from any cause;
 - gg. Any service or supply in connection with identification of a donor from a local, state or national listing;
 - hh. Any services or supplies in connection with cigarette smoking cessation;
 - ii. Any service which is not documented in the Insured Person's medical file;
 - jj. A Pre-Existing Condition, until a continuous period of: (a) twelve (12) months from the Enrollment Date (CA – 6 months, IN – 9 months, KS – 90 days), with respect to other than Late Enrollees, and (b) eighteen (18) months with respect to Late Enrollees (CA – 12 months, IN – 15 months) has elapsed during which he was insured under this Part;
 - kk. Treatment, drugs, or devices for sexual dysfunction;
 - ll. Hypnotherapy when used to treat conditions that are not recognized as Nervous, Mental or Emotional Disorders by the American Psychiatric Association;
 - mm. Consultations and/or treatments provided over the Internet; or
 - nn. Services and supplies related to narcotic maintenance for narcotic addiction.