

SUMMARY OF BENEFITS

Note: The coverage provided by this Policy is individual coverage only. A separate Policy will be issued to each person eligible for and accepted for coverage.

Note: Many covered services require pre-certification or the benefit level is reduced to 50% of covered charges. Please review the Policy carefully to determine which covered services require pre-certification.

Major Medical Expense Benefits For All Plans For Each Covered Person

No Pre-Existing Condition Exclusion shall apply to any Eligible Enrollee as defined in this Policy.

The Plans are defined by the Deductible amount and Stop Loss Limit (Maximum Out-Of-Pocket Expense). Deductible means the amount of Eligible Expenses that a Covered Person must pay before the Policy starts to pay. Stop Loss Limit means the amount of Eligible Expenses that must be incurred by each Covered Person after the applicable Deductible is met.

Maximum Benefits Payable per Lifetime	\$	500,000
Maximum Benefits Payable per Calendar Year	\$	100,000
Maximum Benefits Payable for Prescription Drugs Per Calendar Year	\$	15,000*
Maximum Benefits Payable for Eligible Transplants Per Lifetime (including work ups, and other procedures to determine the suitability of a patient for transplant)	\$	100,000**

Note Regarding All Deductibles Under All Plans:

A policyholder renewing coverage may not select a lower deductible than the deductible selected when the original application was completed. A Policyholder on renewal may only select a higher deductible, or keep the current deductible.

Deductible

NO BENEFITS WILL BE PROVIDED UNTIL THE DEDUCTIBLE HAS BEEN MET.

All Eligible Expenses incurred are subject to the following deductible per Calendar Year for individuals

* The Prescription Drug Benefit is included in, and is not in addition to the \$100,000 Calendar Year Maximum Benefit.

** The Lifetime Maximum Transplant Benefit is included in, and is not in addition to the \$500,000 Lifetime Maximum Benefit.

Plan J	\$	1,000
Plan K	\$	2,000
Plan L	\$	3,500
Plan M	\$	5,000

Benefit Period Calendar Year (Jan. 1 - Dec. 31)

Benefit/Coinsurance Percentages

	Benefit Percentage (LHP Pays)	Coinsurance Percentage (You Pay)
Eligible Expenses (in general)	75%	25%
Eligible Inpatient Hospital Expenses		
**without Pre-Certification	50%	50%
with Pre-Certificatio	75%	25%
Eligible Outpatient Surgery		
**without Pre-Certification	50%	50%
with Pre-Certification	85%	15%
Pre-Admission Testing	85%	15%
*Second Surgical Opinion Benefit	100%	0%

Second Surgical Opinion is mandatory for the following procedures only:

1. All surgery of the nose or jaw (except after trauma)
2. All surgery of the breast (except biopsies or cancer)
3. Podiatric Surgery
4. Any plastic or reconstructive surgery, when cosmetic versus medical necessity is in question.

Stop Loss Limits (Medical Only) (Out-Of-Pocket Expenses)

Maximum Out-Of-Pocket (Medical Expenses Only)

(for each Covered Person after deductible met)

Plan J	\$3,500
Plan K	\$4,500
Plan L	\$4,500
Plan M	\$4,500

** The coinsurance (unreimbursed amount) will not be applied to this Policy's Stop Loss Limit if pre-certification is not obtained.

* The deductible will be waived on these eligible expenses when a Second Surgical Opinion is secured.

- ✓ Pre-Certification of Hospital Admissions and Outpatient Surgery
- ✓ Continued Stay Review
- ✓ Discharge Planning
- ✓ Pre-Certification of Home Health Care
- ✓ Pre-Certification of Hospice Care
- ✓ Pre-Certification of Skilled Nursing Care Facilities
- ✓ Pre-Certification of Chemotherapy and Radiation Treatment
- ✓ Physical, Occupational and Speech Therapy
- ✓ Durable Medical Equipment and Oxygen Services

The Benefit Percentage for inpatient Hospital charges and outpatient surgery is 50%. However, if MediCor Managed Care, LLC is used to obtain Pre-Certification, the Benefit Percentage will be 75% for Hospital admissions and 85% for outpatient surgery, and co-insurance (unreimbursed) amounts will be applied to the Stop Loss Limit.

Mammography Examination & Pap

Testing Benefit

One Visit per Calendar Year

The Benefit Percentage for inpatient Hospital charges and outpatient surgery is 50%. However, if MediCor Managed Care, LLC is used to obtain Pre-Certification, the Benefit Percentage will be 75% for Hospital admissions and 85% for outpatient surgery, and co-insurance (unreimbursed) amounts will be applied to the Stop Loss Limit.

MAJOR MEDICAL EXPENSES NOT COVERED

No Pre-Existing Condition Exclusion shall apply to any Eligible Enrollee as defined in this Policy.

Benefits are **NOT** provided for and this Policy does **NOT** cover care or services for:

- A. Any Injury or Illness covered by any Workers' Compensation Act, Occupational Disease Law or similar law.
- B. Any Injury or Illness arising out of the commission of or attempt to commit an assault, battery, felony or act of aggression, insurrection, rebellion, participation in a riot, or self-inflicted.
- C. Any Injury or Illness due to war or act of war, declared or undeclared.
- D. Charges that in the absence of coverage would not be made; or, charges for which there is no legal obligation to pay.
- E. Any and all charges incurred after termination of coverage.
- F. Charges for care or services furnished by any federal agency.
- G. Any Injury or Illness while serving as a member of the Armed Forces.
- H. Charges that are not Medically Necessary (as defined) for treatment of Illness or Injury.
- I. Charges in excess of the Maximum Allowable Charge (as defined) for care or services provided under this Policy.
- J. Care or treatment given by a member of the Covered Person's immediate family. (Parents, spouse, children or siblings).
- K. Any charges for services that are not related to and consistent with the treatment of any Injury or Illness of the Covered Person.
- L. Charges for routine physicals or general health exams other than those specifically listed as covered.
- M. Charges for medical care, services, or supplies that are not furnished or prescribed by a Physician (as defined).
- N. Charges for experimental or investigational treatment or procedures, or for research purposes, or when not a generally recognized accepted medical practice.
- O. Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an Injury or Illness by any of the following:
 - 1. The American Medical Association; or
 - 2. The U.S. Surgeon General; or
 - 3. The U.S. Department of Public Health; or
 - 4. The National Institute of Health; or
 - 5. The Medical Necessity Review Organization(ies) which administer(s) the Utilization Review Program.

Contact the Medical Necessity Review Organization for information concerning whether particular goods, services, treatments or procedures are approved under the Policy.

- P. Charges related to Cosmetic Surgery and Treatment, as defined.
- Q. Charges not specifically listed as covered under “Major Medical Charges” for:
 - 1. Dental treatment;
 - 2. Oral Surgery.
- R. Charges for diagnosis and treatment of Mental and Nervous Disorders or Substance Abuse Disorders, including charges for prescription drugs prescribed, used or intended for use in treating such disorders.
- S. Charges incurred by a Special Enrollee that relate to a Pre-Existing Condition, as defined in this Policy, until the Special Enrollee has been covered under this Policy for twelve (12) consecutive months. The Special Enrollee shall be given credit against the twelve (12) month Pre-Existing Condition Exclusion period for the aggregate of any prior Creditable Coverage that the Special Enrollee may have. This exclusion shall not apply to Special Enrollees that are dependent children who were enrolled within sixty-three (63) days of birth, adoption or placement for adoption.

No Pre-Existing Condition Exclusion shall apply to any Eligible Enrollee as defined in this Policy.

- T. Charges for eye refractions, eyeglasses or hearing aids or their fitting.
- U. Subject to possible Health Incentives offered as part of the Plan’s Cost Containment Program, Charges in connection with obesity, weight reduction, or dietetic control, including, but not limited to, any surgical procedures related thereto.
- V. Charges for treatment or services for temporomandibular joint dysfunction or TMJ pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.
- W. Charges for procedures in connection with male or female sterilization, or procedures to reverse same.
- X. Charges for routine immunizations and vaccinations, including but not limited to polio, mumps, measles, small pox, DPT, or tuberculosis tine tests.
- Y. Charges for services in the nature of educational or vocational testing or training.
- Z. Any charges for elective abortions.
- AA. Any charges for outpatient food, food supplements or vitamins.
- BB. Any charges for radial keratotomy, photo refractive keratotomy, or other surgery to correct myopia (nearsightedness) or hyperopia (farsightedness).
- CC. Any charges for human heart, human lung, human heart-lung, human bone marrow, human liver, human kidney, human pancreas, or human kidney-pancreas transplants not performed at approved hospital centers in the United States, as designated by Center for Medicare and Medicaid Services of the Department of Health and Human Services of the United States or the United Network for Organ Sharing. A list of approved hospital centers is available from the Medical Necessity Review Organization, and that list is incorporated by reference as a part of this Policy.
- DD. Any charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum; or artificial insemination including but not limited to:
 - 1. Drugs and medicines;
 - 2. Diagnostic and surgical procedures including but not limited to:

- a. Aspiration of ovarian cysts; or
 - b. Harvesting or obtaining eggs; or
 - c. Other surgical treatment of infertility; or
 - d. Diagnostic laboratory and pathology procedures; or
 - e. Diagnostic radiology, nuclear medicine and ultra sound procedures.
- EE. Any charges for stand-by surgeons, pediatricians, anesthesiologists, anesthesiologists, or other Physicians as defined by this Policy; or stand-by supplies, equipment, rooms, or any other service, supply or treatment not actually used in the care or treatment of an Illness or Injury.
- FF. Charges made by; durable medical equipment recommended by, or drugs dispensed by, a physician, surgeon, nurse or other Physician (as defined) who:
- 1. Normally lives with the Covered Person; or
 - 2. Is a member of the Covered Person's family; or
 - 3. Is the Covered Person's employer.
- GG. Any charges for Custodial Care.
- HH. Any charges related to smoking cessation.
- II. Any charges not included in "Major Medical Charges", except those alternate forms of treatment or facilities suggested for use by the Medical Necessity Review Organization which have been approved by the Plan.
- JJ. Any charges incurred for Hospice Care services, unless recommended by a physician and pre-certified by the Medical Necessity Review Organization.
- KK. Any charges incurred for Private Duty Nursing.
- LL. Any charges incurred for Maternity Care, as defined, except that charges for Maternity Care will be covered, as a limited portability benefit only, and only under the following circumstances:
- 1. The applicant is an Eligible Enrollee (i.e., not a Special Enrollee); and
 - 2. The applicant had maternity benefits under her last group coverage; and
 - 3. The applicant was terminated involuntarily from her last group coverage; and
 - 4. The applicant was neither eligible for nor offered any other health coverage providing maternity benefits; and
 - 5. The applicant was pregnant at the time application was made for coverage under this Policy; and
 - 6. The applicant requested maternity coverage at the time application was made for coverage under this Policy
- In the event that all of the foregoing requirements are met, the applicant shall have coverage for Maternity Care under this Policy, but only for the pregnancy which existed at the time application was made for coverage under this Policy. Coverage for Maternity Care shall be subject to all the other terms, conditions, and limitations of this Policy, including all deductibles, co-payment requirements, and policy limits.
- Complications of Pregnancy, as defined, are covered.
- MM. Any charges for sex transformations or treatment of sexual dysfunctions, including, but not limited to, prescription medications and surgical procedures.
- NN. Sales tax or interest.

- OO. Penile prostheses implantation.
- PP. Electrical power, water supply and sanitary waste disposal systems, or the installation and operation of any equipment.
- QQ. Any charges for air conditioners, dehumidifiers, air purifiers, arch supports, corrective or orthopedic shoes, heating pads, hot water bottles, home enema equipment, rubber gloves and deluxe equipment.
- RR. Charges made by a Hospital owned or operated by the U.S. Government, where the individual is not required to pay by law, or charges for a hospital confinement in any other Hospital for which the Covered Person is not required to pay if no insurance coverage exists.
- SS. Charges incurred as a result of a sports-related injury in which the participant is engaged in the sport for profit.
- TT. Charges incurred for smoking cessation, weight loss, or other lifestyle modification programs intended to improve health or wellness, unless in connection with an authorized case management or disease management program under this Policy.
- UU. Any charge for services or articles the provision of which is not within the scope of the authorized practice of the institution or individual providing the services or articles.
- VV. Any charge for confinement in a private room to the extent such charge is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a Physician.
- WW. Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to an eligible person each Calendar Year.
- XX. Personal supplies or personal services provided by a hospital or nursing home or any other non-medical or non-prescribed supply or service.
- YY. Any expense incurred prior to the effective date of coverage by the Plan, or during any Pre-existing Condition Exclusion period that may be applicable to a Special Enrollee. No Pre-Existing Condition Exclusion will be applied to any Special Enrollee who is a Dependent Child of an Eligible Enrollee.
- ZZ. In the event the amounts charged for services and articles provided by or at the direction of a (Non-Preferred) health care Provider exceed the Maximum Allowable Charge for covered expenses as provided herein, the health care provider may seek payment of the balance owed from the Policyholder. Reimbursement by Preferred Providers, however, may not exceed the contracted amount for covered expenses. Preferred Providers may not collect from the policyholder or plan any reimbursement exceeding contracted amounts. Preferred Providers may collect any applicable deductible, co-payment, co-insurance or ineligible charges. As to the deductible, co-payment or co-insurance, Preferred Providers agree not to collect more than the contracted rate.
- AAA. Any charges relating to organ transplants, except for the following human organ transplants only:
1. Cornea transplants
 2. Artery or vein transplants
 3. Kidney transplants
 4. Joint replacements
 5. Heart valve replacements

6. Implantable prosthetic lenses in connection with cataracts
7. Prosthetic by-pass or replacement vessels
8. Bone marrow transplants
9. Heart transplants
10. Liver transplants
11. Lung transplants
12. Pancreas transplants

No charges incurred by organ donors are covered.

No charges for organ procurement, organ harvesting or organ acquisition are covered, even if incurred in connection with a covered procedure.

No experimental replacement of tissue or organs is covered by this Policy.

Charges for workups, or other procedures to determine a patient's need for or suitability for an organ transplant are excluded unless such charges relate to a covered organ transplant. Even if such charges relate to a covered organ transplant, such charges shall be included in the Lifetime Maximum benefit for organ transplants.

The Lifetime Maximum for transplants shall not apply separately to multiple organ transplants. When the Lifetime Maximum Benefit has been reached, no further benefits will be paid under the Policy for any charges relating to organ transplants, including workups.

BBB. Diagnosis, treatment of, or counseling for sleep disorders, including, but not limited to, sleep apnea.

ELIGIBILITY

Any natural person who is a resident of the State of Louisiana as of the date application for coverage is made, and who meets the definition of "eligible individual" as set forth in La. R. S. 22:250.12 (B), 42 U.S.C.A. § 300gg-41 (b), 45 C.F.R. § 148.103 and 45 C.F.R. § 148.120 (f), or La. R.S. 22:250.13(H).

Subject to the requirements of the statutes and regulations referred to in the preceding paragraph, an "eligible individual" must:

1. Be a resident of the State of Louisiana at the time application for coverage is made; and
2. Have an aggregate of eighteen (18) months of Creditable Coverage as of the date for which coverage is sought with no "significant break in coverage"; for persons qualifying under Section 3 B., below, the eighteen (18) months of creditable coverage be continuous, and must all have been earned in this state, as required by La. R.S. 22:250.12 H. (1)
3. Meet either of the following requirements:
 - A. Have had his/her most recent prior health coverage under a Group Health Plan, a Governmental Plan or a Church Plan;
 - or
 - B. Have had his/her most recent prior coverage under an individual policy which was discontinued by the insurance company under La. R.S. 22:250.13 C., and has not had an offer of individual health insurance coverage by a health insurance issuer that does not include exclusions from coverage as required by La. R.S. 22:250.12 H; and
4. Not have any other health insurance or be eligible for coverage under any Group Health Plan, Medicare or Medicaid; and
5. Not have had his/her most recent health coverage terminated for nonpayment of premium, fraud, or intentional misrepresentation of material fact with respect to such coverage; and
6. Have elected COBRA Continuation Benefits or other similar continuation benefits and must have exhausted such benefits, if such benefits were available and offered.

Additionally, persons who do not qualify as Eligible Individuals may qualify for coverage as Special Enrollees, if they meet the definition of that classification of coverage. See the definition of Special Enrollee in the Definitions section for more information. Special Enrollees will be subject to a twelve (12) month Pre-Existing Condition Exclusion, **except** for children enrolled within sixty-three (63) days of birth, adoption or placement for adoption.

Notwithstanding the foregoing, a child who was enrolled within sixty-three (63) days of birth, adoption or placement for adoption will be treated as an Eligible Individual and no Pre-Existing Condition Exclusion will be applied to such a child.

A "significant break in coverage" shall have the meaning set forth in 42 U.S.C.A. § 300gg (c) (2) and 45 C.F.R. § 146.113 (b) (3) (iii), and shall have the effect set forth in La. R. S. 22:250.2 (B).

Subject to the definitions set forth in the above cited statutes and regulations, a "significant break in coverage" occurs, and an individual loses all Creditable Coverage acquired prior to the "significant break in coverage," when the individual has a period of sixty-three (63) consecutive days during which the individual had no Creditable Coverage.

The period of time spent in affiliation periods or waiting periods does not count against the 63 day period for purposes of calculating a "significant break in coverage." The period of time spent in affiliation periods or waiting periods does not constitute Creditable Coverage.

A) For federally qualified Health Coverage Tax Credit (HCTC) individuals, an aggregate of three (3) months of Creditable Coverage as of the date for which coverage is sought with no "significant break in coverage" is required.

B) HCTC qualified individuals:

- 1) Must be identified specifically as an eligible HCTC qualified individual
- 2) Cannot be covered by qualified health insurance
- 3) Cannot be claimed as a dependent on another individual's tax return
- 4) Cannot have other specified coverage, including Medicare
- 5) Cannot be in a federal, state or local prison; and
- 6) Must meet any additional requirements under the HCTC provisions, including, but not limited to, CMS, Internal Revenue Service, Treasury Department, or Louisiana Department of Insurance requirements. This includes regulations and administrative requirements provided by any and all applicable governmental agencies.

Although this Policy is guaranteed renewable at the option of the Policyholder, eligibility requirements must be satisfied at the time of the initial application for coverage under the Policy, and upon each annual renewal of the Policy.

WHEN WILL THE APPLICANT BECOME A COVERED PERSON?

An Applicant will become a Covered Person on the postmark date of the application, or the date of submission of the application to Federal Express, UPS or other commercial delivery service that provides independent documentation of the date of submission of items for delivery, or such later date as the Applicant may qualify. LHP will not accept hand delivery of applications. **All applications are subject to final approval by LHP and coverage is not considered in effect until a certificate of coverage is issued by LHP to the Covered Person. The certificate of coverage will reflect the date coverage became effective.**

A Special Enrollee who is a Dependent Child of an Eligible Enrollee will be covered retroactively to the date of the Special Enrollee's birth, adoption or placement for adoption, as applicable, **provided** that premiums for such coverage are paid retroactively to the date coverage begins.