2009 HIPAA PLAN 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%, or lower, 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 amounts and Medical Stop Loss Limits (Out-Of-Pocket Maximum Expenses).

There is a Medical Deductible and a Prescription Drug Deductible. There is a Medical In-Network Out-of-Pocket Maximum and a Medical Out-of-Network Out-of-Pocket Maximum. Each deductible and out-of-pocket maximum is determined by the deductible chosen upon initial application or renewal.

Once you meet your medical deductible, your medical benefit payments will begin. Once you meet your prescription drug deductible, your prescription drug payments will begin. Your applicable medical deductible AND prescription drug deductible will be determined by the Plan that you have selected. You can only select ONE plan (i.e. you cannot select one Plan's medical deductible and another Plan's prescription drug deductible. You must select one Plan and ALL of the deductible amounts under that plan will apply.)

Deductible means the amount of Eligible Expenses that a Covered Person must pay before the Policy starts to pay. Stop Loss Limit (Out of Pocket Maximum) means the amount of Eligible Medical Expenses that must be incurred by each Covered Person after the applicable Deductible is met.

Maximum Benefits Payable per Lifetime	$	625,000
Maximum Benefits Payable per Calendar Year	$	125,000
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**

* The Prescription Drug Benefit is included in, and is not in addition to the $125,000 Calendar Year Maximum Benefit.
** The Lifetime Maximum Transplant Benefit is included in, and is not in addition to the $625,000 Lifetime Maximum Benefit.

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.

Deductibles

UNLESS SPECIFICALLY PROVIDED HEREIN, NO MEDICAL BENEFITS WILL BE PROVIDED UNTIL THE MEDICAL DEDUCTIBLE HAS BEEN MET.

UNLESS SPECIFICALLY PROVIDED HEREIN, NO PRESCRIPTION DRUG BENEFITS WILL BE PROVIDED UNTIL THE PRESCRIPTION DRUG DEDUCTIBLE HAS BEEN MET.

The medical expenditures accrued towards the medical deductible CANNOT be used towards the prescription drug deductible. The prescription drug expenditures accrued towards the prescription drug deductible CANNOT be used towards the medical deductible.

All Eligible Expenses incurred are subject to the following deductibles per Calendar Year:

	Separate Medical Deductible	**Separate Prescription Drug Deductible**
Plan J	$ 1,000	$ 250
Plan K	$ 2,000	$ 500
Plan L	$ 3,500	$ 875
Plan M	$ 5,000	$1,250

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

Medical Benefit/Coinsurance Percentages

LHP has contracted with many In-Network providers that have agreed to cost containments. These providers will file claims on your behalf and receive direct reimbursement. These providers have also agreed that they will NOT balance bill you for any covered benefit within policy limits. Your benefit reimbursement percentages are higher when using an In-Network Provider.

Also, when using an Out-of-Network Provider, you are financially responsible for any difference between the Reasonable and Customary Charge amount allowed by LHP and the amount charged by the Provider. The Reasonable and Customary Charge is defined by this Policy. This is the charge upon which the benefit percentage is paid.

Selecting a provider is your option. See the table below for the benefit and coinsurance

percentages.

Please see the Preferred Provider Networks listed at pages 1-3 of your policy to make sure that you are utilizing an In-Network provider. You may utilize the website or telephone number to inquire whether your provider is currently in the network.

Note that FACILITY based physicians or providers may **NOT** be contracted health care providers (for example, emergency room physicians, radiologists, pathologists, anesthesiologists, hospitalists, intensivists, and other on-call physicians). Please make sure that the facility based physicians or providers are ALSO part of the In-Network Providers. Any provider(s) NOT contracted as an In-Network provider, will be paid at the Out-of-Network benefit rate.

	In-Network Benefit Negotiated Charges / Rates **No** Balance Billing Allowed		Out-of-Network Benefit Reasonable and Customary Charge *AS DEFINED* Balance Billing May Occur	
	Benefit Percentage (LHP Pays)	Coinsurance Percentage (You Pay)	Benefit Percentage (LHP Pays)	Coinsurance Percentage (You Pay)
Eligible expenses, in general	80%	20%	60%	40%
Inpatient Hospital with Pre Certification	80%	20%	60%	40%
Inpatient Hospital without Pre Certification	50%	50%	40%	60%
Outpatient Surgery with Pre Certification	85%	15%	60%	40%
Outpatient Surgery without Pre Certification	50%	50%	40%	60%
Pre Admission Testing	85%	15%	60%	40%
Second Surgical Opinion	100%	0%	60%	40%
Dialysis Program	100%	0%	60%	40%
Diabetic Supply Program	100%	0%	See Prescription Drug Benefit	See Prescription Drug Benefit

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 Maximum - Medical ~~Provision~~ Only)
(For each Covered Person after medical deductible met)

Plan	In-Network Out of Pocket Medical Maximum	Out-of-Network Out of Pocket Medical Maximum
Plan J	$ 3,500	$ 7,000
Plan K	$ 4,500	$ 9,000
Plan L	$ 4,500	$ 9,000
Plan M	$ 4,500	$ 9,000

There are two **separate** Stop Loss Limits. The lower limit is for services obtained from In-Network Providers and the higher limit is for services obtained from Out-of-Network Providers.

In-Network Medical Deductible and Stop Loss (Out-of Pocket Medical Maximum) ONLY applies to In-Network Providers. Out-of Network Deductible and Stop Loss (Out-of-Pocket Medical Maximum) ONLY applies to Out-of-Network Providers.

The In-Network and Out-of-Network claims CANNOT be combined for application to the Stop Loss Limit. Each claim is applied to the SEPARATE Stop Loss Limit. In-Network claims are applied to the In-Network Stop Loss Limit and Out-of-Network claims are applied to the Out-of-Network Stop Loss Limit. EACH of the Stop Loss Limits (In-Network and Out-of-Network) must be reached individually. They cannot be combined.

After the Stop Loss Limits (Maximum Out-Of-Pocket Expense) are reached in medical benefits (both In-Network and Out-of-Network), LHP will pay 100% of Maximum Allowable Charge(s), as defined, up to the applicable maximum benefit(s) allowed.

Lifetime and Annual Maximum Benefits are calculated as TOTAL benefits (both medical and prescription drug benefits). Maximum benefits will be the calendar year maximum or the lifetime maximum, whichever occurs first.

Prescription drug benefits do not have a Stop Loss Limit. A policyholder will always pay a co-insurance or minimum payment amount for prescription drugs (including the period AFTER the Medical Maximum Out-Of-Pocket Medical Expense listed above is reached). This co-insurance or minimum payment amount for prescription drug benefits begins after the

prescription drug deductible period and continues until the annual prescription drug benefit is reached. Thereafter, the policyholder must pay 100% of prescription drugs.

Daily Hospital Room & Board Maximum Room & Board Limit	In-Network contracted rate or Out-of-Network Reasonable and Customary charge, not to exceed Semi-Private room charge
Skilled Nursing Facility***	Limited to 120 Days per Calendar Year
Home Health***	Limited to 270 Days per Calendar Year
Hospice***	Requires Pre-certification
Chemotherapy and Radiation Treatment***	Requires Pre-certification
Physical, Occupational or Speech Therapy***	Requires Pre-certification
Durable Medical Equipment and Oxygen Services***	Requires Pre-certification
Mammography Examination & Pap Testing Benefit	One Visit per Calendar Year
Other Charges	Please See Specific Benefit Listed in the Plan OR contact the Provider, or Preferred Provider Network or Policy Supervisor, for Cost Estimates

Prescription Drug Benefits

The annual prescription drug deductibles are as follows:

Plan J	$ 250
Plan K	$ 500
Plan L	$ 875
Plan M	$1,250

After your annual Prescription Drug Deductible has been met, Prescription Drug Benefits will be provided as follows:

*** These services must be pre-certified or benefits will be limited to specified percentage of covered charges **and** will not be applied to the Stop Loss Limits.

YOU PAY

Retail Prescription Drug (Pharmacy) Network (30 day supply)

(You must pay whichever is GREATER – minimum or co-insurance amount)

Retail (30 Day Supply)	**Minimum**	**or**	**Co-Insurance**
1st Tier -Generic Medications:	$10	or	20% co-insurance
2nd Tier –Preferred Brand:	$20	or	30% co-insurance
3rd Tier-Non-Preferred Brand	$30	or	40% co-insurance

Retail (90 Day Supply)	**Minimum**	**or**	**Co-Insurance**
1st Tier -Generic Medications:	$30	or	20% co-insurance
2nd Tier –Preferred Brand:	$60	or	30% co-insurance
3rd Tier-Non-Preferred Brand	$90	or	40% co-insurance

Mail Order (90 day Supply)

(You must pay whichever is GREATER – minimum or co-insurance amount)

1st Tier Generic:	$25	or	20% co-insurance
2nd Tier Preferred Brand:	$45	or	30% co-insurance
3rd Tier Non-Preferred Brand:	$85	or	40% co-insurance

4th Tier - Specialty Prescription Drug (Pharmacy) Program (30 day Supply)

Specialty Generic Drugs	20% co-insurance
Specialty Brand Name Drugs	40% co-insurance

*Case Management may, when available, negotiate specialty prescription drugs on behalf of the policyholder. LHP will pay the lower of the negotiated case management rate, or the scheduled specialty drug rate, if Case Management has negotiated a lower amount.

Medical Necessity Review Organization

Medicor Managed Care, LLC (Medicor)

This Plan uses the services of MediCor Managed Care, LLC (Medicor) for the following:

- ✓ Maintenance of lists of Approved Hospital Centers for organ transplants
- ✓ 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

Without pre-certification, the Benefit Percentage for inpatient Hospital charges and outpatient surgery is listed in the Summary of Benefit Percentages. However, if the Medical Necessity Review Organization is used to obtain Pre-Certification, the Benefit Percentage for hospital admissions will be higher as listed in the Summary of Benefit Percentages.

Diabetic Supply Program

The Plan may contract with one or more Diabetic Supply Program Preferred Providers. Participation in the diabetic supply program will provide 100% coverage of diabetic supplies, without application of the deductible or coinsurance payments. In order to qualify for the Diabetic Supply Program, you **must be enrolled, and actively participating in, disease management**. The Disease Management Supervisor is listed in your policy at pages 1 – 3. You must enroll, in writing, with the Disease Management Supervisor in order to participate in the Diabetic Supply Program. You will no longer be enrolled in the program if you are contacted, in writing, by the disease management provider and fail to respond within thirty (30 days) of written notice.

If you do not maintain enrollment in disease management, benefits for diabetic supplies will be paid at the non-preferred provider rate, or at those rates described in your prescription drug benefits.

In no event, shall the Plan pay any amounts that exceeds the annual or lifetime limit.

Dialysis Program

The Plan may contract with one or more In-Network Dialysis Providers to provide a dialysis program to the Plan's Policyholders at discounted rates and for which Policyholders may access enhanced benefits.. In order to qualify for the Dialysis Program, **you must be enrolled, and actively participating in, disease management**. The Disease Management Supervisor is listed in your policy at pages 1 – 3. You must enroll, in writing, with the Disease Management Supervisor in order to participate in the Dialysis Program. You will no longer be enrolled in the program if you are contacted, in writing, by the disease management provider and fail to respond within thirty (30 days) of written notice.

If enrolled, and actively participating in disease management, as defined, the Plan will pay 100% of dialysis benefits **AFTER** the deductible amount has been paid by the policyholder.

In no event, shall the Plan pay any amounts that exceeds the annual or lifetime limit.

Preventative and Wellness Care Benefit

LHP offers a preventive and wellness care benefit designed to prevent more serious and costly illnesses by providing coverage for routine health care. Wellness benefits will be paid at 100% of allowable charges, up to $300 maximum per calendar year for each covered person. The deductible and coinsurance are waived for any wellness benefit, including, but not limited to, the following services when rendered by an **In-Network Provider** up to the maximum $300 per calendar year maximum:

- routine physical exams and associated lab tests
- one routine Pap smear per benefit period
- one prostate (PSA) screening and one digital rectal exam
- one mammography exam
- one routine colon (hemoccult) test
- one routine pelvic exam
- Childhood immunizations, vaccinations and other routine immunizations such as flu, pneumonia, hepatitis B, or human papillomavirus/HPV, if recommended by a physician

Please note that this benefit is limited to $300 per calendar year and is ALSO limited to In Network providers only.

Services must be billed with a preventive/ wellness diagnosis code in order to receive proper credit under the $300 maximum allowance

Regular deductible and coinsurance will apply for these services rendered by an Out-of Network Provider.

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(s) 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 or disease management program, Charges in connection with obesity, weight reduction, or dietetic control. In no event shall any surgical procedure for obesity or weight reduction be covered.

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 male or female sterilization.

X. Charges for routine immunizations and vaccinations, including but not limited to polio, mumps, measles, small pox, DPT, or tuberculosis tine tests unless these services are covered as part of the wellness benefit.

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, anesthetists, 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 that 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 that 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-insurance 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 an **Out-of-Network 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 In-Network Providers, however, may not exceed the contracted amount for covered expenses. In-Network Providers may not collect from the policyholder or plan any reimbursement

exceeding contracted amounts. In-Network Providers may collect any applicable deductible, co-payment, co-insurance or ineligible charges. Ineligible charges include those amounts exceeding the maximum calendar or lifetime maximums and the calendar prescription drug maximum.
As to the deductible, co-payment or co-insurance, In-Network 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.