

Individual Major Medical Insurance Plans

We agree buying health insurance can be difficult - and confusing. There are many companies offering several plans. Benefits are different. Fine print is hard to read and understand. Insurance terms are unfamiliar. And the cost can be surprising. It's important to select a plan that not only fits your budget, but your needs as well. Here are a few things to consider.

KEY BENEFITS

- Both Copay and High Deductible plans available
- Nationwide network of doctors and hospitals
- Choose a plan design to meet your needs
- Convenient payment options: Check, money order, Visa/MasterCard, or automatic bank withdrawal

What are you looking for in a health insurance plan?

- Copay for doctor visits for yourself and your family? Are you mainly concerned about routine health care expenses?
- Lower premiums - are you more concerned about a serious illness? How much responsibility are you willing to take for routine expenses in exchange for lower premiums?

Know what you are responsible for paying.

- **Copay:** a fixed amount you must pay at the time of service (i.e. doctor visit).
- **Deductible:** a flat amount that you are required to pay before the insurance company will pay any benefits.
- **Coinsurance:** the percentage (for example, 80%) paid by the insurance company and the percentage (in this example, 20%) you would pay of the covered expenses once the deductible is met.

Research the network

Network: health care providers (physicians, hospitals and other facilities) that are contracted by the insurance company to provide care at a discounted price as opposed to non-network providers. Are the doctors and hospitals you want to use part of the network offered by the insurance company thereby allowing you to maximize the benefits of the plan?

Copay Plans - "Copay Select" or "Copay Saver"

- Copay plans are more like traditional employer plans with a copayment for routine health care expenses. When you use a Preferred Network doctor for an office visit, the plan will pay 100% of history and exam fees after a \$35 copay with "CoPay Select". The "Copay Saver" plan provides the convenience of copays for doctors visits (limited to 2 visits per person, per calendar year) for a lower monthly premium. Office visit expenses outside your network are not eligible for copay benefits.
- Adult and Child preventative care and child immunization benefits are available with the "Copay Select" plan. Preventative care office visit for \$35 copay (not subject to deductible). X-ray and lab tests are covered at 80% - you pay 20%. Child immunization vaccine and preventative mammogram, pap smear and PSA testing are covered at 80% (not subject to deductible).
- Prescription drug* card benefits are available with the "Copay Select" plan. Tier 1 drugs - \$15 copay; Tiers 2-4 drugs - combined \$150 per person, per calendar-year deductible, then: Tier 2 drugs - \$30 copay; Tier 3 drugs - \$60 copay; 25% coinsurance (you pay) for Tier 4 drugs. The "Copay Select" plan offers a benefit buy-up option to eliminate the \$3,000 annual limit. (*according to a preferred drug list, which changes periodically)

High Deductible Plans - Choice of Deductible and Coinsurance Amounts

- Lower Premiums - With high deductible plans, you're keeping more of your money and taking responsibility for covering minor or routine health care expenses - if they come up. The higher the deductible, the lower the premium. This plan provides coverage for hospital confinements, surgical procedures and the more costly outpatient expenses, such as CAT scans and MRIs.
- You may add optional benefits such as prescription drug card benefits, increase the maximum lifetime benefit to 5 million or add an enhanced "Preventative Care Benefits Package" to the basic plans.

SEE MORE INFORMATION ON REVERSE SIDE

The Benefit Alliance Plan

 Leslie & Associates, Inc.

How Do I Apply For A Major Medical Plan?

The premium for Major Medical coverage is determined by the plan design you choose, your age, sex, state of residence and zip code. **Therefore, it is necessary for you to call Leslie & Associates via the TOLL FREE CUSTOMER SERVICE NUMBER: 1-800-644-6854. Leslie & Associates Customer Service Representatives will answer your questions regarding the Major Medical plans available (coverage not available in all states), provide individualized rate information and assist you with applying for coverage if it meets your needs.** Golden Rule, a UnitedHealthcare company, underwrites the application, issues your policy upon approval, handles the premium billing and pays claims. All Major Medical coverage is subject to approval of your application by the insurance company and submission of the first monthly premium. You will be notified of the actions taken within 45 days after the date of application, or be given the reason for delay.

Dependents

For purposes of this coverage, eligible dependents are your lawful spouse and eligible children. Eligible children must be unmarried and under 25 years of age at the time of application.

Maternity Benefits

No benefits are payable due to pregnancy (except for complications of pregnancy) or routine newborn care unless optional maternity benefit is selected. Additional premium is required and is not available in AR, MD, NC, or VA. This optional benefit helps cover the costs for routine pregnancy and delivery. You pay 20%; the insurance company pays 80% of covered expenses. Benefit Years 1 & 2 the maximum payable is \$2,000; Benefit Years 3 & 4 the maximum payable is \$4,000. After 4 + benefit years, the maximum payable is \$7,500. No covered expenses will be considered for reimbursement for a pregnancy beginning before the maternity benefit's effective date.

General Limitations & Exclusions *(subject to state variations)*

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs are not covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms that could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.
- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a 10 year period.
- Charges for an assistant surgeon are limited to 20% of the primary surgeon's covered fee.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, are limited to a lifetime maximum benefit of \$3,000 (not covered in Saver Plans, subject to state variations). Covered expenses for outpatient diagnosis or treatment of mental disorders are further limited to \$50 per visit. As with any other illness or injury, inpatient care that is primarily for educational or rehabilitative care is not covered.
- Covered outpatient expenses relating to the diagnosis or treatment of any spine or back disorders are limited to a maximum of \$2,000 per calendar year. CAT scan and MRI tests are not subject to this limitation.
- Covered expenses are limited to no more than a 34-day supply for any one outpatient prescription drug order or refill.
- Expenses incurred for cosmetic or aesthetic reasons, such as weight modification or surgical treatment of obesity.
- Expenses which are for any drug treatment or procedure that promotes conception or for any procedure that prevents conception or childbirth.
- Expenses in relation to, or incurred in conjunction with, investigational treatment.
- Expenses resulting from intoxication, as defined by applicable state law in the state where the illness or injury occurred, or under the influence of illegal narcotics or controlled substances unless administered.
- Expenses for alternative treatments, except as specifically identified as covered expenses under the policy/certificate, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Premiums & Renewability

You may renew the coverage by paying the premium as it comes due. The insurance company may decline renewal only for failure to pay premium or if they decline to renew all certificates just like yours issued to everyone in the state where you are then living. Premium rates are set by class, and you will not be singled out for a premium change regardless of your health. The policy plan, age and sex of covered persons, type and level of benefits, time the certificate has been in force and place of residence are factors that may be used in setting rate classes. Premium rates may be adjusted from time to time.

PLEASE NOTE – This is only a brief description of the Major Medical Plan benefits, exclusions and other policy provisions. It is not a contract. All coverage is subject to the terms, conditions and limitations of the insurance company issuing the policy. Individual state limitations and/or variations may apply.