

**PLAN DOCUMENT AMENDMENT #1
FOR**

LOUISIANA ASSESSORS' ASSOCIATION

EMPLOYEE BENEFIT PLAN

EFFECTIVE APRIL 1, 2009

NOTICE IS HEREBY GIVEN that the Louisiana Assessors' Association Employee Benefit Plan document is amended effective April 1, 2009.

CHANGE 1. The following is added to the subsection "Special Enrollment," which appears in the section entitled "PERSONS COVERED AND EFFECTIVE DATES":

Special enrollment rights are also available for employees and/or their dependents who lose coverage under Medicaid or a State Children's Health Insurance Program (SCHIP) or become eligible for a premium assistance subsidy from Medicaid or SCHIP as provided for in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In these cases, the employee must make a request for Special Enrollment to the Plan Administrator within 60 days of loss of Medicaid or SCHIP coverage, or notice of eligibility for a premium assistance subsidy, whichever applies. Coverage will become effective no later than the first day of the month after application is made to the Plan Administrator.

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This Employee Benefit Plan document amendment is hereby adopted in its entirety.

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

FOR

**INSURANCE COMMITTEE OF THE ASSESSORS'
INSURANCE FUND DBA LOUISIANA ASSESSORS'
ASSOCIATION**

EMPLOYEE BENEFITS PLAN

**INSURANCE COMMITTEE OF THE ASSESSORS' INSURANCE
FUND DBA LOUISIANA ASSESSORS' ASSOCIATION**

EMPLOYEE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to describe the provisions of the Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association Employee Benefits Plan, which is a form of a group health plan sponsored and maintained by Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association. The terms of this Summary Plan Description are effective as of January 1, 2009, and govern the administration and payment of claims Incurred on or after that date. **Please review the following information carefully; it supersedes any prior written information about the Plan.**

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HIGHLIGHTS OF THE EMPLOYEE BENEFITS PLAN

This Plan is maintained for the purpose of providing benefits for Eligible Employees and their Eligible Dependents. Although it has no present intention to do so, the Plan Sponsor has reserved the right to amend or even terminate the Plan. Examples of amendments include, but are not limited to, the inclusion of additional cost containment features, increases in deductibles and out-of-pocket expense amounts, and changes in the benefits provided under this Plan. In addition, your Employer may require you to pay a portion of the cost of coverage (employee only or family coverage). Your share of the cost is determined annually, or more frequently if deemed appropriate, by the Plan Administrator.

Eligible Employee

The term “Eligible Employee” shall mean an employee who is regularly scheduled to work at least 35 hours a week for the Employer, who has completed a waiting period of thirty consecutive days while employed, and who is eligible for the Employer’s retirement plan.

The term “Eligible Employee” shall also mean a duly elected or appointed Assessor.

“Eligible Employee” shall also mean retired Assessors or retired employees of the Employer who:

1. are at least 55 years of age (or have at least 30 years of service regardless of age);
2. have at least 12 years of service with the employer; and
3. were covered under the Plan for a minimum of 30 consecutive days immediately preceding the date of retirement.

If such retired employee does not elect to continue coverage in the 30 days prior to the date he ceases to be an employee, or declines or drops coverage at any time after retirement, he will not again be eligible to participate in the Plan. Retired employees are eligible to continue dependent coverage; however, if dependent coverage is not continued or elected at the time of retirement, it cannot be continued or elected at a later date.

The Plan Administrator determines status as an Eligible Employee hereunder.

Eligible Dependent

The Plan Administrator determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a

dependent is an Eligible Dependent under the Plan. The term “Eligible Dependent” shall mean any one or more of the following except that no employee eligible for coverage shall be eligible for coverage as a dependent.

1. The Spouse, as defined by the Plan in the Definitions section, of an Eligible Employee until the date of legal separation or divorce, whichever occurs first. A common law spouse is not eligible for coverage under the Plan, even in a state where common law marriage is recognized. A Domestic Partner is not eligible for coverage under the Plan, even in a state where domestic partnership is recognized.
2. Any unmarried Child of an Eligible Employee who is:
 - a. under the age of 19; or
 - b. under the age of 24 and a Full-Time Student; or
 - c. incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age 19 or 24, whichever is applicable under (a) or (b) above. Such Child must have had continuous coverage as a dependent prior to attainment of such age and have remained covered continuously thereafter. The Plan Administrator may require proof of prior coverage. Additionally, at reasonable intervals following the dependent’s reaching limiting age, the Plan Administrator may require subsequent proof of the Child’s disability and continued incapability of self-sustaining employment. After such two-year period, the Plan Administrator may not require proof more than once each year.

“Child” includes:

- a. a natural child following birth; or
- b. a legally adopted child; or
- c. a child legally placed in the employee’s home for the purpose of adoption by the employee; or
- d. a stepchild who resides in the employee’s household; or
- e. a child of the employee for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order (QMCSO) in accordance with procedures adopted by the Plan Administrator. (Special rules apply to QMCSOs. Contact the Plan Administrator in situations of divorce and child custody for information regarding QMCSOs.)

Eligibility Date

(See “Persons Covered and Effective Dates” section for enrollment details and effective dates.)

Employee: The first day you meet the Plan's definition of an Eligible Employee.

Dependent: The same as the employee's Eligibility Date, if you have Eligible Dependents when you first become eligible to participate in the Plan.

Pre-existing Condition

“Pre-existing Condition” means any illness or injury (other than pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a health care provider or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the three months immediately prior to the Enrollment Date. The following additional rules govern Pre-existing Conditions:

1. Any condition for which medical care was first received during the waiting period cannot be considered a Pre-existing Condition.
2. Genetic status is not an excludable condition in the absence of a diagnosis of the condition related to the genetic information.
3. Pregnancy cannot be excluded under any circumstance.
4. The Pre-existing Condition exclusion period cannot be longer than 12 months (i.e., 365 days) from your Enrollment Date or 18 months from your Enrollment Date for a Late Enrollee, less any period of prior Creditable Coverage. See paragraph following Item 7 below for details.
5. A Pre-existing Condition exclusion may apply if there is a Significant Break in Coverage. “Significant Break in Coverage” means a period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but does not include waiting periods.
6. Pre-existing Condition exclusions cannot apply to newborns or adoptees (under age 18) who are enrolled within 30 days of birth, adoption or placement for adoption.
7. The waiting period must run concurrently with the Pre-existing Condition exclusion period.

Charges for a Pre-existing Condition will not be covered until the Participant has satisfied a period of 12 consecutive months from his Enrollment Date or, for a

Late Enrollee, 18 consecutive months. Prior Creditable Coverage may offset these periods.

“Late Enrollee” means a Participant who enrolls in the Plan other than during the original eligibility period or during a Special Enrollment Period. Refer to the section, “Persons Covered and Effective Dates”, for information concerning Special Enrollment.

If a Participant was covered under the prior plan of benefits of the Employer, and the Pre-existing Condition exclusion still is in effect for him on the effective date of this Plan, the exclusion will end not later than 12 months or 18 months for a Late Enrollee from the beginning of the Pre-existing Condition exclusion period under the prior plan.

You may prove Creditable Coverage by either of two methods:

1. For prior coverage effective on or after July 1, 1996, you may present a written Certificate of Coverage from the source that provided the coverage showing:
 - a. The date the Certificate of Coverage was issued;
 - b. The name of the group health plan that provided the coverage;
 - c. The name of the individual to whom the Certificate of Coverage applies;
 - d. The name, address, and telephone number of the plan administrator or issuer providing the Certificate of Coverage;
 - e. A telephone number for further information (if different);
 - f. Either:
 - (1) A statement that the individual has at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage; or
 - (2) The date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and
 - g. The date Creditable Coverage ended, unless the Certificate of Coverage indicates that coverage is continuing; or
2. If for any reason you are unable to obtain a Certificate of Coverage from another plan (including because the prior coverage was effective prior to July 1, 1996), you may demonstrate Creditable Coverage by other

evidence, including documents, records, third-party statements, or telephone calls by this Plan to a third-party provider of medical services. This Plan will treat an individual as having provided a Certificate of Coverage if that individual:

- a. Attests to the period of Creditable Coverage;
- b. Presents relevant corroborating evidence of some Creditable Coverage during the period; and
- c. Cooperates with the Plan Administrator's efforts to verify his status.

You have the right to request a Certificate of Coverage from your prior health plan, and the Plan Administrator will help you in obtaining the Certificate of Coverage.

If, within a reasonable time after receiving the information about Creditable Coverage, the Plan Administrator determines that a limitation for Pre-existing Conditions applies, it will notify you of that conclusion and will specify the source of any information on which it relied in reaching that determination. The notification will also explain the Plan's appeals procedures and give you a reasonable opportunity to present additional evidence.

Schedule of Medical Benefits

This is only a summary of the Plan’s benefits and is not intended to be all-inclusive. Important information is contained in other sections, including benefit exclusions and limitations. You may find the Definitions section helpful in understanding some of the capitalized terms used throughout this Summary Plan Description, and within certain sections where a term is defined and used there. In addition, the Plan has other requirements and provisions that may affect benefits, such as those described in the sections for Utilization Management and Preferred Provider Organization, and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You also may contact Gilsbar, Inc., the Benefits Services Manager, or the Plan Administrator for assistance. All maximums are per Participant, unless specifically noted as per family.

BENEFIT DESCRIPTION	PPO	NON-PPO	Out-of-Area
LIFETIME MAXIMUM	\$2,000,000		
DEDUCTIBLE, PER CALENDAR YEAR			
Expenses applied toward the satisfaction of the PPO deductible amount will <u>not</u> be applied toward satisfaction of the Non-PPO deductible amount, and vice versa.			
Per Participant	\$500	\$500	\$500
Per Family	3 deductibles	3 deductibles	3 deductibles
The Calendar Year deductible is waived for the following Covered Charges: <ul style="list-style-type: none"> • Outpatient Surgery (PPO and OOA only) • Second/Third surgical opinion • Wellness benefit (First \$100; PPO only) 			
MAXIMUM OUT-OF-POCKET EXPENSES, PER CALENDAR YEAR			
Expenses applied toward the satisfaction of the PPO out-of-pocket amount will <u>not</u> be applied toward satisfaction of the Non-PPO out-of-pocket amount, and vice versa.			
Per Participant	\$2,500	\$10,000	\$5,000
NOTE: The following charges do not apply toward the out-of-pocket expense amount and are never paid at 100%: <ul style="list-style-type: none"> • Deductibles, PPO copayments, and Utilization Management Penalties • Expenses paid at a percentage other than 60%, 80% or 90% • Prescription drug card copayments and expenses • Outpatient treatment of Mental/Emotional Disorders (Non-PPO only) • Outpatient treatment of Substance Abuse (Non-PPO only) 			

BENEFIT DESCRIPTION	PPO	NON-PPO	Out-of-Area
UTILIZATION MANAGEMENT PENALTY			
<ul style="list-style-type: none"> • Reduction of benefit percentage for Inpatient confinements to 60% for the first \$15,000 of eligible expenses for failure to precertify. • Reduction of benefit percentage to 0% for Morbid Obesity for failure to precertify expenses. • No Penalty for failure to precertify Organ Transplants, Durable Medical Equipment over \$500 or Prosthetics, however, precertification is strongly recommended. <p>See the Utilization Management section for details.</p>			
COPAYMENTS AND BENEFIT PERCENTAGES			
Allergy Testing	90% after deductible	60% after deductible	80% after deductible
Allergy Treatment	90% after deductible	60% after deductible	80% after deductible
Ambulance	90% after deductible	60% after deductible	80% after deductible
Attention Deficit Disorder	90% after deductible	60% after deductible	80% after deductible
Cardiac Rehabilitation (Phases I and II only)	90% after deductible	60% after deductible	80% after deductible
CAT Scan	90% after deductible	60% after deductible	80% after deductible
Chemotherapy & Radiation Therapy	90% after deductible	60% after deductible	80% after deductible
Chiropractic Treatment (\$2,000 Calendar Year maximum)	90% after deductible	60% after deductible	80% after deductible
Contraceptives (Injectable or Implantable only)	90% after deductible	60% after deductible	80% after deductible
Durable Medical Equipment	90% after deductible	60% after deductible	80% after deductible
Durable Medical Equipment over \$500 must be precertified. See the Utilization Management section for details.			
Emergency Room	90% after deductible	60% after deductible	80% after deductible
Extended Care/ Skilled Nursing Facility (eligible charge 50% of Hospital semi-private rate) (60 days Calendar Year maximum)	90% after deductible	60% after deductible	80% after deductible

BENEFIT DESCRIPTION	PPO	NON-PPO	Out-of-Area
Extended Care/Skilled Nursing Facility (continued)...			
Participant must have been confined in a Hospital for at least 3 days and then admitted to the facility within 14 days after discharge from the Hospital.			
Home Health Care	90% after deductible	60% after deductible	80% after deductible
Hospice Care	90% after deductible	60% after deductible	80% after deductible
Bereavement Counseling (\$200 Calendar Year maximum)	90% after deductible	60% after deductible	80% after deductible
Hospital Expenses	\$100 copay per day for up to 3 days, and 90% after deductible	\$100 copay per day for up to 3 days, and 60% after deductible	\$100 copay per day for up to 3 days, and 80% after deductible
Room and Board is limited to the semi-private room rate, or if the Hospital has private rooms only, 90% of the lowest private room rate.			
Copay is applied per Continuous Period of Confinement.			
Hospital Intensive Care Unit (eligible charge is ICU charge)	\$100 copay per day for up to 3 days, and 90% after deductible	\$100 copay per day for up to 3 days, and 60% after deductible	\$100 copay per day for up to 3 days, and 80% after deductible
Copay is applied per Continuous Period of Confinement.			
Infertility/Sterility (\$1,000 Calendar Year maximum)	90% after deductible	60% after deductible	60% after deductible
See the Medical Benefits section for details about this benefit.			
Maternity	90% after deductible	60% after deductible	80% after deductible
Pregnancy expenses for dependent Children are covered.			
Mental/Emotional Disorder – Inpatient (30 days Calendar Year maximum)	\$100 copay per day for up to 3 days, and 90% after deductible	\$100 copay per day for up to 3 days, and 60% after deductible	\$100 copay per day for up to 3 days, and 80% after deductible
Physician's visits are limited to one per day.			
Mental/Emotional Disorder – Outpatient (45 visits Calendar Year maximum)	60% after deductible	50% after deductible	60% after deductible

BENEFIT DESCRIPTION	PPO	NON-PPO	Out-of-Area
Morbid Obesity (Precertification required)	90% after deductible	60% after deductible	80% after deductible
See the Medical Benefits section for details about this benefit.			
MRI	90% after deductible	60% after deductible	80% after deductible
Occupational Therapy	90% after deductible	60% after deductible	80% after deductible
Organ Transplants (Precertification Required)	90% after deductible	60% after deductible	80% after deductible
Outpatient Surgery (Facility and Physician combined)	\$200 copay, then 90%, no deductible	60% after deductible	\$200 copay, then 80%, no deductible
Physical Therapy	90% after deductible	60% after deductible	80% after deductible
Physician Services	90% after deductible	60% after deductible	80% after deductible
Preadmission Testing	90% after deductible	60% after deductible	80% after deductible
Prescription Drugs – Inpatient (See Hospital Expenses)			
Prescription Drugs – Outpatient (See Prescription Drug Benefits schedule and section)			
Private Duty Nursing (Limited to Outpatient only)	90% after deductible	60% after deductible	80% after deductible
Prosthetics (Precertification Required)	90% after deductible	60% after deductible	80% after deductible
Routine Colonoscopies	90% after deductible	60% after deductible	80% after deductible
Second/Third Surgical Opinion	100%, no deductible	100%, no deductible	100%, no deductible
Sleep Disorders	90% after deductible	60% after deductible	80% after deductible
Speech Therapy	90% after deductible	60% after deductible	80% after deductible
Substance Abuse – Inpatient (\$25,000 Lifetime maximum, combined with Outpatient treatment)	\$100 copay per day for up to 3 days, and 90% after deductible	\$100 copay per day for up to 3 days, and 60% after deductible	\$100 copay per day for up to 3 days, and 80% after deductible
Physician's visits are limited to one per day.			

BENEFIT DESCRIPTION	PPO	NON-PPO	Out-of-Area
Substance Abuse – Outpatient (eligible charge \$80 per visit) (\$25,000 Lifetime maximum, combined with Inpatient treatment)	60% after deductible	50% after deductible	60% after deductible
Physician's visits are limited to one per day.			
Temporomandibular Joint Syndrome (\$2,000 Calendar Year maximum)	90% after deductible	60% after deductible	80% after deductible
Maximum includes surgical and nonsurgical treatment combined, including orthognathic surgery.			
Tubal Ligation & Vasectomy	90% after deductible	60% after deductible	80% after deductible
Urgent Care Facility (includes all non-surgical covered charges billed by facility)	90% after deductible	60% after deductible	80% after deductible
Vision Therapy	90% after deductible	60% after deductible	80% after deductible
Wellness Benefit First \$100	100%, no deductible	60% after deductible	80% after deductible
After the first \$100	90% after deductible	60% after deductible	80% after deductible
Adult Wellness benefit includes physical exam, X-ray & lab, immunizations that are recommended by the Centers for Disease Control, gynecological exam, mammogram*, pap smear, prostatic/testicular exam, colon exam or cholesterol screening. *Mammograms are limited to 1 every 12 months.			
X-Ray & Lab	90% after deductible	60% after deductible	80% after deductible
Other Covered Expenses	90% after deductible	60% after deductible	80% after deductible

Schedule of Prescription Drug Benefits

The following schedule summarizes amounts paid by the Plan. Please refer to the Prescription Drug Benefit section for a description of covered expenses and benefit exclusions and limitations.

Prescription Drug Deductible (waived for Generic drugs)	
Per Participant, per Calendar Year	\$100

Prescription Card Options	Copayment	Percentage Payable
Retail Pharmacy Option (34-day supply)		
Generic drug	\$5.00	100%
Preferred Brand Name drug	\$25.00	100%
Non-Preferred Brand Name drug	\$40.00	100%
Specialty drugs	\$40.00	100%
Retail 90 Program (34 – 90 day supply)		
Generic drug	\$12.50	100%
Preferred Brand Name drug	\$62.50	100%
Non-Preferred Brand Name drug	\$112.00	100%
Specialty drugs	\$112.00	100%
Mail Order Option (90-day supply)		
Generic drug	\$12.50	100%
Preferred Brand Name drug	\$62.50	100%
Non-Preferred Brand Name drug	\$112.00	100%
Specialty drugs	\$112.00	100%

Brand Name means a trade name medication.

Generic drug means a prescription drug that has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Preferred Brand Name drug means a list of trade name prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Non-Preferred Brand Name drug means a trade name prescription medication that is not on the Preferred Brand Name drug list.

Specialty Pharmacy Benefit – Certain injectable medications used for the treatment of complex health conditions, if covered, must be obtained through the Specialty Pharmacy Benefit Program. The following conditions may require drugs that fall under the Specialty Pharmacy Provider Network, if covered, and may include, but are not limited to: Cystic Fibrosis, Multiple Sclerosis, Hemophilia, Rheumatoid Arthritis, and Viral Hepatitis. Prescriptions for these types of drugs may be filled only after enrolling in the Specialty Pharmacy Program. Members must enroll in the Specialty Program which uses one of Caremark's 21 Therapeutic Resource Centers

Schedule of Dental Benefits

The following schedule summarizes amounts paid by the Plan. Please refer to the Dental Benefits section for a description of covered expenses and benefit exclusions and limitations. The Calendar Year deductible for medical benefits does not apply to dental services.

DEDUCTIBLES

Dental Deductible (waived for Type I expenses)	
Per Participant, per Calendar Year (3 per family)	\$50

BENEFIT PERCENTAGES & MAXIMUMS

The Calendar Year maximum is for Type I, II and III benefits combined. The Lifetime maximum is for Type IV benefits only.

BENEFIT DESCRIPTION	PERCENTAGE PAYABLE	MAXIMUM BENEFIT
Type I - Preventative	100%, no deductible	\$2,000 Calendar Year maximum for Type I, II and III combined
Type II - Basic Restorative	80% after deductible	
Type III - Major Restorative	50% after deductible	
Type IV – Orthodontics	60% after deductible	\$2,000 Lifetime maximum

DEFINITIONS

For this Summary Plan Description, the following terms have the meanings given them in this section, unless otherwise defined elsewhere in the Summary Plan Description for the purpose of specific provisions. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.**

Accident: An unintentional, unforeseeable and undesirable happening that results in bodily Injury for which medical or dental treatment is required.

Actively at Work and Active Work: Actually performing the regular duties of the employee's occupation at an Employer-designated work site. For a vacation, holiday or scheduled non-working day (e.g., weekend, etc.), Actively at Work and Active Work mean the capacity to perform the regular duties of the employee's occupation at an Employer-designated work site. An employee will be deemed Actively at Work if the employee is absent from work due to a health factor.

Allowable Charge: The Preferred Provider Organization's contracted rate for PPO provider charges. For Non-PPO provider charges, the Allowable Charge is the Reasonable and Customary amount; however, if the Plan Administrator secures a discount, the allowable charge will be the discounted amount.

Benefit Services Manager: Gilsbar, Inc., the entity that performs certain contracted nondiscretionary administrative services for the Plan pursuant to the terms of the Benefit Services Management Agreement.

Calendar Month: The period starting from one date to the same date in the following month less one, or if that date does not exist in the following month, the last date in that following month.

Calendar Year: A period of twelve months commencing January 1 and ending December 31 of the same year.

Certificate of Coverage: A written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Chiropractic Treatment: Skeletal adjustments, modalities, spinal/cerebral manipulation or other treatment in connection with the detection and correction, by manual means, of structural imbalance or subluxation of the human body. Such treatment is done to remove interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Continuous Period of Confinement: All periods of confinement due to the same or a related cause or condition, unless periods are separated by one month during which the Covered Employee or Covered Dependent was not confined in either a Hospital or an Extended Care Facility or Skilled Nursing Facility.

Cosmetic or Cosmetic Surgery: Services or supplies designed to improve appearance, or surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Covered Dependent: A dependent covered pursuant to the eligibility requirements of the Plan; however, a dependent eligible as a dependent of more than one Covered Employee may not be a Covered Dependent of more than one employee.

Covered Employee: An employee covered pursuant to the eligibility requirements of the Plan, except that no employee may be covered simultaneously as an employee and a dependent.

Creditable Coverage: Coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, or a State Children's Health Insurance Program.

Custodial or Custodial Care: Care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Elective Surgical Procedure: Any non-Emergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

Eligibility Date: The day on which employees and dependents of employees become eligible to participate in the Plan.

Eligible Dependent: (See Highlights section.)

Eligible Employee: (See Highlights section.)

Emergency: An emergency medical condition is defined as a severe medical condition of recent onset that would lead a reasonably prudent and knowledgeable lay person to believe that failure to obtain immediate medical attention could result in serious jeopardy to health or serious impairment to bodily function or to any bodily organ or part.

Examples of Emergency medical conditions are:

- Chest pain
- Heart attack
- Head injuries
- Strokes (cerebrovascular accidents)
- Poisoning
- Convulsions
- Severe bleeding
- Fractures
- Vomiting blood
- Extreme difficulty breathing
- Sudden severe pain anywhere in the body
- Threat of bodily harm to self or others

If you believe you are having a medical emergency, call 911 (or the appropriate emergency number in your area) or go immediately to the nearest appropriate medical facility.

Employer: Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association, including any affiliate or subsidiary thereof.

Enrollment Date: The first day of coverage or the first day of the waiting period, whichever comes first. For a Late Enrollee, the Enrollment Date is the first day of coverage.

Experimental or Investigational: Any treatment, equipment, new technology, drug, procedure or supply which:

1. is not recognized by the state or national medical communities;
2. does not have final approval from the appropriate government regulatory bodies of the United States;
3. is not supported by conclusive, scientific evidence regarding the effect on health outcome; or

4. is not considered standard medical treatment for the patient's specific condition when compared with established, more conventional or widely recognized treatment alternatives.

Any treatment, equipment, new technology, drug, procedure or supply may be considered Experimental or Investigational within this definition, even if a Physician has previously prescribed, ordered, recommended or approved such treatment. The Plan Administrator determines what is considered Experimental or Investigational.

Extended Care or Skilled Nursing Facility: A licensed facility operating pursuant to law which is primarily engaged in providing (for compensation from its patients) skilled nursing care on an Inpatient basis during the convalescent stage of Illness or Injury under 24-hour-a-day supervision of a Physician or registered graduate Nurse, and which maintains permanent facilities for the care of ten or more bed patients. Such a facility must maintain complete medical records on each patient and have established methods and procedures for the dispensing and administering of drugs. In no event shall the term include a facility that is primarily:

1. A rest home, retirement home or home for the aged;
2. A school or similar institution;
3. Engaged in the care and treatment of Substance Abuse, or of mentally ill or senile persons; or
4. Engaged in Custodial Care.

Full-Time Student: An Eligible Dependent enrolled in and regularly attending an accredited college, university or vocational school and carrying the minimum number of credit hours required to maintain Full-Time Student status. If the covered student loses full-time status due to a decrease in credit hours, coverage will continue until the beginning of the next regular session. Also, a Full-Time Student's coverage will continue until the beginning of the next regular session unless graduation occurs, terminating coverage. Regular session dates are January 1 thru August 31 for the spring semester, and September 1 thru December 31 for the fall semester.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency: An agency that:

1. Is primarily engaged in providing skilled nursing and other therapeutic services to the patient in his home;

2. Is duly licensed or approved by the appropriate governmental body if such licensing or approval is legally required;
3. Has policies established by a professional group associated with the organization, including at least one Physician and at least one registered Nurse to govern the services provided;
4. Provides for full-time supervision of such services by a Physician or by a registered Nurse; and
5. Maintains a complete medical record of each patient.

Home Health Care Expenses: The Allowable Charge made by a health care agency for the following necessary services or supplies furnished to the Covered Employee or Covered Dependent in such individual's home in accordance with the home health care plan for care for which the patient would otherwise have been hospitalized:

1. Part-time or intermittent nursing care by or under the supervision of a registered Nurse;
2. Part-time or intermittent home health care aide services that consist primarily of caring for the patient;
3. Physical therapy, Occupational Therapy and speech therapy provided by the Home Health Care Agency; and/or
4. Medical supplies, drugs and medications prescribed by a Physician and laboratory services by or on behalf of a certified Home Health Care Agency, to the extent such items would have been covered under any other provisions of the Plan had the Covered Employee or Covered Dependent been confined in a Hospital.

Hospice: A licensed service that offers a coordinated program of home care and Inpatient care for a Terminally Ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social and economic stresses often experienced during the final stages of life.

Hospital: An institution operated pursuant to law that is accredited by the appropriate national regulatory body for Hospital accreditation. It must be primarily engaged in providing (for compensation from its patients) medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis. It must also provide such facilities under the supervision of a staff of Physicians and with 24-hour-a-day nursing service by

registered graduate Nurses. In addition, the definition of a Hospital shall include the following:

1. A surgery center;
2. A rehabilitation hospital, if it provides medical supervision by a Physician, 24-hour-a-day nursing services by registered graduate Nurses and treatment programs developed by a staff of professionals who specialize in rehabilitative care, and has transfer arrangements with at least one other Hospital providing acute care and surgical facilities;
3. A Substance Abuse treatment center that is licensed by the state or federal government, subject to any exclusions and limitations on such treatment contained in this Plan.

The definition of a Hospital shall not include any institution or part thereof which is used principally as a rest facility, residential treatment facility, Extended Care Facility, nursing facility, facility for the aged or for Custodial Care, or a halfway house.

Illness: A bodily or Mental/Emotional Disorder of any kind of any Participant. Illness includes pregnancy for the purpose of benefit determination. Illness also includes Injury where appropriate to the context.

Incurred or Incurred Date: The actual date a specific service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Injury: A bodily injury resulting from an Accident sustained by any Participant. All injuries sustained by a Participant in one Accident will be considered one Injury.

Inpatient: A person who is confined in a Hospital as a registered bed patient and who is charged at least one day's room and board by the Hospital.

Late Enrollee: A Participant who enrolls in the Plan other than:

1. during the first period in which the individual is eligible to enroll under the Plan; or
2. during a Special Enrollment Period.

Lifetime Maximum Benefit: The Lifetime Maximum Benefit is the absolute limit on what this Plan will pay for each Participant's covered expenses, even if other

provisions of the Plan appear to entitle the Participant to more. "Lifetime" shall mean while covered under this Plan or any other plan maintained by the Employer.

Marriage or Married: A legal union between one man and one woman as husband and wife.

Medically Necessary or Medical Necessity: Describes medical or dental treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;
2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;
3. Is not primarily Custodial Care; and
4. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

Medicare: All parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act of 1965, as now constituted or as hereafter amended.

Mental/Emotional Disorder: Any disorder characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental/Emotional Disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

Morbid Obesity: A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Participant.

Nurse: A licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) who does not usually live with the patient and is not a member of his family.

Occupational Therapy: The therapeutic use of self-care, work or other therapy activities for the sole purpose of reducing disability and restoring function and motor skills following an Injury or Illness.

Out-of-Area: The area outside a 30-mile radius of the Employee's primary residence.

Outpatient: A person who is not admitted as an Inpatient but who receives medical care.

Outpatient Surgery: Surgery performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office. An ambulatory surgical facility is defined as a licensed, specialized facility, within or outside the Hospital facility, that meets all the following criteria:

1. Is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located and primarily for the purpose of performing surgical procedures;
2. Is operated under the supervision of a Medical Doctor (M.D.) who is devoting full time to such supervision;
3. Provides at least two operating rooms and one post anesthesia recovery room;
4. Provides the full-time service of one or more Registered Nurses for patient care in the operating rooms;
5. Maintains a written agreement with at least one or more Hospitals in the area for immediate acceptance of patients who develop complications;
6. Maintains an adequate medical record for each patient. The medical record must contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Participant: Any Eligible Employee or Eligible Dependent who has elected coverage under this Plan. Participant, covered individual, and covered person have the same meaning.

Physician: A duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor and auxiliary personnel which can include clinical

psychologists, board-certified social workers, licensed professional counselors, Family Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service:

1. within the scope of the license; and
2. applicable state law requires such practitioner to be licensed.

Plan: The arrangement created by this Plan Document and Summary Plan Description, and which may be amended from time to time.

Plan Administrator: Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association.

Plan Document: This Plan Document and Summary Plan Description.

Plan Year: A period of twelve consecutive months commencing on either the effective date of the Plan or on the day following the end of the first Plan Year if the first Plan Year is a short year.

Pre-existing Condition: Any illness or injury (other than pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a health care provider or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the three months immediately prior to the Enrollment Date.

Preferred Provider Organization or PPO: A network of providers offering discounted fees for services and supplies to Participants. The network will be identified on the Participant's Plan identification card.

Reasonable and Customary: Charges made for medical or dental services or supplies essential to the care of the Participant will be considered Reasonable and Customary if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received. This may be established by the Plan Administrator by use of any customary or accepted method. In determining whether charges are Reasonable and Customary, the Plan Administrator will give due consideration to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill, or experience.

Reconstructive Surgery: Surgery performed to restore function by reshaping abnormal structures of the body caused by Illness, Injury, congenital defects or developmental abnormalities.

Routine Dental Exam: Exam by dentist not required because of Illness or Injury.

Routine Physical Exam: Exam by doctor not required because of Illness or Injury.

Second Surgical Opinion: A written report from a qualified Physician, who is not financially or professionally associated with the first Physician, as to the Medical Necessity of a future surgical procedure that was recommended by another Physician. This will include all Outpatient tests and diagnostic procedures Medically Necessary to render such opinion.

Significant Break in Coverage: A period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but does not include waiting periods and affiliation periods.

Sound, Natural Tooth: Any tooth that is sufficiently supported by its surrounding natural structures and is not decayed or weakened by previous dental work to the extent that it is more susceptible to damage. This susceptibility includes, but is not limited to, a tooth that is restored by a multisurface restoration or a tooth that has had root canal therapy.

Spouse: A person of the opposite sex who is a husband or a wife.

Substance Abuse: The regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Summary Plan Description: This Plan Document and Summary Plan Description.

Temporomandibular Joint (TMJ) Syndrome: One or more jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Terminally Ill: Someone who has a life expectancy of approximately six months or less, as certified in writing by the Physician who is in charge of the patient's care and treatment.

Total Disability or Totally Disabled: A disability which prevents the Covered Employee from engaging in any of the significant duties of his regular occupation due to an Injury or Illness; or

A disability which prevents the Covered Dependent from engaging in all the normal activities of healthy persons of the same age and sex due to an Injury or Illness.

PERSONS COVERED AND EFFECTIVE DATES

Election of Coverage

If you are an Eligible Employee as defined by the Plan in the Highlights, you may elect coverage under the Plan by submitting a completed, valid enrollment form which you may obtain from the Plan Administrator. You may elect coverage for yourself only, you and your Spouse, you and your dependent children, or your whole family. The application process involves electing coverage and paying the required contribution, if any, for the type of coverage you've chosen. The Plan Administrator determines annually, or more frequently if deemed appropriate, whether (and to what extent) employees will be required to contribute towards the cost of coverage under the Plan. Contributions may be required to obtain employee and/or dependent coverage.

Effective Date of Employee Coverage

Your Eligibility Date is listed in the Highlights section. This is the earliest date that you may become covered under the Plan. If you choose not to enroll within 30 days of your Eligibility Date, you will be considered a Late Enrollee. You will also be considered a Late Enrollee if you do not enroll within 30 days of a Special Enrollment event described later in this section.

However, if you were covered under the prior plan when this Plan became effective, your Eligibility Date is the effective date of the Plan. Any Pre-existing Condition exclusion still in effect will end not later than 12 months (or 18 months for a Late Enrollee) from the beginning of the Pre-existing Condition exclusion period.

Your coverage is effective as follows:

1. At 12:01 A.M. on your Eligibility Date, if you apply on or prior to this date; or
2. At 12:01 A.M. on the date of the request for enrollment, if you apply within 30 days after your Eligibility Date; or
3. If you are a Late Enrollee, at 12:01 A.M. on the date of the request for enrollment.

If you are not required to make a contribution to the cost of your coverage (that is, it is non-contributory), it is effective at 12:01 A.M. on your Eligibility Date. However, you must complete an enrollment form in order for your claims to be paid promptly.

You must actually begin work for your Employer before your coverage will become effective; however if, for reasons not related to a health condition, you are not Actively at Work on the date you would otherwise become covered under the Plan, your coverage will not begin until the day you return to Active Work.

Coverage of Pre-existing Conditions is excluded as described in the Highlights and the General Exclusions and Limitations section.

Effective Date of Dependent Coverage

Your dependents may be covered under the Plan only if you are a Covered Employee and if the dependents meet the Plan's requirements for Eligible Dependents. If you have Eligible Dependents when you first become eligible to participate in the Plan, the Eligibility Date for these dependents is the same as your Eligibility Date. Any dependent not enrolled within 30 days of the Eligibility Date is considered a Late Enrollee. A dependent will also be considered a Late Enrollee if not enrolled within 30 days of a Special Enrollment event described later in this section. Dependent coverage is effective as follows:

1. At 12:01 A.M. on the Eligibility Date, if you apply for dependent coverage on or prior to this date; or
2. At 12:01 A.M. on the date of the request for enrollment, if you apply within 30 days after the Eligibility Date; or
3. If a dependent is a Late Enrollee, at 12:01 A.M. on the date of the request for enrollment.

If dependent coverage is non-contributory, coverage is effective at 12:01 A.M. on the Eligibility Date. Your dependents must be listed on your enrollment form in order for claims to be paid promptly.

If you did not have an Eligible Dependent when you first became eligible to participate in the Plan, but you later acquire one, coverage for this dependent is effective as described above. However, in this case the Eligibility Date is the date the Eligible Dependent was acquired. For a newborn child, the Eligibility Date is the date of birth. For an adopted child (under age 18), the Eligibility Date is the date of adoption or the date of placement in your home while you are covered under this Plan.

Contributory coverage for a newborn child is effective on the date of birth only if application is made within 30 days after this date. Contributory coverage for an adopted child (under age 18) is effective on the date of adoption or the date of placement in your home if application is made within 30 days after this date. These are exceptions to provision (2) above.

The Pre-existing Condition exclusion may apply to contributory dependent coverage if application is not made within 30 days of the Eligibility Date.

Special Enrollment Periods

The employee must make a request for Special Enrollment to the Plan Administrator within 30 days of marriage, birth, adoption or the loss of other coverage (including Medicaid). The request must be made in writing to the Plan Administrator. For marriage, the effective date of coverage is the date of marriage if the request for enrollment is received on or prior to the date of marriage, or the date the completed request for enrollment is received if such enrollment is made after the date of marriage but within the Special Enrollment period. For loss of coverage, the effective date of coverage is the date the request for enrollment is made to the Plan Administrator (see above subsections, "Effective Date of Employee Coverage" and "Effective Date of Dependent Coverage"). For birth or adoption, the effective date is the date of birth or adoption, or the date the child is placed in the home for adoption.

If an employee or a dependent does not enroll within 30 days of marriage, birth or adoption or the loss of other coverage, and requests coverage later, he is considered a Late Enrollee. His coverage is subject to an 18-month Pre-existing Condition exclusion period, beginning on his Enrollment Date, and reduced by any period of Creditable Coverage.

Change in Family Status

Once you are in the Plan, you must notify the Plan Administrator within 30 days of any family status change, such as a newborn baby, or when your first family member becomes eligible, or when you no longer need coverage for a certain family member, or when they are no longer eligible as defined in the Plan.

Change in Coverage Status

If your coverage status changes from dependent to employee, or from employee to dependent, all individual deductibles, benefit maximums, and out-of-pocket expense amounts applicable to your individual coverage will carry over as if there had been no change in status.

When Both Spouses Are Covered Employees

When both you and your Spouse are Covered Employees and you have family coverage for dependent children, one Spouse will be treated as a dependent for

billing purposes and in calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses are Covered Employees to get the full benefit of their family coverage. The Spouse who was hired last will be the one treated as a dependent for the purposes stated in this section unless the Plan Administrator determines otherwise.

Election of Coverage Regarding Medicare

Medicare regulations applicable to employers with twenty or more employees require that any active Participant who has reached age 65 and is eligible for Medicare must choose one of the following coverage options:

1. Primary coverage under this Plan (Plan benefits will be paid without regard to Medicare), or
2. Sole coverage under Medicare (coverage under this Plan will terminate).

When eligible, Plan Participants must enroll in Medicare coverage in a timely manner in order to assure maximum coverage.

Benefits will be payable as described in the Coordination of Benefits section.

Court-ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully.

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a “medical child support order” (“MCSO”) or “national medical support notice” (“NMSN”) that is a “qualified medical child support order” (“QMCSO”) if the child named in the MCSO is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

“Alternate recipient” shall mean any child of a Covered Employee who is recognized under a MCSO as having a right to enrollment under this Plan as the Covered Employee’s Eligible Dependent. “MCSO” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Employee’s child or directs the Covered Employee to provide coverage under a health benefits

plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

“NMSN” shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Employee or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipients(s)); and
4. Identity of an underlying child support order.

“QMCSO” is an MCSO that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Employee or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Employee and the name and mailing address of each Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a NMSN shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “NMSN”;
 - a. Identifies either the specific type of coverage or all available group health coverage. If the employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the employer and the Plan Administrator will assume that all are designated; or

- b. Informs the Plan Administrator that, if a group health plan has multiple options and the Eligible Dependent is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSOs, as described in Social Security Act §1908.

Upon receiving a MCSO, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a NMSN, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - a. Whether the child is covered under the Plan; and
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
3. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.

PREFERRED PROVIDER ORGANIZATION

The Preferred Provider Organization (“PPO”) is a network of local Physicians, Hospitals and other health care providers established specifically to provide comprehensive medical services to Plan Participants at reduced rates. As a Participant in the Plan, you will receive a list of providers that belong to the PPO network. It is the Participant’s choice as to which provider to use.

If you choose the PPO option, please follow the procedures for its use carefully. When medical care is needed, be sure the provider is still under contract with the PPO shown on your ID card. When your doctor refers you to another provider, make sure that provider is also under contract with the PPO before services are rendered.

Eligible expenses for services rendered in a PPO Hospital by a Non-PPO provider, are limited to an emergency room Physician, anesthesiologist, radiologist or pathologist. Such charges will be payable at the same benefit percentage level that a PPO provider would be paid for such services if you did not have the option of choosing a PPO provider. All other charges by Non-PPO providers will be payable at the Non-PPO benefit percentage shown in the Highlights, even if you are referred to the Non-PPO provider by a PPO provider.

The copayment amounts and the applicable benefit percentages for Hospital services are shown in the Highlights. After the copay, the Plan will apply the applicable benefit percentage to the remaining expenses up to the benefit maximum, if any.

When you receive care from a PPO provider, the benefit percentage payable for your covered expenses will be the highest percentage shown in the Highlights. When you receive care from a Non-PPO provider, the benefit percentage payable will be the lowest percentage shown in the Highlights. The lowest percentage will apply to any expenses covered by the Plan, if you had the option of using a PPO provider and chose instead to use a Non-PPO provider. The Out-of-Area percentage will apply if you must use a Non-PPO provider in an Emergency, if the care you need is not available at a PPO provider, or if you are outside of the geographical area served by a PPO provider at the time care is needed. For the purposes of the Plan, the service area is defined as the area within a 30-mile radius of the Employee’s primary residence.

The limit on your out-of-pocket expenses will be increased up to the maximum shown in the Highlights for covered expenses Incurred at a Non-PPO provider. This means that you will pay more out of your pocket before the Plan increases its benefit percentage to one hundred percent (100%).

A current list of PPO network providers is available, without charge, from Private Healthcare Systems or through the website located at www.phcs.com. If you do

not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer.

Each Participant has a free choice of any provider, and the Participant, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO network provider.

DEDUCTIBLES AND OUT-OF-POCKET EXPENSES

Deductibles and out-of-pocket expenses represent the portion that the Participant pays of covered expenses. This section describes generally these cost-sharing provisions of the Plan. The Plan Sponsor determines these amounts.

Calendar Year Deductible

The Calendar Year deductible is the amount of covered expenses Incurred by an individual during the Calendar Year for which no benefits will be paid. After you or a Covered Dependent has satisfied the Calendar Year deductible, the Plan pays a certain percentage of the covered expenses for that individual that are Incurred during the rest of the Calendar Year. Deductible accumulation period is January 1 through December 31.

Family Calendar Year Deductible

After the individual Calendar Year deductible is met by the number of Participants specified in the Highlights, no other Calendar Year deductibles, or portions thereof, are required to be satisfied for the rest of the Calendar Year. Until the required number of Calendar Year deductibles is met, covered expenses Incurred by each family member will be subject to the Calendar Year deductible. No more than one Calendar Year deductible will be applied to any one Participant's covered expenses. Reimbursement of covered expenses following satisfaction of the family Calendar Year deductible will apply only to covered expenses submitted on or after the date that satisfaction of the family limit for deductibles is established.

Common Accident Deductible

If more than one Participant in a family is injured in the same Accident, the amount that these family members have to pay of covered expenses resulting from the Accident in order to meet their Calendar Year deductible requirements will not exceed the amount of one individual Calendar Year deductible. This special benefit applies only to the covered expenses resulting from that Accident. Any covered expenses not related to the Accident are still subject to the normal Calendar Year deductible requirements.

Out-of-Pocket Expense

Out-of-pocket expense is the amount of covered expenses you must pay after the satisfaction of the Calendar Year deductible before certain benefits begin to be paid at one hundred percent (100%).

If during the Calendar Year your out-of-pocket covered expenses satisfy the out-of-pocket expense amount, the rate of payment for certain covered charges will be increased to a full one hundred percent (100%). The one hundred percent (100%) will continue for covered expenses Incurred during the remainder of that Calendar Year. You must satisfy your deductible plus your out-of-pocket amount before these benefits will be paid at one hundred percent (100%).

NOTE: See Highlights for a list of charges that do not apply to the out-of-pocket expense amount.

MEDICAL BENEFITS

Covered Medical Expenses

Covered expenses (sometimes identified as covered charges, eligible charges, eligible expenses or similar terms) include only the charges and fees that:

1. Are Medically Necessary for the care and treatment of Illness or Injury of a Participant; and
2. Are recommended by an attending Physician; and
3. Do not exceed the Reasonable and Customary charge; and
4. Are not excluded by other provisions applicable to this coverage.

The following expenses are covered by the Plan, provided they meet the requirements for covered medical expenses described above and are not excluded elsewhere in the Plan. Reimbursement is based upon the Lifetime and Calendar Year limits, benefit percentages and other limitations previously described in the Highlights section.

1. Transportation by a professional **ambulance** service to a local Hospital or convalescent facility for Inpatient care, if Medically Necessary, or to the nearest Hospital for Emergency care. Transportation by ambulance to a non-medical facility will be covered only if Medically Necessary. Expenses for transportation by air will be covered only if an air ambulance is Medically Necessary.
2. Services and supplies used in the administration of **anesthesia**, when not duplicated in the Hospital charges.
3. Services and supplies for treatment of **attention deficit**/hyperactivity disorder.
4. **Blood** and blood derivatives that are not donated or replaced.
5. **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Hospital as defined by this Plan.
6. **Chiropractic** treatment.
7. Injectable and implantable **contraceptives**.

8. Rental of **durable medical equipment** when such equipment is deemed Medically Necessary, including, but not limited to, a wheelchair, hospital-type bed, respirator, and equipment for the administration of oxygen. Such equipment may be purchased if, in the judgment of the Plan Administrator, purchase of the equipment would be less expensive than rental or the equipment is not available for rental. If purchased, the Plan will cover replacement only after a five-year period.
9. Room, board and supplies (other than drugs and medicines) billed by an **Extended Care Facility** or Skilled Nursing Facility. Benefits are payable only if the confinement is required due to a need for extended medical care and not for Custodial Care. Confinement and discharge requirements, if any, listed in the Schedule of Benefits may be waived if prior authorization is obtained from the Plan Administrator.
10. **Home health** care, if prescribed by a Physician as a plan of treatment and begun within seven days after a Hospital confinement (the seven day requirement may be waived if prior authorization is obtained). The Physician must certify that the proper treatment of the Injury or Illness would require continued confinement as an Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan. Each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.
11. **Hospice** care. Covered charges are as follows:
 - a. Inpatient Hospice care;
 - b. Services of a Physician;
 - c. At-home care including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds;
 - d. Emotional support services and physical/chemical therapies; and
 - e. Bereavement counseling sessions for covered family members following the death of a Terminally Ill Participant.
12. **Hospital** room and board, at the semi-private Hospital room and board rate. If confinement is in a Hospital providing private rooms only, the covered expense shall be no greater than the rate listed in the Schedule of Benefits. If Medical Necessity requires an intensive care unit, the Plan will cover the room and board up to the maximum listed in the Schedule of Benefits.

13. Other **Hospital** services and supplies furnished by the Hospital for medical care during confinement, exclusive of Physician's and other professional services.
14. Care, supplies and services for the diagnosis, treatment and charges for surgical correction of physiological abnormalities of **infertility**. Fertility drugs are not covered.
15. Medical **laboratory** charges in connection with treatment of an Illness or Injury.
16. Treatment of **Mental/Emotional** Disorders.
17. Charges for **Morbid Obesity** may be covered if it is certified in writing by the attending Physician that such obesity is the direct cause of a life-threatening disorder and if eligibility of such charges is approved by the Plan Administrator.
18. **Occupational Therapy** performed by a licensed occupational therapist and ordered by a Physician. It must be considered progressive therapy, not maintenance therapy, and must not be performed for the purpose of vocational rehabilitation. Covered expenses do not include either recreational programs or supplies used in Occupational Therapy.
19. Covered medical expenses Incurred for care and treatment due to an **organ transplant** are subject to the following:
 - a. The recipient must be a Participant in the Plan;
 - b. Covered organ transplants are limited to transplants of the kidney, cornea, bone marrow and/or stem cell, heart, heart/lung, liver, lung, and pancreas or other organ transplant approved by the FDA that is not Experimental or Investigational. Bone marrow and/or stem cell transplants are considered organ transplants for the purposes of this Plan;
 - c. Charges for obtaining donor organs are covered under the Plan when the recipient is a Participant and the donor has no other coverage or his or her other coverage excludes organ transplants. Donor charges include those for:
 - i. evaluating the organ;
 - ii. removing the organ from the donor; and
 - iii. transportation of the organ to the place where the transplant is to be performed.

- d. Except as provided under (c) above, organ procurement does not include donor-related expenses while the Participant is awaiting the transplant, unless the donor is covered under this Plan.

Prior to undergoing the procedures, the Participant who is the recipient of the transplant must receive two opinions with regard to the need for transplant surgery. Each opinion must be in writing by a board-certified specialist in the involved field of surgery. The specialist must certify that alternative procedures, services, or course of treatment would not be effective in the treatment of the Participant's condition.

20. The initial purchase, fitting and repair of an **orthotic appliance** (not including corrective or orthopedic shoes, arch supports or other similar, corrective foot devices or appliances) such as a brace, splint or other appliance required for support of a malfunctioning or deformed limb as a result of Injury, Illness or a disabling congenital condition. The Plan will cover subsequent repair, modification or replacement of the appliance only if the attending Physician certifies in writing that it is Medically Necessary due to:
 - a. a physical change in the condition of the patient's site of attachment;
 - b. the normal, physical growth of a dependent child; or
 - c. the fact that the existing orthosis is unusable and cannot be repaired or modified to achieve proper fit and function.
21. **Outpatient Surgery** charges for necessary services and supplies for surgical procedures performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office, provided that benefits for such charges would be payable if the procedure were performed during a Hospital confinement.
22. **Physician's** fees for medical care and treatment of an Illness or Injury covered under the terms of this Plan.
23. **Physical therapy** by a licensed physical therapist.
24. **Preadmission testing** ordered by a Physician, done on an Outpatient basis and related to the condition for which the patient is to be hospitalized. These tests must be performed at a Hospital, ambulatory surgical facility, or Physician's office prior to confinement as an Inpatient. No benefits will be payable if the same tests are repeated after Hospital admission, unless Medically Necessary.
25. **Pregnancy** expenses. Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in

connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

26. **Prescription drugs** necessary for the treatment of an Illness or Injury, if obtainable only on a Physician's written prescription and dispensed by a licensed pharmacist (see Prescription Drug Benefits section).
27. **Private duty nursing** care done only on an Outpatient basis if prescribed by a Physician as Medically Necessary and if performed by a registered Nurse or a licensed practical Nurse. Outpatient private duty nursing on a 24-hour shift basis is not covered.
28. Replacement of a natural eye or limb with an artificial one (**prosthesis**), and subsequent repair, modification or replacement if it is Medically Necessary. Subsequent replacement is covered only if the attending Physician certifies in writing that such replacement is Medically Necessary due to:
 - a. a physical change in the condition of the patient's site of attachment;
 - b. the normal, physical growth of a dependent child; or
 - c. the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.
29. **Radiological** tests (X-rays), radium treatments, and treatments with other radioactive substances.
30. **Reconstructive surgery** of the breast on which a **mastectomy** was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant. Reimbursement will be made according to the "Schedule of Medical Benefits" section by type of service.
31. **Rehabilitation Hospital** charges, provided all the following conditions are met:
 - a. The patient has a physical disability, and his medical condition and functional performance can realistically be improved through the intensive rehabilitation program offered by the Hospital;

- b. Other treatment programs offering less intensive care or Outpatient treatment would not achieve the realistic goals sought by the patient through the Hospital's rehabilitation program; and
- c. The patient requires close medical care by a Physician and 24-hour-a-day nursing supervision.

The Utilization Management organization should be notified of the intended stay.

- 32. **Second Surgical Opinion** charges to confirm that recommended surgery is needed. The Physician who provides the second opinion must be board-certified for the medical condition for which surgery is advised. He must not be scheduled to perform the surgery or be in partnership with or have any financial affiliation with the first Physician in order for the surgical opinion benefit to be paid. If the second Physician disagrees with the first Physician, the Plan will cover a third surgical opinion.
- 33. **Speech therapy** by a qualified speech therapist. The therapy must be to restore or rehabilitate speech loss due to an Illness or Injury, or due to surgery for an Illness or Injury (other than a learning or mental disorder). If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.
- 34. Elective surgery for **sterilization**, including tubal ligation and vasectomy.
- 35. Treatment of **Substance Abuse**.
- 36. Medical **supplies** that are Medically Necessary for treatment, including, but not limited to, an electronic heart pacemaker, surgical dressings, casts, splints, and crutches.
- 37. **Surgeon's** fees for the performance of surgical procedures, including necessary related postoperative care by a Physician, subject to the Reasonable and Customary fees in his area.
- 38. Treatment of **Temporomandibular Joint** syndrome, whether surgical or nonsurgical.
- 39. **Vision therapy** (nonsurgical treatment to the eye muscles).
- 40. **Wellness** care (see Highlights section for details).

UTILIZATION MANAGEMENT

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain cost management services. This call must be made at least 1 day in advance of services being rendered, or within 48 hours or on the first business day after an emergency.

Failure to precertify required medical services will result in the application of the Utilization Management Penalty, if any, shown in the Schedule of Medical Benefits.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the maximum out-of-pocket limit.

UTILIZATION MANAGEMENT

Utilization Management (“UM”) is a program designed to help ensure that all Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:
 - Inpatient confinements
 - Morbid Obesity
 - Durable Medical Equipment over \$500
 - Prosthetics
 - Organ Transplants
- (b) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician;
- (c) Certification of services and planning for discharge from a medical care facility or cessation of medical treatment; and
- (d) Retrospective review of the Medical Necessity when precertification or concurrent review/discharge planning has not been secured.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The UM organization's staff cannot and does not verify benefits or eligibility. The UM organization's staff cannot and does not ensure that all plan requirements are met or will be met on the date services are rendered. The UM program's purpose is strictly the verification of Medical Necessity and the appropriateness of care.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Participant enters a medical care facility on a non-emergency basis, the Utilization Management administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.

The Utilization Management program is set in motion by a telephone call from the Participant. Contact the Utilization Management administrator at the telephone number on your ID card **at least 1 day before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee,
- The name, social security number and address of the covered Employee,
- The name of the Employer,
- The name and telephone number of the attending Physician,
- The name of the medical care facility, proposed date of admission and proposed length of stay, and
- The diagnosis and/or type of surgery.

If there is an **emergency** admission to the medical care facility, the patient, patient's family member, medical care facility or attending Physician must contact the utilization management administrator **within 48 hours** or on the first business day after the admission.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

The Utilization Management administrator will determine the number of days of medical care facility confinement authorized for Medical Necessity.

Precertification is designed to assist with your hospital stay, not to determine which benefits will be payable. To find out which benefits are payable, please refer to the appropriate sections of this Summary Plan Description.

Under the Newborns' and Mothers' Health Protection Act of 1996, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours following a vaginal delivery, or 96 hours following a cesarean section. Notification is still encouraged at the time of admission, and is **required** for any Hospital stay that is in excess of the minimum length of stay. Failure to notify the UM administrator of any stay that is in excess of the minimum length of stay will result in application of the penalty shown in the Highlights to the Hospital expenses for the excess days not certified.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the Utilization Management program. The Utilization Management administrator will monitor the Participant's medical care facility stay or use of other medical services and coordinate with the attending Physician, medical care facilities and Participant either the scheduled release or an extension of the medical care facility stay or extension, or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Participant to receive additional services or to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

CASE MANAGEMENT

Case Management is a program whereby a Case Manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The Case Manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient,

- contacting the family to offer assistance and support,
- monitoring Hospital or Skilled Nursing Facility,
- determining alternative care options, or
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan will consider care outside its normal benefit limitations if the use of an alternative treatment plan results in savings for the Plan and is endorsed by the Participant. The objective of this service is to direct the patient toward the most appropriate care in a cost-effective environment. The Plan Administrator, attending Physician, patient and, in some circumstances, the patient's family must all agree to the alternate treatment plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Retrospective Utilization Management

When Hospital precertification or continued stay review/discharge planning has not been secured, the UM organization may elect to use retrospective Utilization Management. Retrospective utilization management is the process in which the UM organization evaluates Inpatient, acute care hospitalizations which were not reviewed during the confinement. Using the established medical criteria for Hospital precertification and concurrent review/discharge planning, the UM organization will determine retrospectively the Medical Necessity and appropriateness of Inpatient hospitalization and treatment plan.

PRESCRIPTION DRUG BENEFITS

Using Your Prescription Drug Card

As a Participant in the Plan, you will receive an ID card that allows you to purchase prescription drugs through the prescription drug card program. Participating pharmacies will display the prescription drug card company logo. If you present this card to a participating retail pharmacy when buying prescription drugs covered by the Plan or purchase eligible prescription drugs through the mail-order program, you will be charged as shown in the Highlights; however, you must first satisfy the prescription drug deductible amount shown in the Highlights. The per Participant, per Calendar Year deductible applicable to medical expenses does not apply to these prescription drug expenses.

A current list of participating pharmacies is available, without charge, from Caremark or through the website located at www.caremark.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer. If you do not have your prescription drug card with you when buying eligible prescription drugs from a participating pharmacy or if you purchase prescription drugs from a non-participating pharmacy, you must pay the full price of the prescription drug and submit a claim form to the prescription drug card company for reimbursement. These expenses are reimbursable only by the prescription drug card company. These claim forms may be obtained from your Personnel or Human Resources Department. Any claim submitted to Gilsbar, Inc. for these expenses will be returned to you with the proper form for reimbursement by the prescription drug card company.

Covered Prescription Drug Card Expenses

Covered prescription drug card expenses are the Reasonable and Customary charges for prescription drugs purchased from a pharmacy participating in the prescription drug card system. Such drugs and medicines are eligible for coverage only if they are used to treat an Illness or Injury of a Participant in the Plan and can be obtained from a licensed pharmacist with a written prescription from a Physician. They are limited to the following:

1. Prescription drugs, including, but not limited to, contraceptives, pre-natal vitamins and vitamins with fluoride;
2. Compounded medications of which at least one ingredient is a prescription drug in a therapeutic amount;
3. Injectable insulin, including insulin syringes and needles, and diabetic supplies, furnished on written prescription of a Physician.

Covered expenses may not exceed a 34-day supply (90-day supply of insulin) when you purchase prescription drugs from a retail participating pharmacy, or a 90-day supply when you are purchasing a maintenance drug through the mail-order program or the Retail 90 Program. The amount may not be more than the amount normally prescribed by your Physician.

Retail 90 allows you to go to a limited network of local pharmacies and fill a 90-day supply of maintenance medications in lieu of going through the mail-order program. Visit www.caremark.com on the web or call 1-800-334-8134 to see if your pharmacy is in the network for the Retail 90 program.

An expense will be considered to be “incurred”, for purposes of this benefit, at the time the drug or medication is received from the pharmacist.

Exclusions and Limitations

Charges for the following are excluded:

1. **Administration:** Any charge for the administration or injection of any drug or medication.
2. **Anorexiant**s or any drug or medication used as an appetite suppressant.
3. **Blood** or blood plasma.
4. **Consumed on site:** Any drug or medication which is consumed or administered at the place where it is dispensed.
5. **Contraceptives** or contraceptive devices of any kind, except oral contraceptives.
6. **Cosmetic purposes:** Drugs used for cosmetic purposes, such as hair growth stimulants or growth hormones; also, Retin-A for a Participant over age 25, unless precertification is obtained from the Pharmacy Benefits Manager.
7. **Devices** of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).
8. **Diagnostic** agents.
9. **Experimental/investigational:** Drugs labeled: “Caution--limited by federal law to investigational use,” or experimental drugs even though a charge is made to the Participant.

10. **FDA:** Any drug that is not approved by the Food and Drug Administration or that is prescribed for non-FDA-approved uses.
11. **Immunization** agents or biological sera.
12. **Impotence:** Drugs for erectile dysfunction or organic impotence in excess of 12 units per month or for 30 days, whichever is less.
13. **Infertility:** Any drug or medication related to or used in the treatment of infertility.
14. **Injectables & supplies:** A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or treatment other than insulin.
15. **Inpatient medication:** Any drug or medication which is to be taken by or administered to the Participant, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing or Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.
16. **Medical exclusions:** Any drug or medication otherwise excluded by the medical plan.
17. **No charge:** Any drug or medication which may be properly received without charge under any local, state or federal program, including Worker's Compensation.
18. **No prescription:** Any drug or medication lawfully obtainable without a prescription order of a Physician, except insulin.
19. **Refills:** Filling or refilling of a prescription in excess of the number prescribed by the Physician, or the filling or refilling of a prescription after one year from the order of the Physician.
20. **Smoking** deterrents or smoking cessation medications or supplies.
21. **Vitamins,** except pre-natal vitamins and vitamins with fluoride that require a prescription.

DENTAL BENEFITS

If you incur expenses for the covered dental services described below, the Plan will deduct the dental deductible from the amount of the total covered dental expenses and pay a percentage of the remainder, until the maximum benefit is reached for that service. Only one Calendar Year deductible per Participant applies to all types of services combined. The deductible, Calendar Year and Lifetime maximums, and benefit percentages for dental benefits are listed in the Schedule of Dental Benefits section of the Highlights.

If you apply for dental coverage more than 30 days after the date you first became eligible (i.e. you are a Late Enrollee), your dental benefits will be limited as shown in the Schedule of Dental Benefits.

Covered Dental Expenses

Covered expenses include the Reasonable and Customary charges for the services described on the lists of covered services below, provided these expenses are:

1. For services that are essential for the necessary care of the teeth and performed by or under the direction of a licensed Dentist; and
2. Incurred by you or a dependent while covered by the dental provisions of this Plan.

An expense is incurred, for purposes of this section, on the date a service is performed or a supply is furnished, with the following exceptions, for which the expense will be deemed to be incurred as described:

1. For an appliance or modification of an appliance, on the date the master impression is made;
2. For a crown, a bridge, or an inlay or onlay restoration, on the date the tooth is prepared; and
3. For root canal therapy, on the date the pulp chamber of the tooth is opened.

If a particular service is listed under more than one type, the expenses for that service will be covered only under the listing for which you receive the greatest benefit.

Because many dental problems can be resolved in more than one way, the Plan Administrator reserves the right to determine the dental procedure codes as it deems appropriate that will represent the lowest-cost treatment which adequately

restores the mouth to normal form and function. The codes used are based on nationally established standards of the dental profession.

Type I -- Preventive or Diagnostic Services

The following are covered expenses:

1. Initial/Periodic exam (limited to 2 every 12 months)
2. Bitewing X-ray (limited to 2 every 12 months)
3. Panoramic X-ray or Full mouth X-ray (limited to 1 every 36 months)
4. Cephalometric film (see Type IV - Orthodontics)
5. Fluoride treatment (limited to 1 every 12 months)
6. Prophylaxis, adult (limited to 2 every 12 months)
7. Prophylaxis, child (limited to 2 every 12 months)
8. Sealants, per tooth (limited to 2 treatments, only to unfilled permanent molars for dependents, maximum age up to 16)
9. Palliative treatment (for non-routine Emergency visits)

Type II -- Basic Services

The following are covered expenses:

1. Extractions (excluding extractions done for orthodontic purposes)
2. Non-routine visits (consultation or observation)
3. Periodontic scaling and maintenance (per quadrant) (limited to 2 every 12 months)
4. Post & Core, including pin retention (combine with charge for filling if done in connection with a filling)
5. Recementing of inlays/onlays
6. Intravenous sedation or general anesthesia (covered only in connection with a surgical procedure)
7. Reline Denture (limited to 1 every 12 months and only within six months following initial installation)

8. Rebase Denture (limited to 1 every 12 months and only within six months following initial installation)
9. Tissue Conditioning (limited to 1 every 12 months)
10. Space Maintainers (limited to 1 every 12 months and only up to maximum age of 14; also limited to initial appliances and all adjustments within six months after installation)
11. Endodontics (root canals)
12. Antibiotic drugs
13. Fillings (other than gold)
14. Repair of crowns, bridgework and removable dentures
15. Oral surgery (limited to the removal of teeth [other than impacted wisdom teeth] preparation of the mouth for dentures, and removal of tooth-generated cysts of less than ¼ inch)

Type III -- Major Restorative Services

The following are covered expenses:

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
2. Crowns
3. Crown replacements, if crown is unserviceable (limited to 1 every 5 years)
4. Post & Core, including pin retention (combine with charge for crown if done in connection with a crown)
5. Denture, full or partial to replace one or more natural teeth. The denture work must be finished within 12 months of the date the tooth is extracted.
6. Installing precision attachments for removable dentures
7. Addition of clasp or rest to existing partial removable dentures
8. Pontics (one or more natural teeth must be extracted while coverage is in effect under this Plan for the pontic to be covered)

9. Bridge, to replace one or more natural teeth
10. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth (pontics) to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only after the later of the following:
 - a. Five years after the denture or bridgework was installed, or
 - b. Two years after the participant's enrollment date.

Thereafter, a maximum of one set of replacement dentures every five years is covered.

Type IV -- Orthodontic Services

The following are covered expenses:

1. Cephalometric film (if done for Orthodontics)
2. Orthodontic treatment for malocclusion, based on a written treatment plan
3. Simple extraction done for orthodontic purposes
4. Orthodontic age limits:
 - Covered for employees and dependents of any age.

Extended Orthodontic Treatment

If, at the time a Participant's dental coverage ends, he has not completed a course of orthodontic treatment which began while covered, benefits will be paid for covered orthodontic charges Incurred for the remainder of the treatment as if coverage had not ended.

No benefits will be paid for any charges Incurred for that course of treatment:

1. after the date the Participant's coverage ends because the Plan terminates, or if coverage for that class of employee terminates, or
2. more than 3 months after the date the Participant's coverage ends for any other reason.

The above provision applies only to orthodontic benefits covered under Dental Benefits.

Dental Exclusions and Limitations

The following expenses are excluded from dental benefits:

1. Charges excluded under the General Exclusions and Limitations section of the Plan, unless stated otherwise.
2. Any service or supply covered in whole or in part under the medical provisions of this Plan.
3. Any service or treatment for Cosmetic purposes. The following are always considered to be for Cosmetic purposes:
 - a. facings on crowns or pontics posterior to the second bicuspid, and
 - b. personalization of dentures.

However, this exclusion does not apply to services required because of Injuries if:

- a. the services are rendered within six months after the Accident, and
 - b. the services are rendered while the person is covered for these dental benefits.
4. Replacement of a lost, missing or stolen prosthetic device or other device or appliance.
 5. Appliances, restorations, or procedures for
 - a. altering of vertical dimensions,*
 - b. restoring or maintaining occlusion,*
 - c. splinting,
 - d. correction of attrition or abrasion,
 - e. bite registration,
 - f. bite analysis, or
 - g. treatment of Temporomandibular Joint Syndrome (TMJ).

* By other than covered orthodontic treatment

6. Any service or supply not furnished by a dentist, except
 - a. a service performed by a dental hygienist working under the supervision of a dentist, and
 - b. X-ray order by a dentist.
7. Charges for plaque control programs or instruction in oral hygiene or diet.
8. Charges for dental implants.
9. Replacement within five years of its last placement of any
 - a. prosthetic appliance,
 - b. crown,
 - c. inlay or onlay restoration, or
 - d. fixed bridge.

However, this exclusion does not apply to any such replacement required because of Injury.

10. Orthodontic services or dental care of a congenital or developmental malformation, unless included in the benefits for orthodontic services for Covered Dependent children.
11. Charges for broken or missed dental appointments.
12. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
13. Orthognathic surgery. Surgery to correct malpositions in the bones of the jaw.
14. No listing. Services which are not included in the list of covered dental services.

GENERAL EXCLUSIONS AND LIMITATIONS

Note: See the Prescription Drug Benefit and Dental Benefit sections for additional exclusions and limitations specifically related to those expenses.

This section applies to all benefits provided under any section of this Summary Plan Description. This Plan excludes or limits coverage as described for the following:

Pre-existing Conditions

Services or supplies for the diagnosis or treatment of a Pre-existing Condition are excluded (see Highlights section for details).

Occupational Illness or Injury

Any Illness or Injury arising out of, or in the course of, employment with the Participant's employer or self-employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation, are excluded. However, any Illness or Injury of an Assessor which occurs as a result of the normal duties of an Assessor will be covered if said Assessor is not covered by Worker's Compensation.

Government Plan

Services or supplies furnished by or on behalf of the United States Government or any other government are excluded unless, as to such other government, payment of the charge is legally required.

Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Participant is or could be covered, unless payment of the charge is legally required.

Unnecessary Services or Supplies

Any services or supplies not Medically Necessary for the care of the Participant's Illness or Injury are excluded. Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the patient are also excluded. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.

Weekend Admissions

If admitted to the Hospital on a Friday, Saturday or Sunday, charges for these days will be excluded unless admitted due to an Emergency or if surgery is performed within 24 hours of admission.

Excess of Reasonable and Customary

That portion of any charge for any services or supplies in excess of the Reasonable and Customary charge, as determined by the Plan Administrator, is excluded. For PPO providers, the part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge is excluded.

Mouth and Teeth Conditions

Medical Benefits for mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure or the alveolar process are excluded unless the charges are for the following:

1. Treatment or removal of malignant or benign tumors or surgical removal of impacted wisdom teeth;
2. Treatment of an accidental Injury to a Sound, Natural Tooth, or for the setting of a jaw fracture or dislocation if the treatment begins within three months of the Accident; or
3. Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O. or D.D.S.) provides satisfactory certification to the Plan Administrator that hospitalization is Medically Necessary.

Foot Conditions

Physicians' services in connection with weak, strained or flat feet, any instability or imbalance of the foot, or any metatarsalgia or bunion are excluded, unless the charges are for an open cutting operation.

Physicians' services in connection with corns, calluses or toenails are excluded, unless the charges are for the partial or complete removal of the nail roots.

Charges for corrective or orthopedic shoes, arch supports or other corrective devices or appliances are excluded.

Vision Care

Medical Benefits for Physicians' services in connection with eye refractions or any other examinations to determine the need for, or the proper adjustment of, eyeglasses or contact lenses are excluded, unless for the initial examination following cataract surgery. The charges for eyeglasses or contact lenses are excluded, unless for the initial set following cataract surgery. Radial Keratotomy and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This exclusion does not apply to any services otherwise covered under vision benefits, if any.

Cosmetic or Cosmetic Surgery

Charges in connection with Cosmetic Surgery and other services and supplies that are for Cosmetic purposes are excluded unless they are:

1. Incurred as a result of accidental Injury;
2. For correction of a congenital anomaly; or
3. For reconstruction of the breast on which a mastectomy was performed, or for surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant.

Injury Due to Act of War

Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.

Hearing Aids

Examinations to determine the need for, or the proper adjustments of, hearing aids are excluded. Also, the purchase of hearing aids is excluded.

Routine or Preventive Care

Routine or preventive care, including but not limited to immunizations and Routine Physical Examinations, is excluded, except as otherwise specifically listed and included for coverage under this Plan.

Well Baby or Well Child Care

Routine well baby or well child care, checkups and immunizations are excluded, except as otherwise specifically listed and included for coverage under this Plan.

Other General Exclusions

Charges for services, surgery, supplies or treatment for the following are not covered:

1. **Abortion:** Elective abortions are excluded unless the life of the mother is endangered by the continued pregnancy. However, complications from abortions, whether elective or non-elective, are covered.
2. **Acupuncture.**
3. **Administrative fees,** interest or penalties.
4. **Blood** and blood derivatives that are donated or replaced, including fees for administration.
5. **Claim filed late:** Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.
6. **Claim form:** Completion of a claim form.
7. **Complications from non-covered services:** Charges that result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure. However, complications from abortions, whether elective or non-elective, are covered.
8. **Contraceptive** substances or devices, except for any that are specifically covered under this Plan.
9. **Coordination of benefits:** Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.
10. **Coverage not in force:** Charges incurred while coverage is not in force under the Plan.
11. **Custodial** care.
12. **Deductible:** Charges that are not payable due to the application of any specified deductible, copayment, or coinsurance provision of this Plan.

13. **Durable medical equipment:** Replacement of durable medical equipment within five years unless approved by the Plan Administrator.
14. **Education,** training, bed and board while confined to an institution that is primarily a school or other institution for training, or instruction in alternate life patterns.
15. **Electrical power,** water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense associated with a residence.
16. **Equipment:** Air conditioners, dehumidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, rubber gloves and any equipment or supplies not Medically Necessary.
17. **Exercise programs:** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
18. **Experimental or Investigational:** Treatment, services, equipment, new technology, drugs, procedures or supplies considered Experimental or Investigational at the time the procedure is performed or service or supply is provided.
19. **Family member:** Services or supplies provided by a member of the Participant's immediate family or by an individual residing in the Participant's home.
20. **Foreign travel:** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
21. **Genetic testing** or treatment.
22. **Hair loss:** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
23. **Hospital employees:** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
24. **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.
25. **Illegal acts:** Medical treatment needed due to a Covered Person's commission of a felony, any act of war, combat or military action of any kind, a riot, insurrection, rebellion, or revolution.

26. **Impotence:** Care, treatment, services, supplies or medication in connection with treatment for impotence that is due to other than organic causes.
27. **Marriage** counseling.
28. **Medicare:** Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits with Medicare when Medicare is the primary payor. This limitation may apply to Participants aged 65 or older, and is subject to federal regulation.
29. **Newborn care:** Hospital care or Physician care of a newborn prior to discharge from Hospital, except in cases of Illness.
30. **No Physician recommendation:** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Illness or Injury.
31. **Non-compliance:** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
32. **Not legally required to pay:** Any item for which the Participant is not legally required to pay, or for which a charge would not have been made if the Participant did not have this coverage.
33. **Not listed:** Any items not listed in “Covered Expenses.”
34. **Not necessary:** Diagnostic services or treatments performed in connection with research studies, pre-marital examinations or any examination not necessary for the diagnosis of an Illness or Injury, unless specifically listed and included for coverage under this Plan.
35. **Obesity:** Surgical operations, procedures or services for the treatment of obesity and any resulting complications of such treatment. Charges for Morbid Obesity may be covered. See the Medical Benefits section for details.
36. **Oral statements:** Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Description.

37. **Organ transplants:** Organ transplants other than those specified as covered under the Plan; or organ transplants that are Experimental or Investigational or which are not approved by the FDA; and

Donor-related health care services and supplies, except as otherwise specifically listed and included for coverage under the Plan or unless the donor is a covered Participant under the Plan.

38. **Personal** or convenience items.

39. **Plan design excludes:** Charges excluded by the Plan design as mentioned in this document.

40. **Prior to or after coverage:** Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Description.

41. **Prison:** Charges for services received while confined in a prison, jail or other penal institution.

42. **Radioactive contamination:** An Injury or Illness caused as a result of radioactive contamination.

43. **Room and board** for any other room at the same time the patient is being charged for use of a special care unit.

44. **Sales tax** on prescription drugs or on any other covered items.

45. **Scheduled visit:** Failure to keep a scheduled medical visit.

46. **Self-inflicted:** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

47. **Sexual dysfunctions:** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

48. **Sleep disorders:** Care and treatment for sleep disorders, unless deemed Medically Necessary.

49. **Sterilization reversal:** Reversal of previous sterilization treatments or surgeries.

50. **Surrogate mother:** Services of a surrogate mother are excluded.
51. **Telephone** conversations with a Physician.
52. **Travel expenses**, even if prescribed by a Physician.
53. **Violation of law:** The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.
54. **Vitamins** (except pre-natal vitamins prescribed by a Physician), minerals, nutritional food supplements, or any over-the-counter items, including, but not limited to nicotine gum or other smoking deterrents, whether or not prescribed by a Physician, unless specifically covered herein.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

WHEN YOU HAVE A CLAIM

Before submitting a claim, review this Summary Plan Description and the bills you have accumulated. Be sure you are submitting itemized bills for which benefits are payable.

The Benefit Services Manager may periodically request a Medical/Dental Family Claim Form to verify continued eligibility for benefits. If you need a Medical/Dental Family Claim Form, you may download one from the Gilsbar web site at www.myGilsbar.com or you may notify your Personnel or Human Resources Department.

If you or a Covered Dependent has to go to the Hospital, get duplicate Medical/Dental Family Claim Forms from your Personnel Department or Gilsbar's web site in advance. Sign the forms and send them to the Benefit Services Manager at the address listed on your ID card.

Keep a separate running record of expenses for yourself and each Covered Dependent.

Save all bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Submit the original bill, not a copy. Each bill must be complete and itemized and should show the patient's full name, date or dates the service was rendered or purchase was made, nature of the Illness or Injury, and type of service or supply furnished. Drug store cash register receipts or labels from containers are not sufficient proof of a claim.

Attach all itemized bills to the fully completed claim form and send all claims Incurred to the name and address shown on your ID card.

All claims, including those first mailed to the Preferred Provider Organization, must be received by Gilsbar, Inc. no later than 12 months after the date the expense is Incurred. A claim received after this deadline will be covered only if the Plan Administrator, or Benefit Services Manager acting on the instructions of the Plan Administrator, finds that there was a reasonable cause for the delay. Contact Gilsbar, Inc. to be sure the Claims Department has received all submitted claims.

CLAIMS PAYMENT AND APPEALS

Assignability

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the provider; however, if those benefits are paid directly to the Participant, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Employee and the assignee, has been received before the proof of loss is submitted.

Claims Procedure

The following is a description of how the Plan processes claims and appeals for health benefits. The times listed are maximum times only. A period of time begins at the time the claim is filed in accordance with the Plan's procedures, which are described below. "Days" means calendar days.

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials. The definitions of the types of health claims are:

Pre-service Claim – a request for certification of Medical Necessity only, performed by the UM organization's staff. No benefits, eligibility, or other Plan requirements can or will be decided at this time. Benefits, eligibility, and all other Plan provisions will be applied at the time the Post-service Claim is received with actual billed charges after the services have been rendered. It is important to remember that, if an individual needs medical care for a condition which could seriously jeopardize his life, health or ability to regain maximum function, or which would subject him to severe pain that cannot be adequately managed without care or treatment, there is no need to contact the UM organization for certification of Medical Necessity. The individual should obtain such care without delay and contact the UM organization within 48 hours, or on the first business day following a Hospital admission.

Concurrent Claim – a claim that arises when the Plan has approved the Medical Necessity of an on-going course of treatment to be provided over a period of time or number of treatments, and either:

1. the Plan determines that the course of treatment should be reduced or terminated, or
2. the individual requests extension of the course of treatment beyond that which was approved.

Remember, if the Plan does not require certification of Medical Necessity prior to getting treatment, then there is no need to contact the UM organization to request an extension of that treatment.

Pre-service and Concurrent Claims are deemed to be filed with the Plan when the request for certification of Medical Necessity is made and received by the UM organization in accordance with the Plan's procedures.

Post-service Claim – a request for a Plan benefit or benefits that is a request for payment under the Plan for covered medical services already received by the Participant. It must be submitted in writing to the Benefit Services Manager, including all information necessary to properly evaluate the submitted charges, made by a Participant or by an authorized representative of a Participant in compliance with the Plan's reasonable procedure for making benefit claims. A Post-service Claim is deemed to be filed with the Plan on the date it is received by the Benefit Services Manager, containing the following information:

1. A properly completed Form HCFA or Form UB92, or an Electronic Data Interchange (EDI) file;
2. The date of service;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges and repricing information;
7. The name of the Plan;
8. The name of the Covered Employee; and
9. The name of the patient.

The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested. This additional information must be received by the Benefit Services Manager within 45 days from the date the Participant receives the request. **Failure to respond within this time period may result in claims being denied or reduced.**

Any reduction of a claim is referred to as an Adverse Benefit Determination. "Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. This includes any reduction or failure to make payment based on the determination of a Participant's or beneficiary's eligibility. It also includes any reduction or failure to make payment resulting from the application of any

utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary.

Timing of Notice of Benefit Determinations:

Pre-service Claim:

1. If the Participant has provided all of the information needed to determine the Medical Necessity of the treatment, the Plan will notify the Participant of a benefit determination in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
2. If the Participant has not provided all of the information needed to determine the Medical Necessity of the treatment, the Participant may be notified as to what specific information is needed as soon as possible, but not later than 15 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the Participant (if additional information was requested during the extension period).
3. If the Participant has failed to follow the Plan's procedures for filing a Pre-service Claim, the Participant will be notified of the failure and the proper procedures to be followed as soon as possible, but not later than 5 days following the failure.
4. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Claim:

1. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), it will do so before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. Request by Participant for Extension of Treatment. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments, the request will be treated as a new Pre-service Claim and decided within the timeframe appropriate to that type of claim.

Post-service Claim:

1. If the Participant has provided all of the information needed to process the claim, the Plan will notify the Participant of an Adverse Benefit Determination in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
2. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, the Participant may be notified of an Adverse Benefit Determination prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
3. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Form of Notice to Participant of Adverse Benefit Determinations:

The Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the Participant:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. Reference to the specific provisions of the Summary Plan Description on which the determination was based.
3. A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures, and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following an adverse benefit determination on review.

5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. The identity of any medical experts consulted in connection with a claim, even if the Plan did not rely upon their advice. If this is not practical, a statement will be included that the identity of the expert will be provided, upon request.
7. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit determination and a copy will be provided free of charge to the Participant upon request.
8. If the Adverse Benefit Determination is based on a medical judgment (such as the Medical Necessity or Experimental or Investigational nature of the treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Procedure for Appeals

When a Participant receives an Adverse Benefit Determination, the Participant has the right to a full and fair review of the claim and Adverse Benefit Determination. More specifically, the Participant has 180 days following receipt of the notification in which to appeal the decision. The Participant must submit a written request for appeal to the Benefit Services Manager, including any written comments, documents, records, and other information relating to the claim. If the Participant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim that is in the possession of the Plan Administrator or the Benefit Services Manager.

A document, record, or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are

made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Participants; or

4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the individual's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is deemed to be filed in accordance with the procedures of the Plan, which are described in this section. It is the Participant's responsibility to submit proof that the claim for benefits is covered and payable under the Plan's provisions. Any appeal must include the following:

1. The name of the Employee/Participant;
2. The Employee's/Participant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination or the subordinate of that individual. This health care

professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

In the event of an Adverse Benefit Determination on review, the Participant will receive written or electronic notice, setting forth the specific reason or reasons for the denial, reference to the specific portions of the Summary Plan Description on which the denial is based, a statement of the Participant's right to bring an action, and the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Further, the Participant will be provided, upon request and free of charge, information regarding any voluntary appeals procedures offered by the Plan; all documents, records, and other information relevant to the individual's claim for benefits; any internal rule, guideline, protocol or other similar criterion relied upon in making the Adverse Benefit Determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.

The Plan Administrator will notify the Participant of the Plan's benefit determination on review within the following timeframes:

Pre-service and Concurrent Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Responsibility for Deciding Claims and Appeals

The Plan Administrator shall be ultimately and finally responsible for adjudicating claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to Gilsbar, Inc.; provided, however, that Gilsbar, Inc. is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Decision on Appeal to be Final

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

No suit concerning the claim may be commenced until the appeal process has been completed and the written decision on the appeal is received by the Participant, or the Plan Administrator has not given a timely response to the appeal. The covered individual has one year from that time to file suit. Suit may not be brought after the one-year period has passed.

Summary of Claims Procedure Timetables

This summary of the timetables is included for your convenience only. Details concerning any applicable time limits are contained elsewhere in this section, and we recommend that you review this section carefully for complete information regarding the timetables that apply to your claim.

Pre-Service Claims:

Notification to Participant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim	
Notification of	15 days
Response by Participant	45 days
Review of Adverse Benefit Determination	30 days

Post-Service Claims:

Notification to Participant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim	
Notification of	15 days
Response by Participant	45 days
Review of Adverse Benefit Determination	60 days

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from Gilsbar, Inc. In the event a claimant designates an authorized representative, all future

communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

Right of Recovery

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person on whose behalf such payment was made.

A covered person, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or deducted from future claims presented by the covered person for processing.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorneys' fees incurred.

Right of Subrogation and Refund

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or

- disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").
2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
 3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized.
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for

the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a claim or pursue damages against:
 - a. the responsible party, its insurer, or any other source on behalf of that party;
 - b. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c. any policy of insurance from any insurance company or guarantor of a third party;
 - d. worker's compensation or other liability insurance company; or,
 - e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:
 - a. the responsible party, its insurer, or any other source on behalf of that party;
 - b. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c. any policy of insurance from any insurance company or guarantor of a third party;
 - d. worker's compensation or other liability insurance company; or
 - e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

1. Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

1. In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

1. It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b. to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.
2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Person(s)' cooperation or adherence to these terms.

Offset

1. Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Minor Status

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

1. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

1. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

COORDINATION WITH OTHER PLANS

The Plan contains a provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a Participant is covered, so the total benefits available will not exceed one hundred percent (100%) of the Allowable Charge. The expenses for services and supplies must be covered, at least in part, by one of the coordinating plans. This provision is commonly called “coordination of benefits.” Benefits payable under other similar plans include the benefits that would have been payable had proper claim been made for them.

If this Plan provides for coverage for eligible retirees, and you are a covered retiree, and you or a Covered Dependent are entitled to Medicare coverage (whether or not you are enrolled for such coverage), this Plan will be the secondary payor and will coordinate its benefits (as described in this section) with Medicare benefits. This Plan also will be the secondary payor and will coordinate its benefits with Medicare as allowed by applicable law for Participants who are entitled to Medicare due to disability or End Stage Renal Disease.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. However, the Plan will continue to be primary on the following participants where there is no Medicare:

Allen Ardoin – Medicare Part A only
Corra Barr – Medicare Part B only
Margaret Gill – Medicare Part B only
Bennie Ruth Hall – No Medicare
Lucy Martin – No Medicare

If the Spouse of an active or retired participant is eligible for group benefits through his or her employment whether as an active employee or a retired employee and whether or not the spouse has elected coverage under that plan, this Plan will pay benefits as the secondary payor for such Spouse.

For the purposes of this coordination provision, the term “plan” means the following types of medical care benefits:

1. Coverage under a governmental plan or required or provided by law, including no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and
2. Group insurance or other coverage for a group of individuals, other than school accident-type coverage for elementary school, high school and

college students. This does not include any law or plan where benefits are provided after those provided by other plans.

In the event of a motor vehicle Accident, this Plan shall not be primary to any auto coverage such as medical, no fault, casualty or liability insurance that by its terms is immediately payable without the necessity of a finding of liability on the part of a third party. The Participant shall be responsible for identifying the motor vehicle Accident as the source of the Injury and completing any requested Accident report forms.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the Allowable Charge. No plan pays more than it would otherwise pay without this coordination provision.

A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient as an active Participant (e.g., employee, member, subscriber) or a dependent of an active Participant, rather than as an inactive Participant (e.g., COBRA beneficiary, retiree, or TRICARE participant) or a dependent of an inactive Participant, is primary and the others are secondary (if the other plan does not have this provision and, as a result, the plans do not agree on the order of benefits, this provision is ignored);
2. If a child is covered under both parents' plans, the parent whose birthday falls earlier in the Calendar Year is primary, or, if both parents have the same birthday, the plan covering the parent longer is primary; but when the parents are separated or divorced, their plans pay in this order:
 - a. the plan of the parent with custody of the child;
 - b. the plan of the Spouse of the parent with custody of the child;
 - c. the plan of the parent not having custody of the child; and
 - d. the plan of the Spouse of the parent not having custody of the child.

However, if a Qualified Medical Child Support Order (QMCSO) has established financial responsibility for the child's health care expenses, the benefits of that plan are determined first.

If none of the preceding provisions determine the order of benefits, the benefits of the plan that covered a Participant longer are determined first.

If none of the preceding provisions of this section make it able to determine which plan is primary, the Allowable Charge shall be shared equally between the plans.

TERMINATION OF COVERAGE

If a Participant's coverage terminates, the Plan will furnish him with a Certificate of Coverage for the period he was covered under the Plan. See "Certificate of Coverage" in the section entitled "DEFINITIONS."

Coverage will terminate for an employee at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;
2. Date employment terminates;
3. Date the employee ceases to be an Eligible Employee (as defined in the Highlights);
4. Date the employee chooses Medicare as his sole coverage;
5. The end of the last period for which any required contribution was received;
6. Date of the employee's death; or
7. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Coverage will terminate for a retiree at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;
2. Date the retiree ceases to be an Eligible Employee (as defined in the Highlights);
3. Date the retiree chooses Medicare as his sole coverage;
4. The end of the last period for which any required contribution was received;
5. Date of the retiree's death; or
6. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Coverage for a dependent will cease at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;
2. Date the employee's coverage terminates;
3. Date the dependent becomes eligible for coverage as an employee;
4. Date the dependent enters active service with armed forces of any country;
5. Date the dependent ceases to be an Eligible Dependent;
6. Date the dependent chooses Medicare as his sole coverage;
7. For a dependent Spouse, on the date of divorce or legal separation;
8. For a dependent child/children, the date of the child's marriage or attainment of the applicable age limit, whichever is the earliest date;
9. The end of the last period for which any required contribution was received; or
10. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Continuation of Coverage for a Surviving Spouse or a Surviving Dependent of a Deceased Covered Employee Eligible for Retirement or a Deceased Covered Retiree.

On the death of a covered retiree or a covered employee who was eligible for retirement, a covered Spouse or Child(ren) may continue to be covered under this Plan. This continuation of coverage for a Spouse and any covered dependent Children must be elected by the Spouse within 90 days following the death of the retiree or covered employee eligible for retirement. If this continuation of coverage is not elected, coverage terminates at the end of the 90-day period. The Spouse is responsible for required contributions both during and after the 90-day period following the covered employee's or retiree's death.

Coverage for such surviving dependent(s) will end on the earliest of the following:

1. The end of the period for which any required contribution was made;

2. The date the Spouse is eligible to be covered by another group health plan;
3. The date the Spouse remarries;
4. The date a dependent Child no longer meets the Plan's definition of an Eligible Dependent;
5. The date the Plan terminates.

This is an exception to provisions elsewhere in the Plan for an Eligible Dependent and Termination of Coverage.

An employee or dependent whose coverage has terminated as described here may have rights to the continued coverage described in the next section, Continuation of Benefits.

CONTINUATION OF BENEFITS

If a Covered Employee ceases active employment, participation may be continued as described below:

For temporary layoff or authorized leave of absence: up to 2 Calendar Months

For disability: up to 12 months

Coverage will be continued pursuant to procedures adopted by the Plan Administrator and applied on a basis uniformly applicable to all employees similarly situated.

Where coverage is continued under these provisions, it shall not be in addition to the continuation period required under the Family and Medical Leave Act, but shall run concurrently with FMLA leave.

Reinstatement of Coverage

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period or Pre-existing Conditions provision provided he meets all the other requirements of the definition of an Eligible Employee. If there is a break in coverage that is a Significant Break in Coverage, the Plan's Pre-existing Condition exclusion will apply (see "Pre-existing Condition" in Highlights). Participants whose coverage is reinstated under this provision will receive credit for any portion of the Calendar Year deductible and other cost sharing amounts that were met for that year while previously covered under the Plan. Benefit maximums for such Participants will be reduced by any amount paid by the Plan while the Participants were previously covered.

Continuation During Family and Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") requires employers to provide up to 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This Plan will comply with the law at all times. Please see the Plan Administrator for details of the FMLA policy adopted by the Employer when you need to take FMLA leave.

COBRA Continuation of Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended

("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Employee. Coverage will end in certain instances, including if you or your dependents fail to make timely payment of premiums. You should check with your employer to see if COBRA applies to you and your dependents.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced;
3. Your Spouse's employment ends for any reason other than his or her gross misconduct;

4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;
2. The parent-Covered Employee's hours of employment are reduced;
3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile to (225) 928-4677:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her Spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at some time before the 60th day of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Insurance Committee of the Assessors' Insurance Fund dba Louisiana
Assessors' Association
Plan Administrator
3060 Valley Creek Drive
Baton Rouge, Louisiana 70808
(225) 928-8886

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;
2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the date you have provided the notice. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until you have provided a copy of the decree of divorce or legal separation or the SSA's determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the Participant is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the Participant an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to

Medicare,” the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee’s (or former employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee’s hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee’s hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee may be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and dependent children in your

family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An extra fee may be charged for this extended COBRA Continuation Coverage.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules). However, a Qualified Beneficiary who becomes covered under a group health plan which has a Pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a Pre-existing condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered)

within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

Insurance Committee of the Assessors' Insurance Fund dba Louisiana
Assessors' Association
Plan Administrator
3060 Valley Creek Drive
Baton Rouge, Louisiana 70808
(225) 928-8886

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

USERRA Continuation of Coverage

May I continue participation while I am absent under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your Covered Dependents, where:

1. They were Participants in the Plan immediately prior to your leave of absence for uniformed service; and
2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

1. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;
2. The cumulative length of this absence and all previous absences with your Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and
3. You comply with the notice requirements set forth in “When will coverage continued through USERRA terminate?”

The law requires your Employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?

The cost of continuing your coverage will be:

1. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;
2. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to apply for, or return to, work for your Employer following completion of your leave. You must notify your Employer of your intent to return to employment within:
 - a. For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine

your fitness to perform service in the uniformed service, by reporting to the Employer:

- i. Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or
 - ii. If reporting within such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.
- b. For leaves of 30 to 180 days, by submitting an application for reemployment with your Employer:
- i. Not later than 14 days after completing uniformed service; or
 - ii. If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.
- c. For leaves of more than 180 days, by submitting an application for reemployment with your Employer not later than 90 days after completing uniformed service.
- d. If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances; or
- i. For elections before December 10, 2004, 18 months from the date your leave began.
 - ii. For elections on or after December 10, 2004, 24 months from the date your leave began.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

How will my coverage be reinstated on return from USERRA leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your Employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your Employer.

PLAN ADMINISTRATION

The Plan Administrator

The Plan Administrator has retained the services of Gilsbar, Inc., as the Benefit Services Manager to provide certain claims processing and other ministerial services, which the Benefit Services Manager may further delegate to others. The Plan Administrator's relationship with Gilsbar, Inc. is governed by the Benefit Services Management Agreement. The Benefit Services Manager has no responsibility or obligation to Plan Participants, but only to the Plan and the Plan Administrator, as set forth in the Benefit Services Management Agreement.

An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Medically Necessary or Experimental and what charges are Reasonable and Customary), to decide disputes which may arise relative to a covered person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a covered person's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a benefit services manager to pay claims;
9. To perform all necessary reporting;
10. To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amendment and Termination

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of covered persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Expenses

All claims, expenses, or charges for the administration and operation of the Plan will be paid by the Plan and the trust, if any, that funds the Plan, or in the absence of a trust, by the Employer, as the Plan Sponsor.

Notices

All payments or notices of any kind to an employee, Participant, beneficiary or Plan official may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been (a) duly delivered on the date post-marked, and (b) duly received three calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each Participant must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

Invalidity

In the event that any provision in this Plan is deemed to be invalid or unenforceable, no other provision of this Plan shall be affected.

Other Statements

This written document and any later amendments to it constitute the complete and only statement of the Plan and cannot be changed by any oral or other written statement regarding the Plan.

HIPAA PRIVACY

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
2. Modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as Required by Law (as defined in the Privacy Standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee Benefits Plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

Executive Director

Appropriate personnel of Administration

- The access to and use of PHI by the individuals described above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing,

auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Benefit Services Manager, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

HIPAA SECURITY

Effective April 20, 2005 (April 20, 2006 for small health plans as defined by 45 C.F.R. § 160.103), the following section will be added to the Plan. It is intended to bring the Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association Employee Benefits Plan ("Plan") into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information.

Accordingly, the following is hereby included in the Plan effective on the applicable date shown above:

1. Definitions

Electronic Protected Health Information – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Security Incident – The term "Security Incident" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware as described below:
 - Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis at renewal, or more frequently upon the Plan's request.

OTHER INFORMATION

Plan Name

Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association Employee Benefits Plan

Plan Number

501

SFP Number

S-2601

State of Organization

Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association is organized under the laws of the State of Louisiana.

Plan Sponsor

Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association
3060 Valley Creek Drive
Baton Rouge, Louisiana 70808
(225) 928-8886

Tax Identification Number

72-6014133

Plan Administrator

Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association
3060 Valley Creek Drive
Baton Rouge, Louisiana 70808
(225) 928-8886

Plan Affiliates/Subsidiaries

None

Benefit Services Manager

Gilsbar, Inc.
P.O. Box 998
Covington LA 70434
Telephone (985) 892-3520 or (800) 445-7227
Fax (985) 898-1500

Type of Plan and Administration

This Plan is a self-funded group medical cost indemnity plan; claims are processed by a claims payment company (the Benefit Services Manager), separate from the Plan Sponsor but under the direction of the Plan Administrator.

Plan Year Ends

December 31

Plan Cost

Employer shares the cost of employee and dependent coverage under this Plan with the Covered Employees.

The level of any employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of employee contributions.

Benefits

Plan benefits are provided by Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association.

Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Plan is Not an Employment Contract

The Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement, or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement which may be made by the Employer with the bargaining representatives of any employees.

Effective Date

This Plan has been adopted by Insurance Committee of the Assessors' Insurance Fund dba Louisiana Assessors' Association effective January 1, 2009.